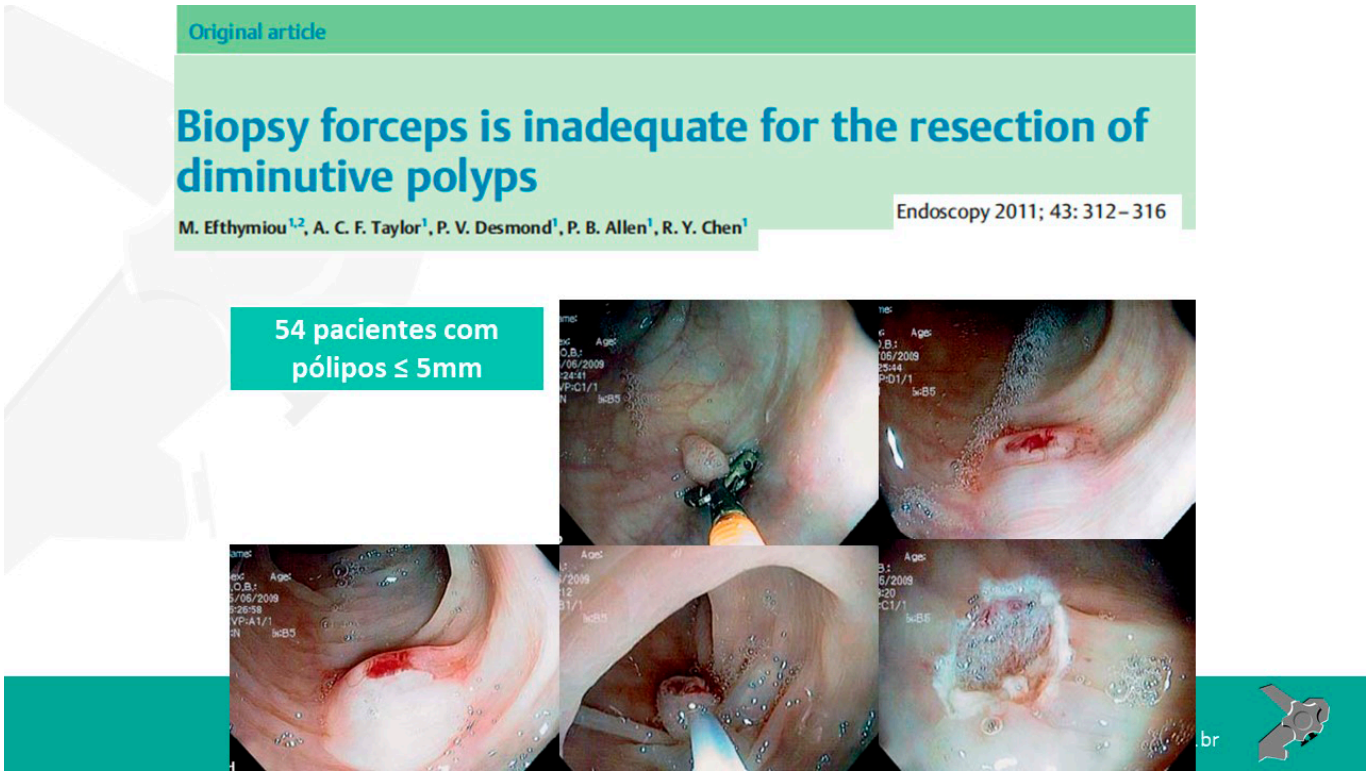
https://www.youtube.com/watch?v=JcHTQRs6mnE

Slides apresentados


Original article
Biopsy forceps is inadequate for the resection of diminutive polyps
M. Efthymiou[1,2], A. C. F. Taylor[1], P. V. Desmond[1], P. B. Allen[1], R. Y. Chen[1]
Endoscopy 2011; 43: 312–316
54 pacientes com pólipos ≤ 5mm

Original article

Biopsy forceps is inadequate for the resection of diminutive polyps

Endoscopy 2011; 43: 312–316

RESSECÇÃO INCOMPLETA	
Adenomas	38 %

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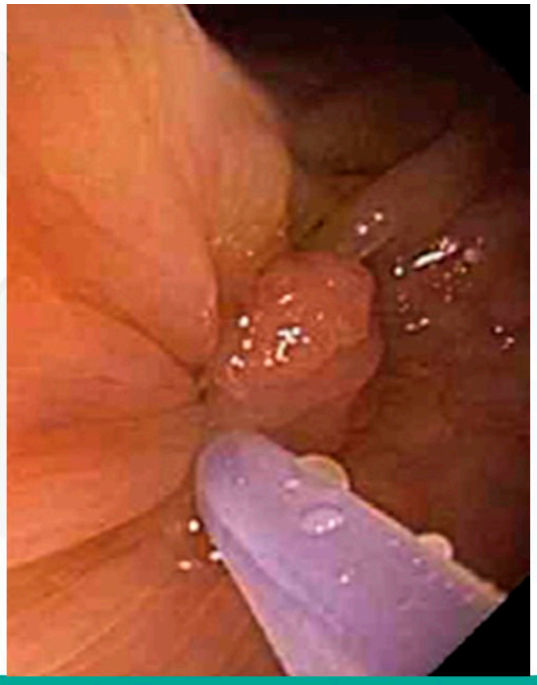

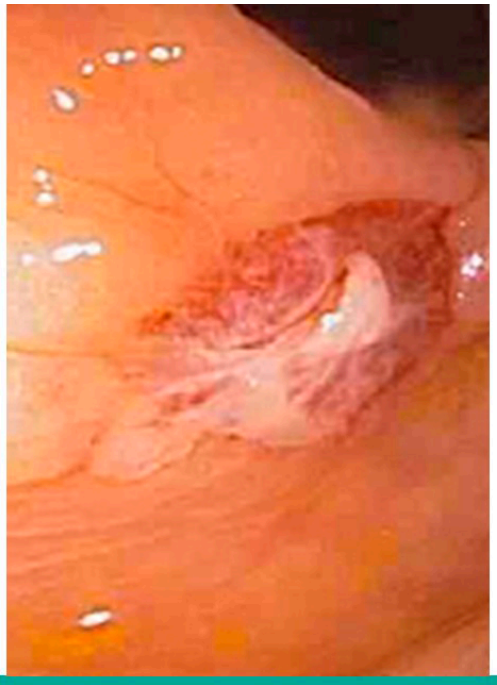

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Entra IVAN
O que fazer para diminuir lesão residual?

Resposta: Alça a frio

Mostrar a técnica (se possível com vídeo)

Mostrar a melhor evidência atual comprovando a superioridade da cold snare

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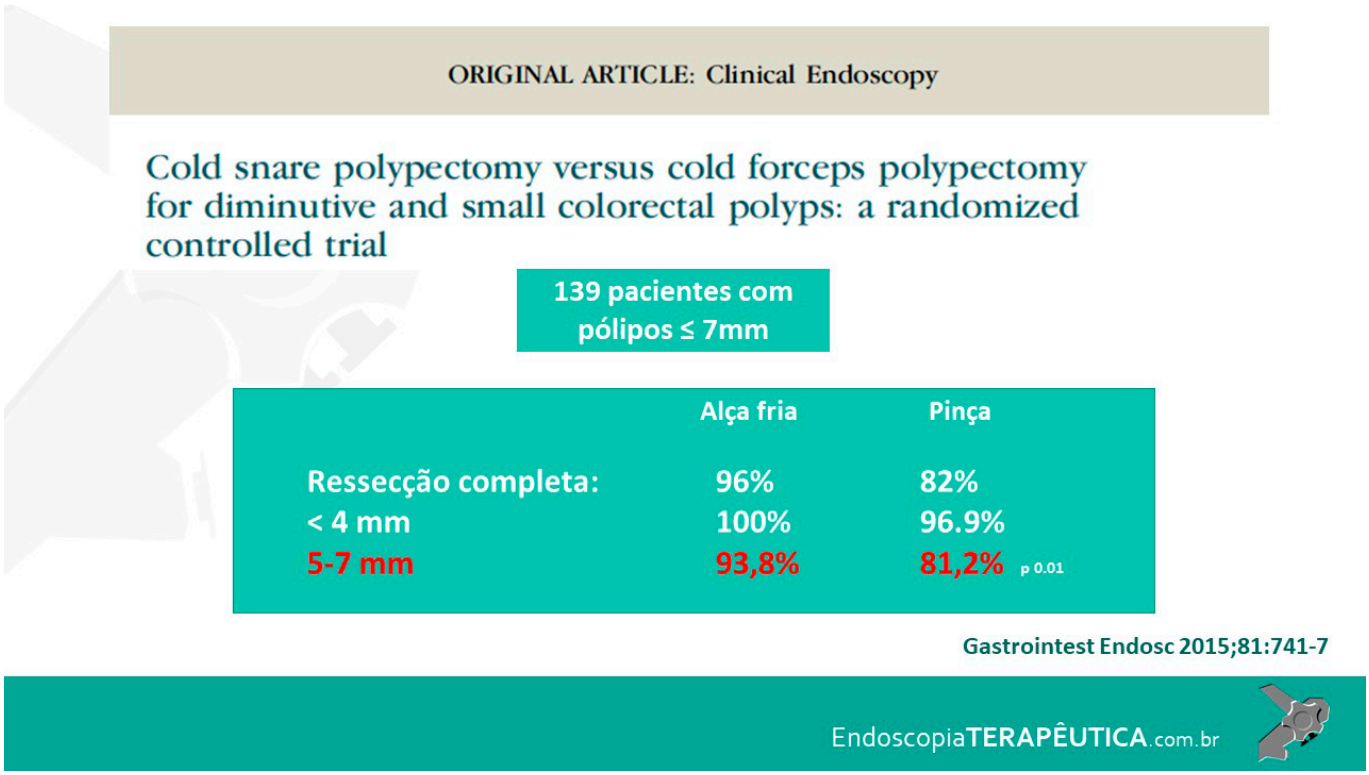
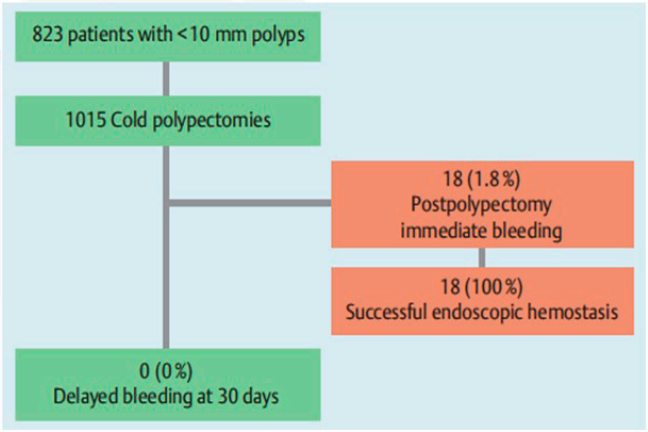
Hewett DG. Gastrointest Endosc. 2015 Oct;82(4):693-6.


ORIGINAL ARTICLE: Clinical Endoscopy
Cold snare polypectomy versus cold forceps polypectomy for diminutive and small colorectal polyps: a randomized controlled trial
139 pacientes com pólipos ≤ 7mm
Alça fria
Pinça
Ressecção completa:
96%
82%
< 4 mm
100%
96.9%
5-7 mm
93,8%
81,2%
p 0.01
Gastrointest Endosc 2015;81:741-7
EndoscopiaTERAPÊUTICA.com.br

Safety of cold polypectomy for < 10 mm polyps at colonoscopy: a prospective multicenter study

Endoscopy. 2012 Jan;44(1):27-31.



8,7% pólipos< 5mm
adenomas avançados

Fatores de risco para sangramento
- **-Uso de antiagregantes plaquetários**
- **-Tamanho do pólipos**

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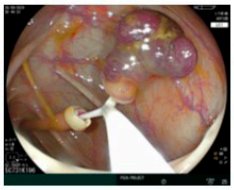
TO CLIP or NOT TO CLIP?



AUTOR	TIPO DE ESTUDO	N	LESÕES	RESULTADO
Forbes N (2018) J Can Ass gastroenterol	Metanálise	5405	pólipos	👎
Takuya I (2020) J Gastroenterol Hepatol	RCT	2960	Pólipos < 20 mm	👎
Forbes N (2020) Am J Gastroenterol	Coorte retrospectiva	8366	pólipos	👎
Spadaccini M (2020) Gastroenterology	Metanálise	7197	Pólipos > 20 mm Pólipos proximais	👍 👍

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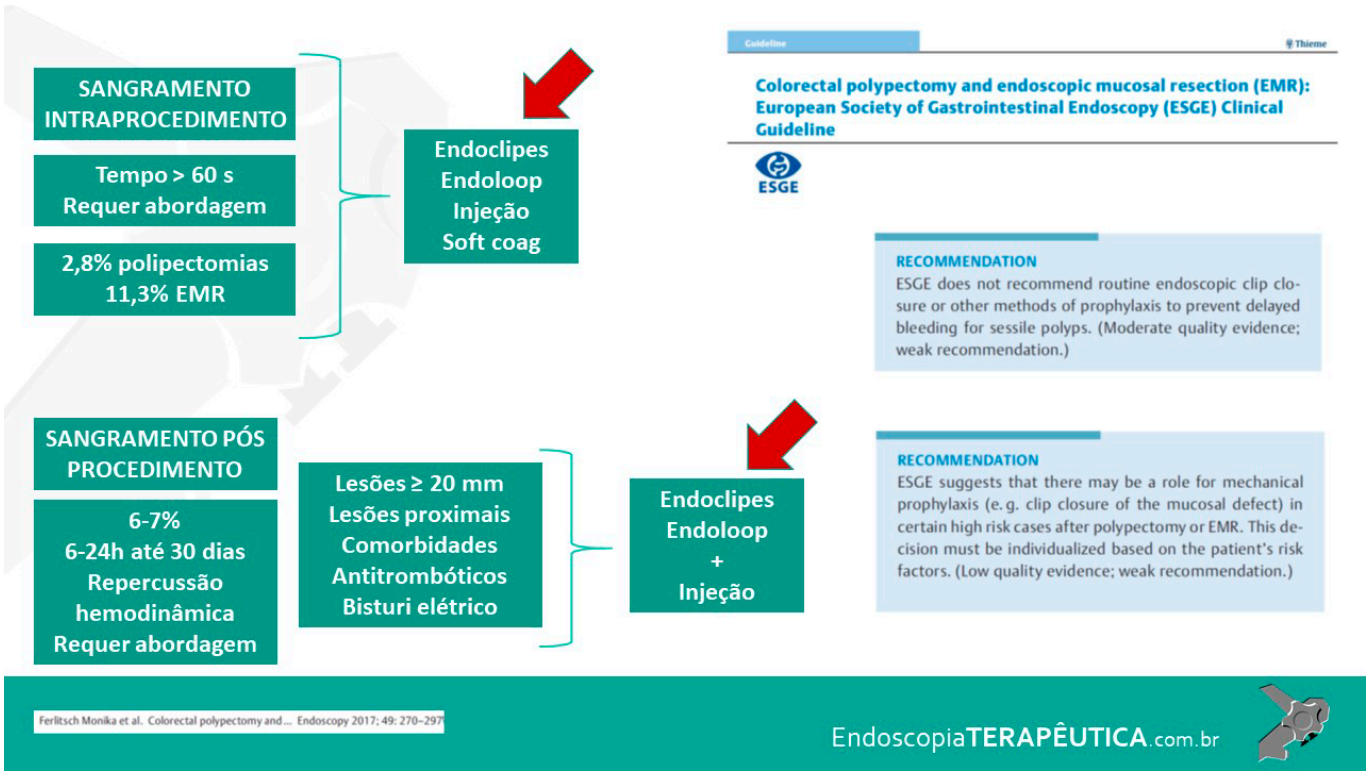
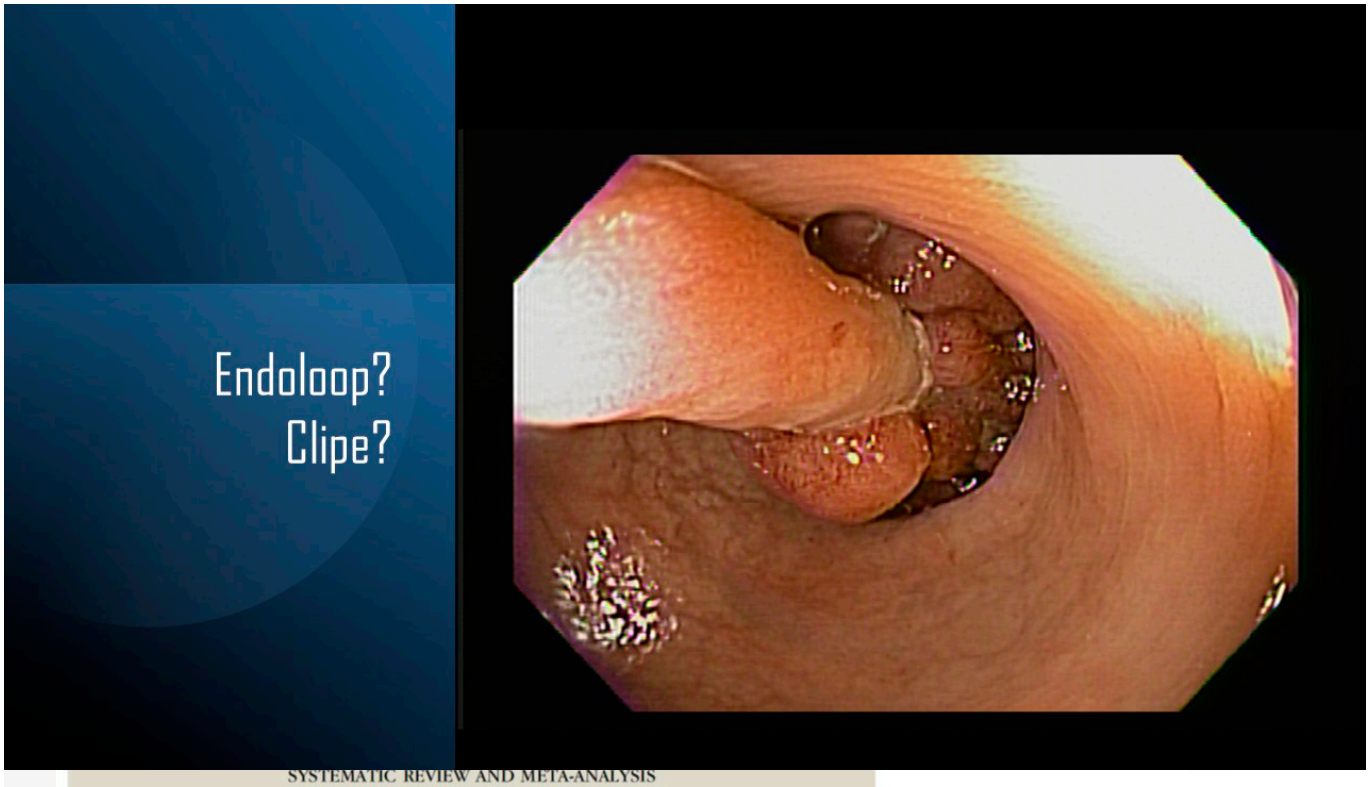

SANGRAMENTO INTRAPROCEDIMENTO
Tempo > 60 s
Requer abordagem
2,8% polipectomias
11,3% EMR
Endoclipes
Endoloop
Injeção
Soft coag
SANGRAMENTO PÓS PROCEDIMENTO
6-7%
6-24h até 30 dias
Repercussão hemodinâmica
Requer abordagem
Lesões ≥ 20 mm
Lesões proximais
Comorbidades
Antitrombóticos
Bisturi elétrico
Endoclipes
Endoloop
+
Injeção
Guideline
Thieme
Colorectal polypectomy and endoscopic mucosal resection (EMR): European Society of Gastrointestinal Endoscopy (ESGE) Clinical Guideline
ESGE
RECOMMENDATION
ESGE does not recommend routine endoscopic clip closure or other methods of prophylaxis to prevent delayed bleeding for sessile polyps. (Moderate quality evidence; weak recommendation.)
RECOMMENDATION
ESGE suggests that there may be a role for mechanical prophylaxis (e.g. clip closure of the mucosal defect) in certain high risk cases after polypectomy or EMR. This decision must be individualized based on the patient's risk factors. (Low quality evidence; weak recommendation.)
Ferlitsch Monika et al. Colorectal polypectomy and ... Endoscopy 2017; 49: 270–297
EndoscopiaTERAPÊUTICA.com.br

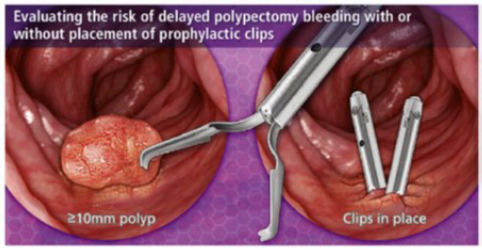


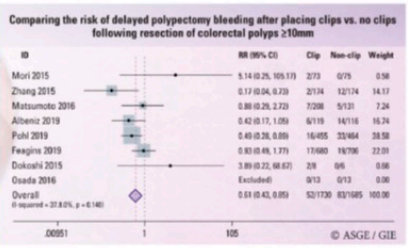
SYSTEMATIC REVIEW AND META-ANALYSIS

Prophylactic clips to reduce delayed polypectomy bleeding after resection of large colorectal polyps: a systematic review and meta-analysis of randomized trials (CME)

Binrui Chen, MD,[1,*] Lijun Du, MD, PhD,[1,*] Liang Luo, MD,[1] Mengsha Cen, MD,[1] John J. Kim, MD, MS[2]

Hangzhou, China; Loma Linda, California, USA





8 estudos
Pólipos > 10 mm
Sgto tardio → 3.9% (IC95% 2.4-5.4)
Clipes reduziram risco de sgto
NNT 52

Pólipos > 20 mm
RR 0,54 (IC 95% 0.35-0.84) NNT 30

Lesões não pediculadas
RR 0,54 (IC 95% 0.36-0.81) NNT 39

Lesões proximais ao âng hepático
RR 0,49 (IC 95% 0.31-0.78) NNT 25

(Gastrointest Endosc 2021;93:807-15.)

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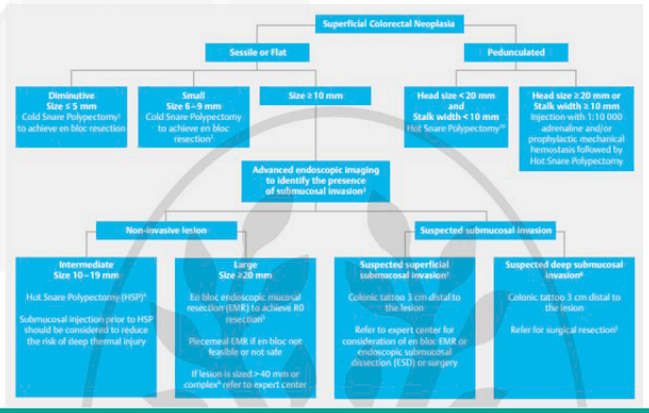
ESGE Guideline 2017



ASGE Guideline 2020

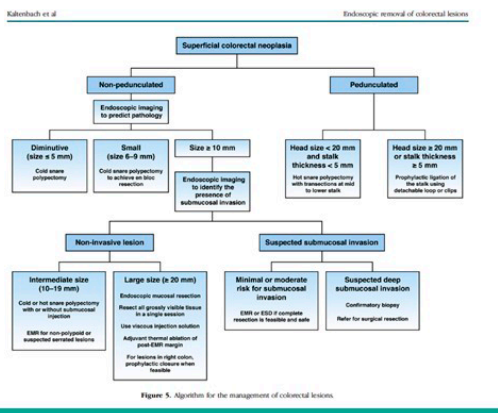


Figure 5. Algorithm for the management of colorectal lesions.

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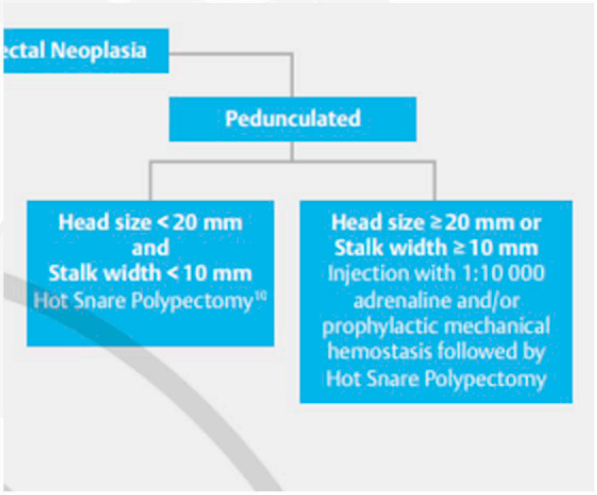
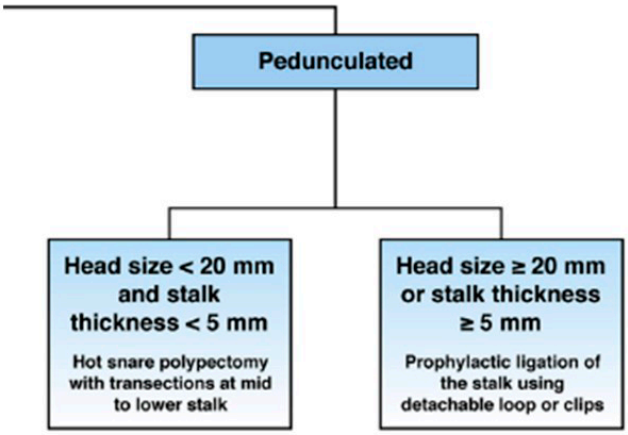

ctal Neoplasia
Pedunculated
Head size < 20 mm
and
Stalk width < 10 mm
Hot Snare Polypectomy[10]
Head size ≥ 20 mm or
Stalk width ≥ 10 mm
Injection with 1:10 000
adrenaline and/or
prophylactic mechanical
hemostasis followed by
Hot Snare Polypectomy


Pedunculated
Head size < 20 mm and stalk thickness < 5 mm
Hot snare polypectomy with transections at mid to lower stalk
Head size ≥ 20 mm or stalk thickness ≥ 5 mm
Prophylactic ligation of the stalk using detachable loop or clips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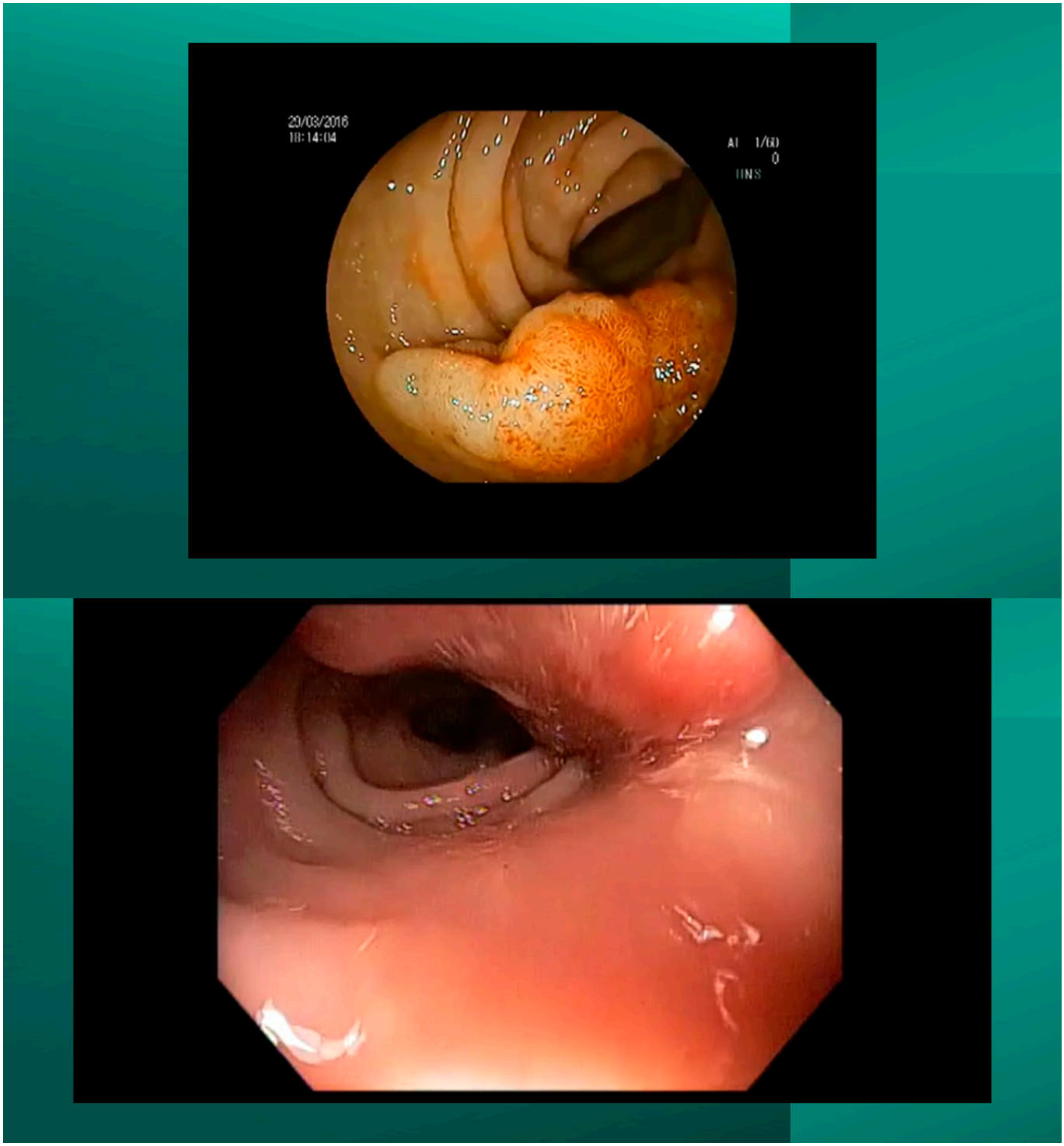
29/03/2016
18:14:04
INS

Variable included	N Patients	% patients with recurrence	Adjusted HR (95% CI)	Adjuste p value
Lesion histology				
SSA/P	190	6.8	1	0.097
Adenoma	1018	18.4	1.7 (0.9 to 3.0)	
Size group (mm)				
≤25	385	6.5	1	
26–35	332	14.8	1.7 (1.1 to 2.9)	0.031
>35	488	25.8	2.5 (1.6 to 4.0)	<0.001
Paris 0-Is component				
No	663	10.1	1	
Yes	545	24.4	2.1 (1.6 to 2.9)	<0.001
Incomplete resection				
No	1012	14.2	1	
Yes	195	28.2	1.7 (1.2 to 2.3)	0.001
Piecemeal resection				
No (En bloc)	191	3.7	1	
Yes	1011	18.8	3.4 (1.5 to 7.6)	0.002
Intraprocedural bleeding				
No	1042	14.9	1	
Yes	166	27.1	1.5 (1.1 to 2.2)	0.013
Age group (years)				
<70	660	14.5	1	
≥70	544	19.1	1.4 (1.1 to 1.8)	0.022

Pellise M, et al. Gut 2016;0:1–10. doi:10.1136/gutjnl-2015-310249

Endoscopic mucosal resection for large serrated lesions in comparison with adenomas: a prospective multicentre study of 2000 lesions

Maria Pellise,[1] Nicholas G Burgess,[1,2] Nicholas Tutticci,[1] Luke F Hourigan,[3,4] Simon A Zanati,[5,6] Gregor J Brown,[5,7] Rajvinder Singh,[8] Stephen J Williams,[1] Spiro C Raftopoulos,[9] Donald Ormonde,[9] Alan Moss,[6] Karen Byth,[10,11] Heok P'Ng,[12] Hema Mahajan,[12] Duncan McLeod,[12] Michael J Bourke[1,2]

O PROBLEMA DA RECIDIVA

CONCEITOS
Lesão residual → < 1 ano
Recidiva → > 1 ano

RECIDIVA

- ✓ Insegurança cri
- ✓ Seguimento pós
- ✓ Necessidade de cirurgia
- ✓ Quais são os fatores envolvidos?

SOLUÇÃO = EVITAR RESSECÇÃO EM MÚLTIPLOS FRAGMENTOS!

ORIGINAL ARTICLE

Risk factors for early and late adenoma recurrence after advanced colorectal endoscopic resection at an expert Western center

Andrew Emmanuel, MBChB, MS,[1,2] Christo Lapa, MD,[1] Anil Ghosh, MBBS, PhD,[1] Shraddha Gulati, MBBS,[2] Margaret Burt, RN,[1,2] Bu'Hussain Hayee, PhD,[2] Amyn Haji, MA, MSc, MD[1,2]
London, United Kingdom

Figure 2. Flow diagram showing the incidence of first-detected recurrence at successive periods of surveillance.

8,3% recidiva
620 ressecções

ecemeal OR 13 (p 0.01)
o argônio OR 2,4 (p 0.01)
75% circuunferência OR
5 (p 0.001)

Piecemeal OR 4,4 (p 0.04)
> 60 mm OR 6,3 (p 0.001)

Gastrointest Endosc 2019

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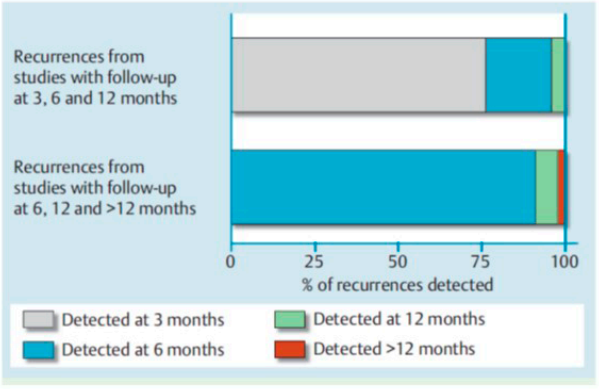
of nonpedunculated colorectal lesions: systematic review and meta-analysis

Authors: Tim D. G. Belderbos, Max Leenders, Leon M. G. Moons, Peter D. Siersema
Institution: Department of Gastroenterology and Hepatology, University Medical Centre Utrecht, Utrecht, The Netherlands



Belderbos Tim DG et al. Recurrence after EMR of nonpedunculated colorectal lesions ... Endoscopy 2014; 46: 388–400

Endoscopic Removal of Colorectal Lesions—Recommendations by the US Multi-Society Task Force on Colorectal Cancer

Tonya Kaltenbach,[1] Joseph C. Anderson,[2,3,4] Carol A. Burke,[5] Jason A. Dominitz,[6,7] Samir Gupta,[8,9] David Lieberman,[10] Douglas J. Robertson,[2,3] Aasma Shaukat,[11,12] Sapna Syngal,[13] Douglas K. Rex[14]

This article is being published jointly in Gastrointestinal Endoscopy, Gastroenterology, and The American Journal of Gastroenterology.

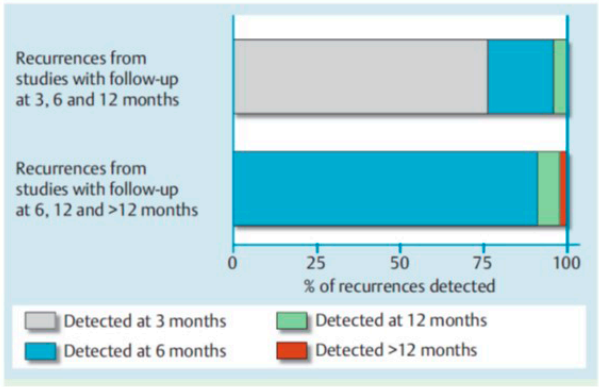
Statement 4: surveillance

- We recommend intensive follow-up schedule in patients after piecemeal EMR (lesions ≥20 mm) with the first surveillance colonoscopy at 6 months, and the intervals to the next colonoscopy at 1 year and then 3 years. (Strong recommendation, moderate-quality evidence)

EndoscopiaTERAPÊUTICA.com.br

Local recurrence after endoscopic mucosal resection of nonpedunculated colorectal lesions: systematic review and meta-analysis

Authors: Tim D. G. Belderbos, Max Leenders, Leon M. G. Moons, Peter D. Siersema
Institution: Department of Gastroenterology and Hepatology, University Medical Centre Utrecht, Utrecht, The Netherlands



Belderbos Tim DG et al. Recurrence after EMR of nonpedunculated colorectal lesions ... Endoscopy 2014; 46: 388–400

US MULTI-SOCIETY TASK FORCE

Endoscopic Removal of Colorectal Lesions—Recommendations by the US Multi-Society Task Force on Colorectal Cancer

Tonya Kaltenbach,[1] Joseph C. Anderson,[2,3,4] Carol A. Burke,[5] Jason A. Dominitz,[6,7] Samir Gupta,[8,9] David Lieberman,[10] Douglas J. Robertson,[2,3] Aasma Shaukat,[11,12] Sapna Syngal,[13] Douglas K. Rex[14]

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Statement 4: surveillance

- We recommend intensive follow-up schedule in patients after piecemeal EMR (lesions ≥20 mm) with the first surveillance colonoscopy at 6 months, and the intervals to the next colonoscopy at 1 year and then 3 years. (Strong recommendation, moderate-quality evidence)
- We recommend against the use of ablative techniques (eg, argon plasma coagulation [APC], snare tip soft coagulation) on endoscopically visible residual tissue of a lesion, as they have been associated with an increased risk of recurrence. (Strong recommendation, moderate-quality evidence)
- We suggest the use of adjuvant thermal ablation of the post-EMR margin, where no endoscopically visible adenoma remains despite meticulous inspection. There is insufficient evidence to recommend a specific modality (ie, APC, snare tip soft coagulation) at this time. (Conditional recommendation, moderate-quality evidence)

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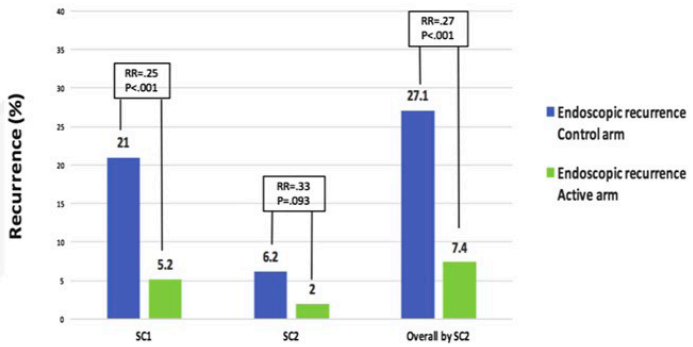
Thermal Ablation of Mucosal Defect Margins Reduces Adenoma Recurrence After Colonic Endoscopic Mucosal Resection

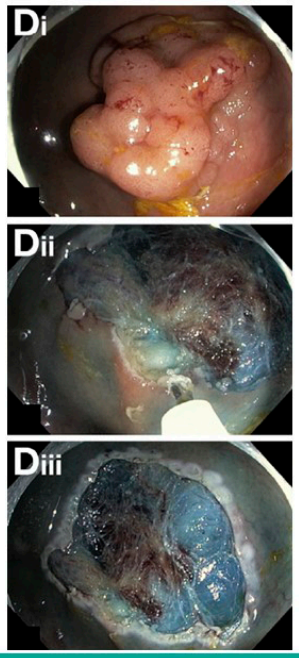
Amir Klein,[1,*] **David J. Tate**,[1,2,*] Vanoo Jayasekeran,[1] Luke Hourigan,[3,4] Rajvinder Singh,[5] Gregor Brown,[6] Farzan F. Bahin,[1,2] Nicholas Burgess,[1,2] Stephen J. Williams,[1] Eric Lee,[1] Naaz Sidhu,[1] Karen Byth,[2] and Michael J. Bourke[1,2]

[1]Department of Gastroenterology and Hepatology, Westmead Hospital, Sydney, NSW, Australia; [2]Westmead Clinical School, University of Sydney, NSW, Australia; [3]Department of Gastroenterology and Hepatology Princess Alexsandra Hospital, Brisbane, QLD, Australia; [4]Gallipoli Medical Research Institute, School of Medicine, The University of Queensland, Greenslopes Private Hospital, Brisbane, QLD, Australia; [5]Department of Gastroenterology and Hepatology Lyell McEwin Hospital, Adelaide, SA, Australia; and [6]Department of Gastroenterology and Hepatology Alfred Hospital, Melbourne, VIC, Australia

Primary outcome - Endoscopic recurrence at follow-up



- SC1 (first surveillance colonoscopy at 5-6 months); SC2 (second surveillance colonoscopy at 18 months)



SOFT COAG mode, 80W Effect 4

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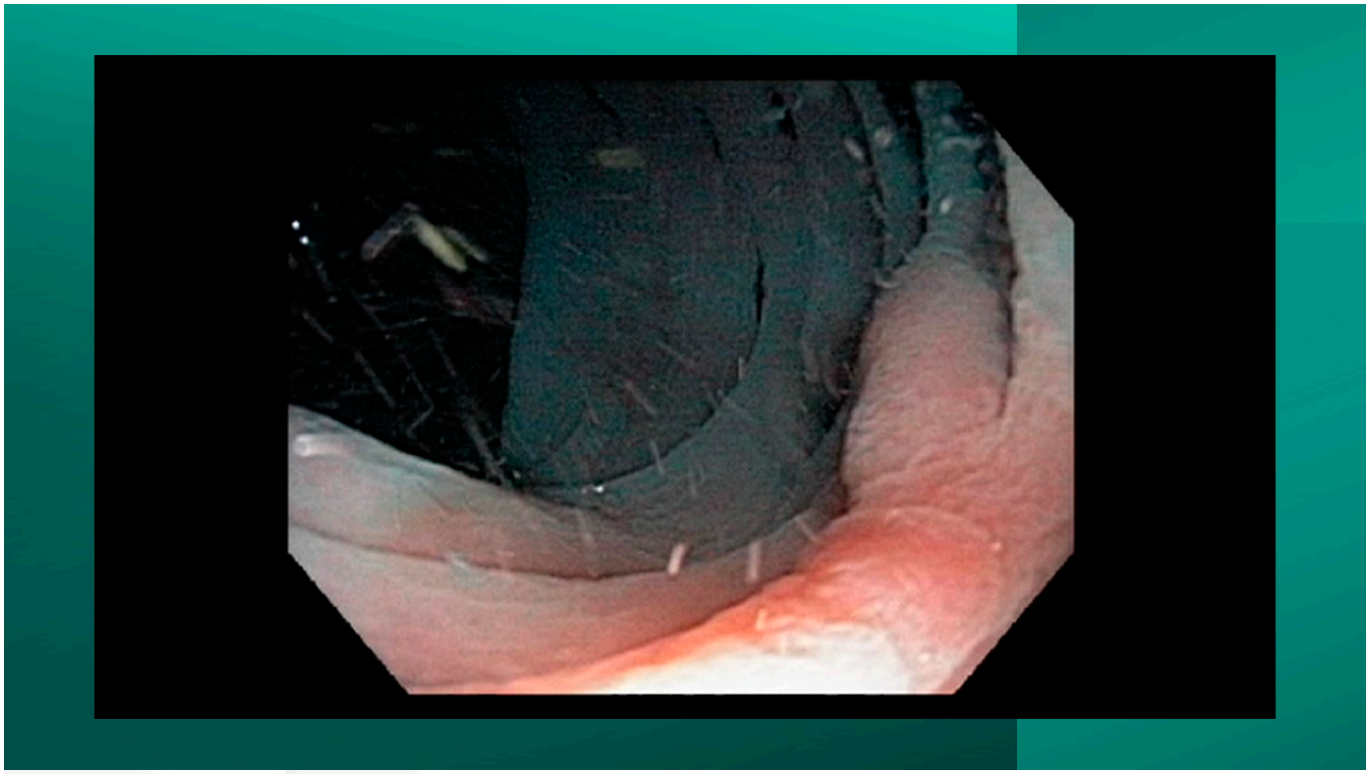
Cyrus Piraka, et al. Cold snare polypectomy for non-pedunculated colon polyps greater than 1 cm. Endosc Int Open. 2017 Mar; 5(3): E184–E189
EndoscopiaTERAPÊUTICA.com.br



UEMR - IVAN

Quais vatagens?

Diminui recidiva?

Aumenta ressecção em monobloco?

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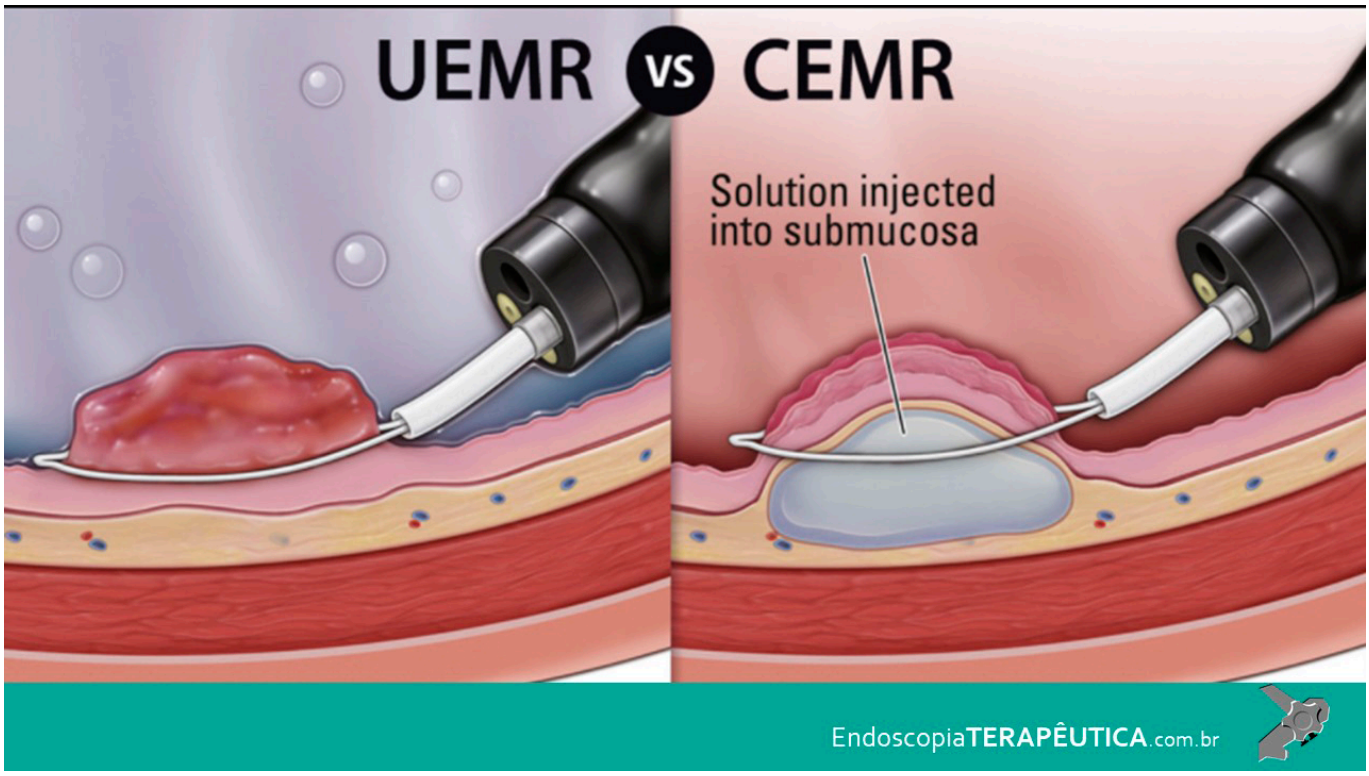
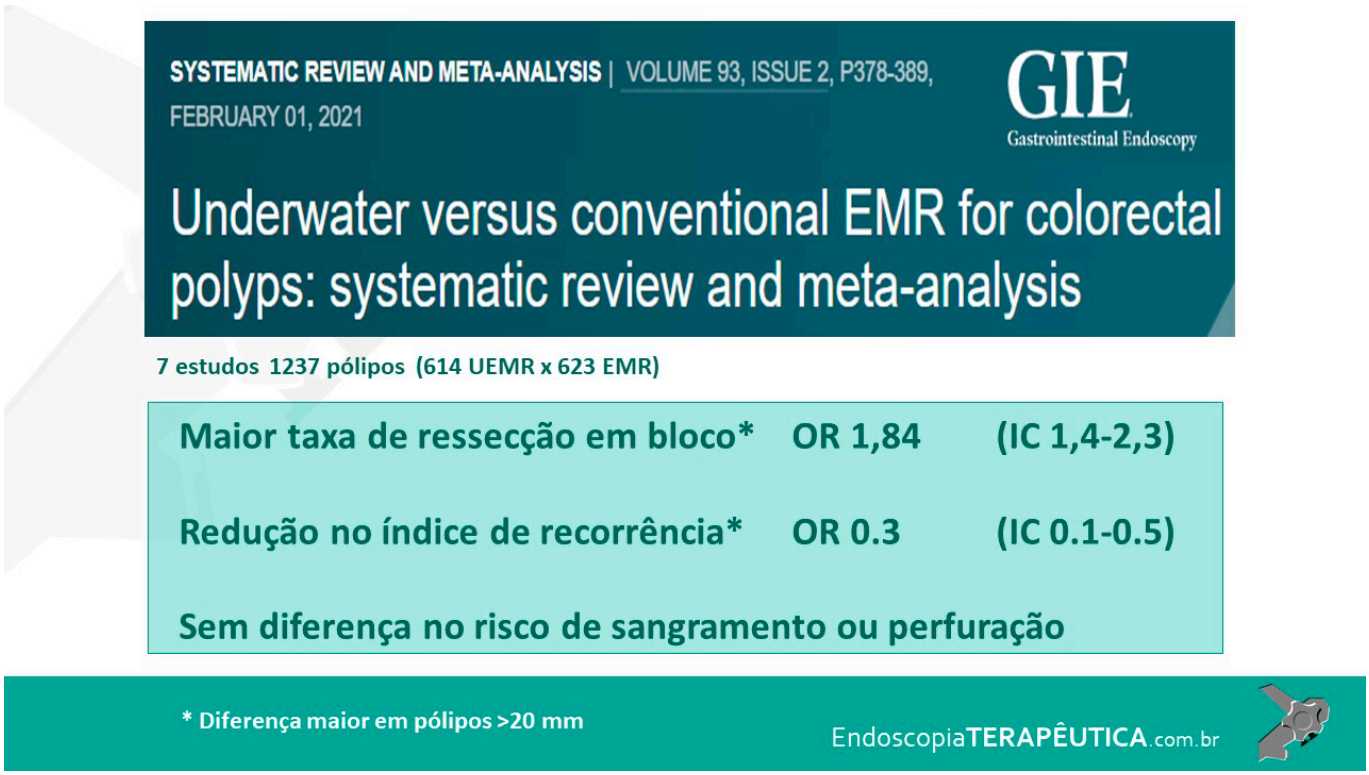

UEMR
VS
CEMR
Solution injected into submucosa
EndoscopiaTERAPÊUTICA.com.br



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