Therapeutic colonoscopy

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The most common therapeutic procedure performed at colo - noscopy is resection of colonic polyps (Figure 9.16). Retrieved specimens can be assessed for risk factors for neoplastic progres - - sion and an appropriate surveillance strategy determined (https://www .bsg.org.uk/wp-content/uploads/2019/09/201. full_.pdf). Non-pedunculated polyps up to 15 /uni00A0 mm should be removed by cheese wiring with a dedicated ‘cold’ snare. Stalked polyps can be resected using ‘hot’ snare polypectomy . thermy is used with either a ‘cut’, ‘coagulation’ or a Here, dia blended current. Postpolypectomy bleeding can be prevented - by preinjection of the stalk with adrenaline, or with application ® . of endoclips or an Endoloop

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Non-pedunculated polyps of between 10 and 19 /uni00A0 mm can be removed en bloc by EMR, which involves lifting the polyp from the muscularis propria with a submucosal injectate to prevent iatrogenic perforation (Figure 9.17). Lesions >20 /uni00A0 mm can be removed with piecemeal EMR (pEMR); on completion, thermal ablation (with either APC or coagulation) is applied to the edge of the resection site to prevent adenoma recurrence. , which is typically performed An alternative to pEMR is ESD with a knife rather than a snare. This technique involves the injection of a submucosal solution, followed by a circumfer ential incision and submucosal dissection, with coagulation of blood vessels that are encountered. This enables an en bloc resection of large polyps and superficial submucosal cancers. Although technically challenging with a steep learning curve, benefits include a more accurate histopathological assessment and lower adenoma recurrence rates. APC and alternative thermal therapies such as heater probes are also used in the treatment of symptomatic angioec - tasias of the colon (Figure 9.18). Laser photocoagulation may be used to debulk colonic tumours not suitable for resection. As with benign oesophageal strictures, TTS balloons can be - used to dilate short (<5 /uni00A0 cm) colonic strictures. The dilata - tion of sur gical anastomoses gives the most durable benefit as inflammatory strictures tend to recur even if intramucosal steroids are injected at the time of the dilatation. Finally , the colonoscopic placement of self-expanding metal stents may provide excellent palliation of inoperable malignant strictures (Figure 9.19) and may also play an invaluable role in decom - pressing an obstructed colon to allow planned as opposed to emergency surgery .

(c) Figure 9.17 Large sessile polyps (a) can be removed by endoscopic

muco

sal resection. First the polyp is raised on a bed of injected saline containing dye (b) . This ensures that there is no submucosal invasion and protects from transmural perforation. A snare is closed around the polyp (c) , which is then resected leaving a clean excision base (d) . Figure 9.18 A large angioectasia of the colon. If this results in symptomatic anaemia, it should be obliterated with argon plasma coagulation. (d)

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