Treatment of rectal polyps

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All rectal polyps should be biopsied or removed for histological analysis. A range of techniques can be used, depending on polyp size and location. The majority are less than 1 /uni00A0 cm in size, benign and amenable to endoscopic polypectomy . Polyps greater than 1 /uni00A0 cm in size have a 10% chance of malignancy . The di ffi cult polyp can be defined by a range of variables, including the number of polyps, a size greater than 15 /uni00A0 mm or a certain shape, whether with a large pedicle or a flat appearance (see Chapter 72). Endomucosal resection (EMR) and endoscopic submucosal dissection (ESD) are techniques to consider when use of biopsy forceps or a snare is not optimal. The resection plane for both EMR and ESD is the superficial submucosal layer. Both techniques utilise an injection into the submucosal layer (Figure 79.14). Importantly , if the mucosa does not lift, this may indirectly indicate deeper invasion of the lesion. A ‘non-lift’ sign may also occur because of fibrosis from previous resection attempts or tattooing (see Chapter 9). EMR is typically used for lesions up to 20 /uni00A0 mm in size, although the piecemeal resection for lesions greater than 20 /uni00A0 mm may obviate surgery at the risk of a higher recurrence rate . ESD was created to counter the shortcomings of EMR as en bloc resection allows assessment of both horizontal and (b) (d)

(a) and in /f_i ltration performed (b) to lift it from the underlying muscle layer. A (d) .

deep margins, which is not possible with a piecemeal resection (Figure 79.15). The submucosal injection is performed at the proximal border of the lesion, after which endoscopic knives are used to create an incision and dissect the submucosal layer free. ESD is informally indicated for lesions larger than 20 /uni00A0 mm, when high-grade dysplasia or superficial submucosal invasion is suspected and when other endoscopic techniques have failed. The bleeding risks for EMR and ESD are roughly similar, whether immediate or delayed, with a reported incidence of 1–10%. Larger polyps are more di ffi cult to remove by EMR and may require a transanal procedure, such as transanal endoscopic microsurgery (TEMS). Summary box 79.7 Polyps in the rectum /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF

Figure 79.15 Endoscopic submucosal dissection of a rectal polyp (courtesy of Dr Noor Mohammed, St James’s Hospital, Leeds, UK). Adenomas are the most frequent histological type Villous adenomas may be extensive and undergo malignant change more commonly than tubular adenomas All adenomas must be removed to avoid malignant change All patients must undergo colonoscopy to determine whether further polyps are present Most polyps can be removed by endoscopic techniques, but sometimes major surgery is required

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