

TUMOURS OF THE LARGE INTESTINE

Benign

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The term 'polyp' is a clinical description of any protrusion of the mucosa. It encompasses a variety of histologically different tumours (Table 77.1). Polyps can occur singly , synchronously in small numbers or as part of a polyposis syndrome. Metaplastic polyps Metaplastic or hyperplastic polyps are common and are generally considered benign. Recently certain subtypes have been recognised to have malignant potential. Sessile serrated lesions and hyperplastic polyps ≥ 10 mm in diameter are associated with KRAS / BRAF mutation that may lead to methylation of tumour-suppressing genes, dysplasia and malignancy along what is termed the 'serrated pathway'. Such polyps should be removed and follow-up colonoscopy arranged (Figure 77.1 John Law Augustine Peutz , 1886–1968, Chief Specialist for Internal Medicine, St John's Hospital, The Hague, The Netherlands. Harold Joseph Jeghers , 1904–1990, Professor of Internal Medicine, New Jersey College of Medicine and Dentistry , Jersey City , NJ, USA. - - Adenomatous polyps Adenomatous polyps are the most common polyps with malignant potential. The risk of malignancy is dependent on). histology , morphology and size. Tubular adenomas have the lowest risk, with increasing risk as villous features predominate. Sessile and particularly depressed lesions have more malignant potential than pedunculated lesions (Figure 77.2). The risk of malignant change increases with size, almost one-third of large (>3 cm) colonic adenomas will have an area of invasive malignancy . Size is easily assessed endoscopically , which, alongside pit pattern and morphological classification, aids management. If felt appropriate and safe to resect endoscopically , various techniques are available, including hot or cold snare polypectomy for the most common smaller pedunculated lesions. Larger or flatter polyps may require infiltration of a solution to 'raise' the polyp before snare resection. The area of the polyp should be tattooed to facilitate later endoscopic or laparoscopic localisation of the site of the polyp. Failure of submucosal injection to elevate a polyp is suggestive of malignancy . In these circumstances, the site should be tattooed. A biopsy should not be taken if referral for endoscopic mucosal resection or endoscopic submucosal dissection is being considered. Such techniques carry a risk of colonic perforation and should only

TABLE 77.1 Classification of intestinal polyps. Inflammatory polyps (pseudopolyps in ulcerative colitis) (see Chapter 75) Hamartomatous Peutz–Jeghers polyp Juvenile polyp Serrated polyps Hyperplastic polyp (serrated lesions) Sessile serrated lesion Sessile serrated lesion with dysplasia Traditional serrated adenomas Mixed polyp Adenoma Tubular Tubulovillous Villous Malignant polyp Adenocarcinoma Colorectal Colonoscopy at cancer 1 year No. Site check at 2–6 months and then after a further

20 mm 12 months non-pedunculated Colonoscopy colorectal polyp with Yes. complete excision One-off colonoscopy at 3 years No. Participate in bowel cancer screening programme when invited High-risk findings* Yes. One-off colonoscopy at 3 years Figure 77.1 Recommendations for polyp follow-up. *Two or more premalignant polyps including at least one advanced polyp (serrated polyp >10 mm or with dysplasia, adenoma more than 10 mm in size or with high-grade dysplasia); or five or more premalignant polyps. (Adapted from Rutter MD, East J, Rees CJ et al . British Society of Gastroenterology/Association of Coloproctology of Great Britain and Ireland/Public Health England post-polypectomy and post-colorectal cancer resection surveillance guidelines. Gut 2020; 69 : 201-23.)

be performed by an experienced endoscopist. Rectal adenomas may also be treated by endoscopic or transanal resection (see Chapter 79). Polyp surveillance After successful endoscopic removal of polyps, there is a risk of further polyp development; however, the risk of subsequent development of colorectal cancer is low . The need for and frequency of follow-up surveillance endoscopy is dependent on polyp morphology , number and size, age and comorbidity of the patient, presence of a family history and accuracy and completeness of the index test. These factors allow polyps to be divided into low , intermediate and high risk. Recent guidelines (Figure 77.1) published by the British Society of Gastroenterology have identified patients at high risk needing follow-up colonoscopy as those with either: two or more premalignant polyps, including at least one advanced colorectal polyp (defined as a serrated polyp ≥ 10 mm in size or containing any grade of dysplasia or as an adenoma ≥ 10 mm in size or containing high-grade dysplasia); or five or more premalignant polyps.

Figure 77.2 Pedunculated polyp of the large intestine showing tubulovillous changes at the apex and normal colonic mucosa at the base (courtesy of Dr Philip Kaye, Nottingham University Hospitals, Nottingham, UK).

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