45 CURSO DE AVANCES EN GASTROENTEROLOGÍA
"BUENAS PRÁCTICAS EN GASTROENTEROLOGÍA"
23-25 de Julio 2025
HOTEL INTERCONTINENTAL SANTIAGO
AV. VITACURA 2885, LAS CONDES

SOCIEDAD INTERAMERICANA DE ENDOSCOPIA DIGESTIVA
SIED
Uniendo la Endoscopía de las Américas

SOU+
SANTA CASA DE CARIDADE DE BAGÉ

MANEJO ENDOSCÓPICO DE PÓLIPOS DE COLON Y RECTO

Carlos Eduardo Oliveira dos Santos
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Speaker de la Fujifilm Co

TÉCNICAS DE RESECCIÓN

POLIPECTOMIA 1

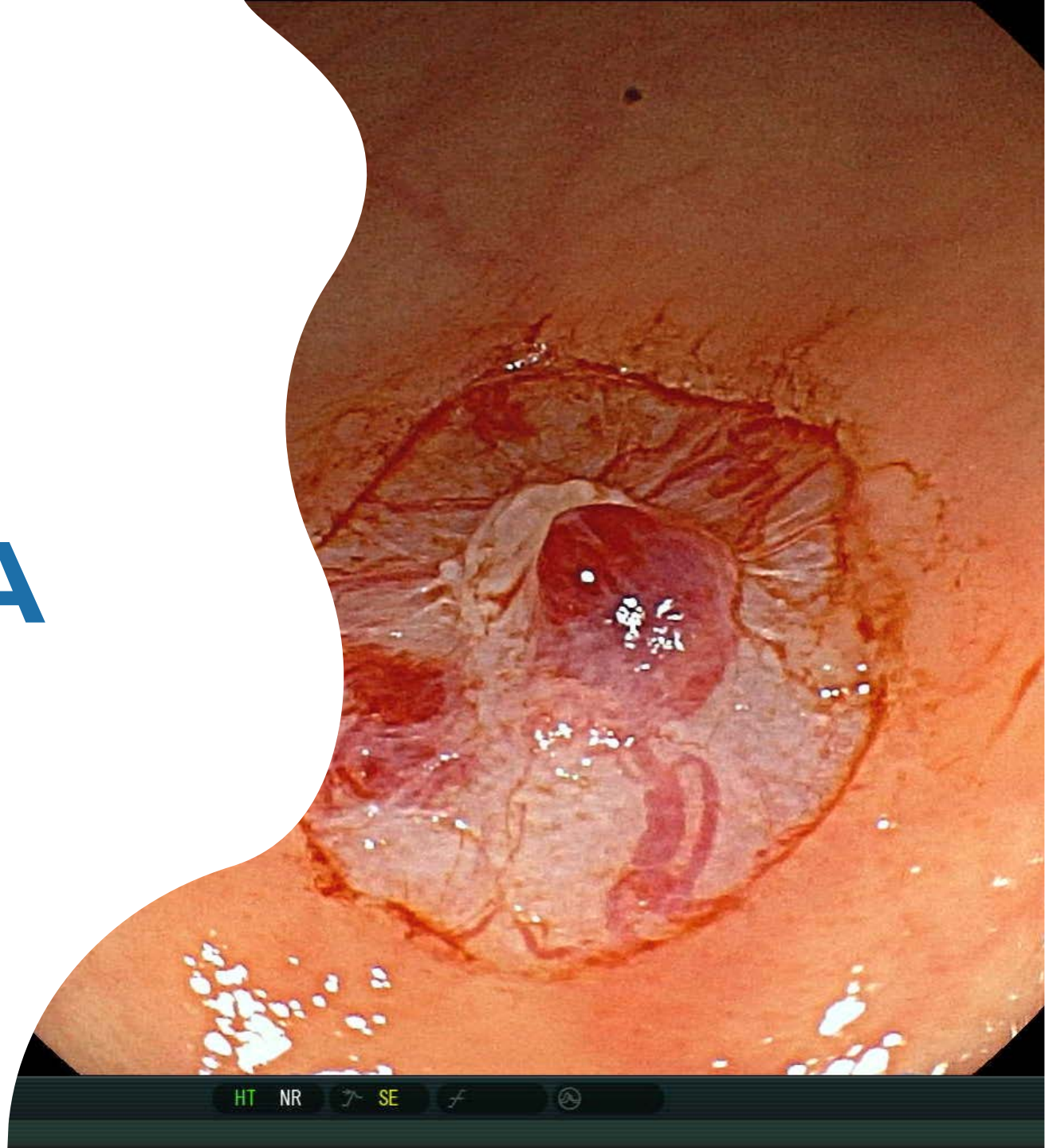
MUCOSECTOMIA 2

EFTR 4

ESD 3

AVULSIÓN ABLACIÓN 5

POLIPECTOMIA



Guideline

Thieme

Colorectal polypectomy and endoscopic mucosal resection: European Society of Gastrointestinal Endoscopy (ESGE) Guideline – Update 2024

ESGE

RECOMMENDATION

ESGE recommends cold snare polypectomy for the removal of diminutive polyps (≤ 5 mm).
Strong recommendation, high quality of evidence.

ESGE recommends including a clear margin of normal tissue (1–2 mm) surrounding the polyp.
Strong recommendation, high quality of evidence.

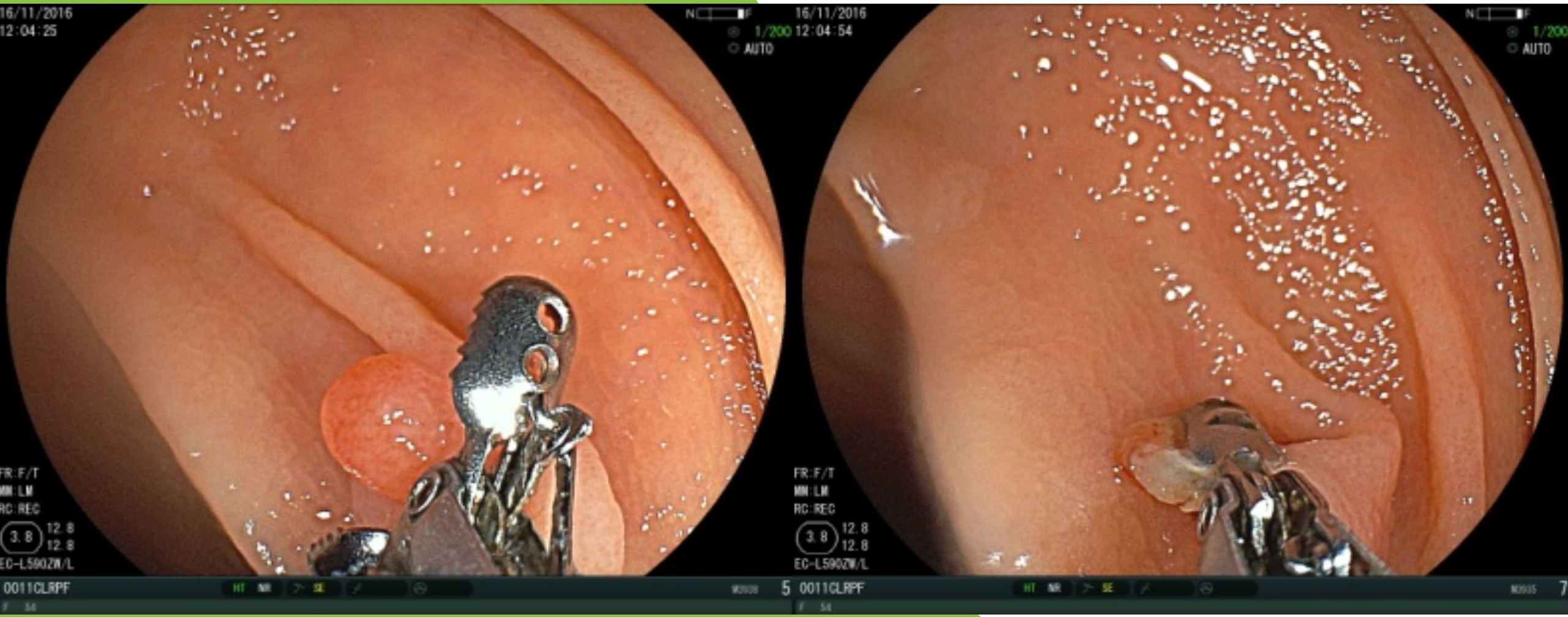
RECOMMENDATION

ESGE recommends cold snare polypectomy for the removal of small polyps (6–9 mm).
Strong recommendation, high quality of evidence.

ESGE recommends including a clear margin of normal tissue (1–2 mm) surrounding the polyp.
Strong recommendation, high quality of evidence.

RECOMMENDATION

ESGE recommends against the use of cold biopsy forceps excision because of its high rate of incomplete resection.
Strong recommendation, moderate quality of evidence.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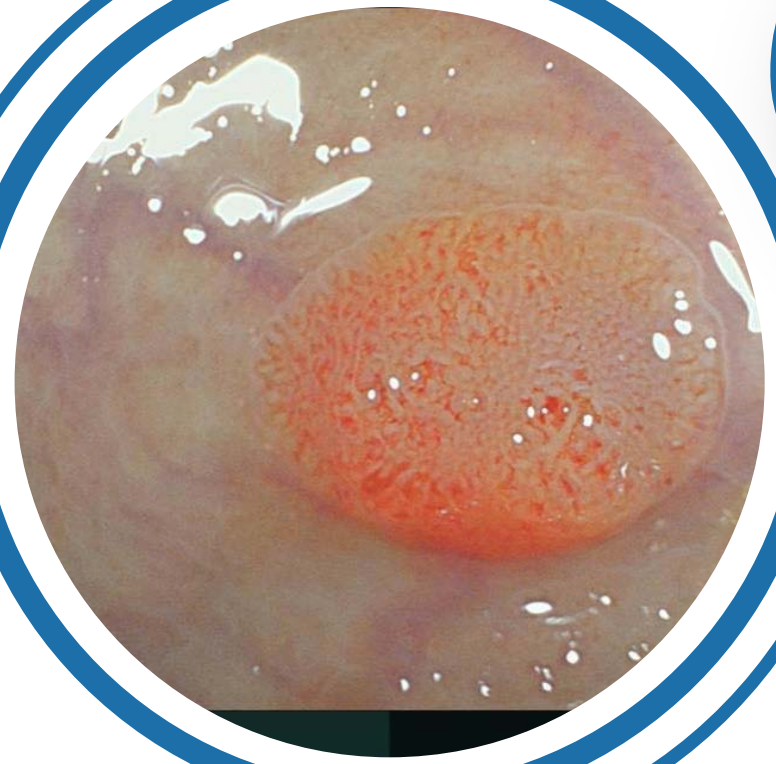
Endoscopic Removal of Colorectal Lesions—Recommendations by the US Multi-Society Task Force on Colorectal Cancer

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]



2a: diminutive (≤5 mm) and small (6–9 mm) lesions

- We recommend cold snare polypectomy to remove diminutive (≤5 mm) and small (6–9 mm) lesions due to high complete resection rates and safety profile. (Strong recommendation, moderate-quality evidence)

- We recommend against the use of cold forceps polypectomy to remove diminutive (≤5 mm) lesions due to high rates of incomplete resection. For diminutive lesions ≤2 mm, if cold snare polypectomy is technically difficult, jumbo or large-capacity forceps polypectomy may be considered. (Strong recommendation, moderate-quality evidence)

Digestive Endoscopy 2022; **34**: 668–675 doi: 10.1111/den.14250

Guidelines

Guidelines for Colorectal Cold Polypectomy (supplement to "Guidelines for Colorectal Endoscopic Submucosal Dissection/Endoscopic Mucosal Resection")

Toshio Uraoka, Kohei Takizawa, Shinji Tanaka, Hiroshi Kashida, Yutaka Saito, Naohisa Yahagi, Hiro-o Yamano, Shoichi Saito, Takashi Hisabe, Takashi Yao, Masahiko Watanabe, Masahiro Yoshida, Yusuke Saitoh, Osamu Tsuruta, Masahiro Igarashi, Takashi Toyonaga, Yoichi Ajioka, Kazuma Fujimoto and Haruhiro Inoue

The indications should be limited to lesions smaller than 10 mm that are preoperatively diagnosed as adenoma and which can be resected completely en bloc.

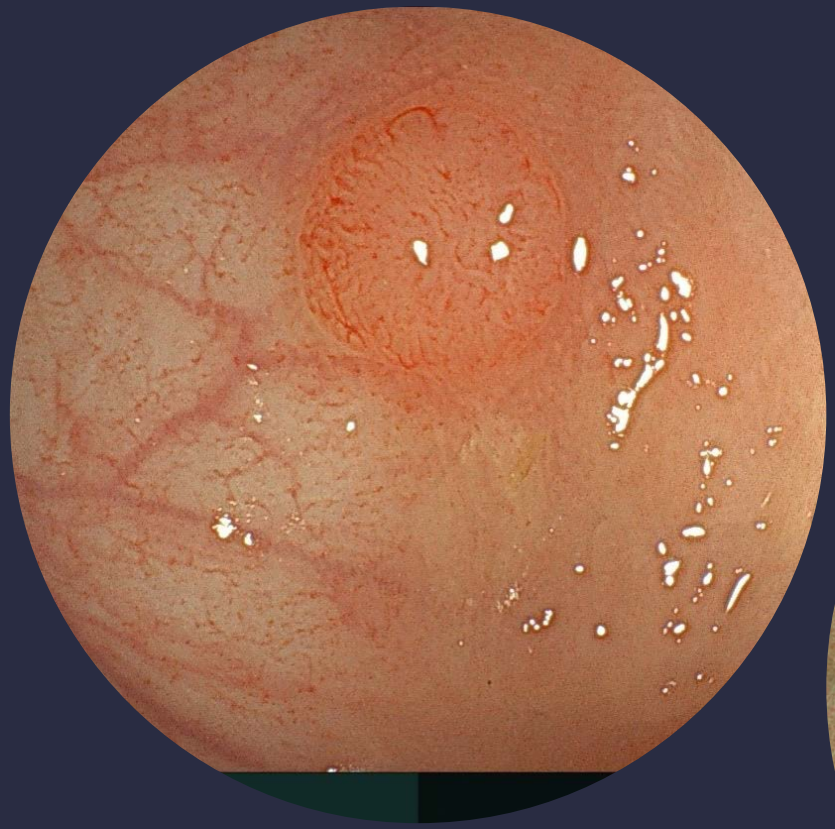
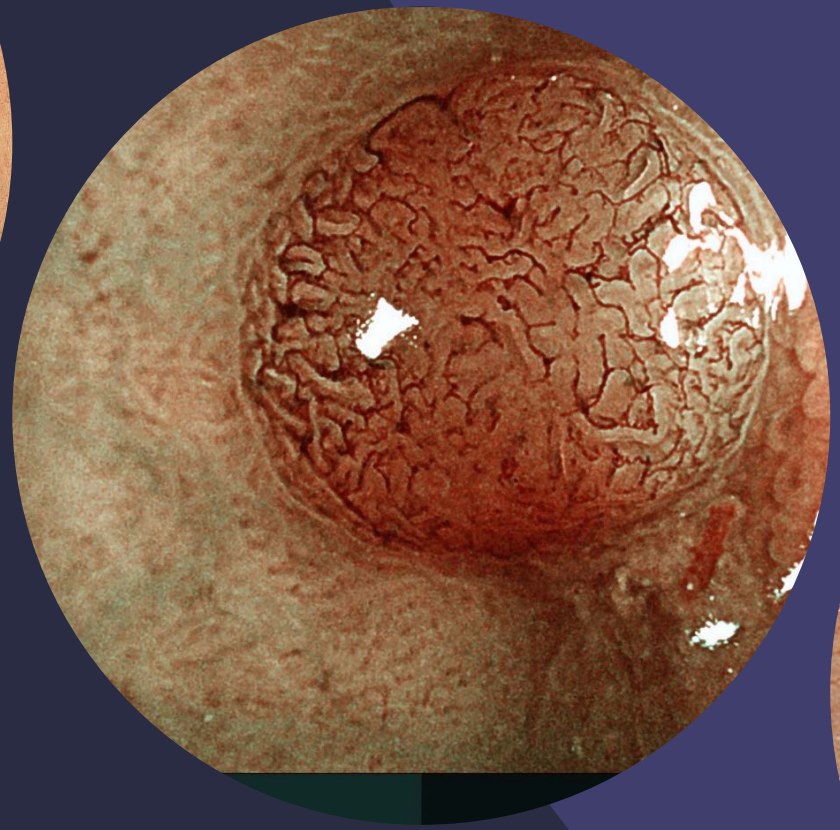
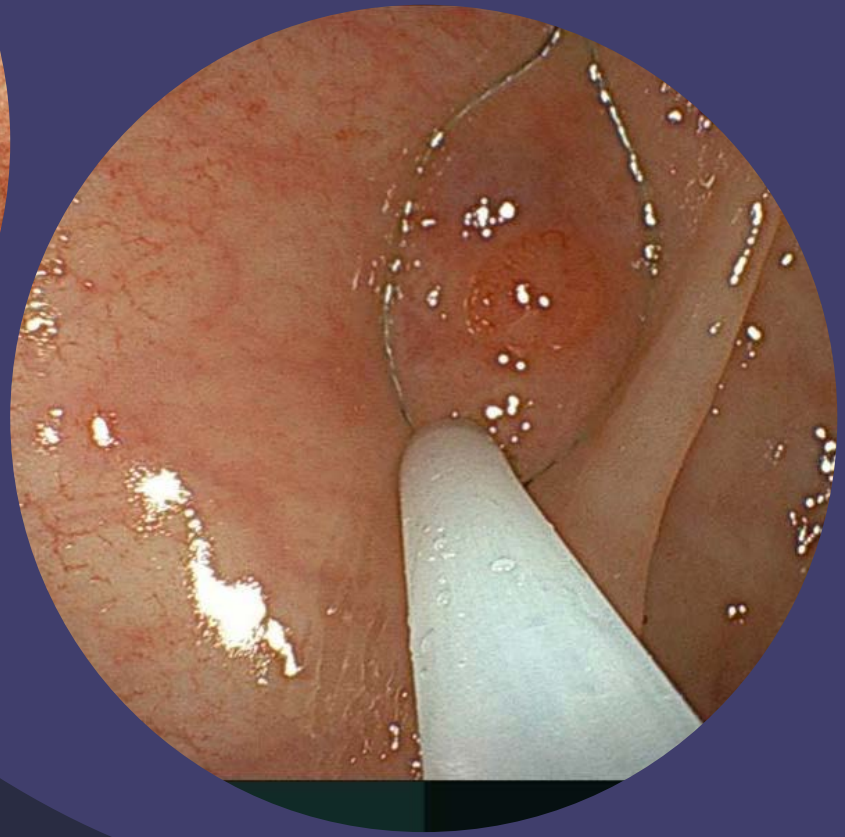
Modified Delphi method evaluation: median 8, minimum 7, maximum 9

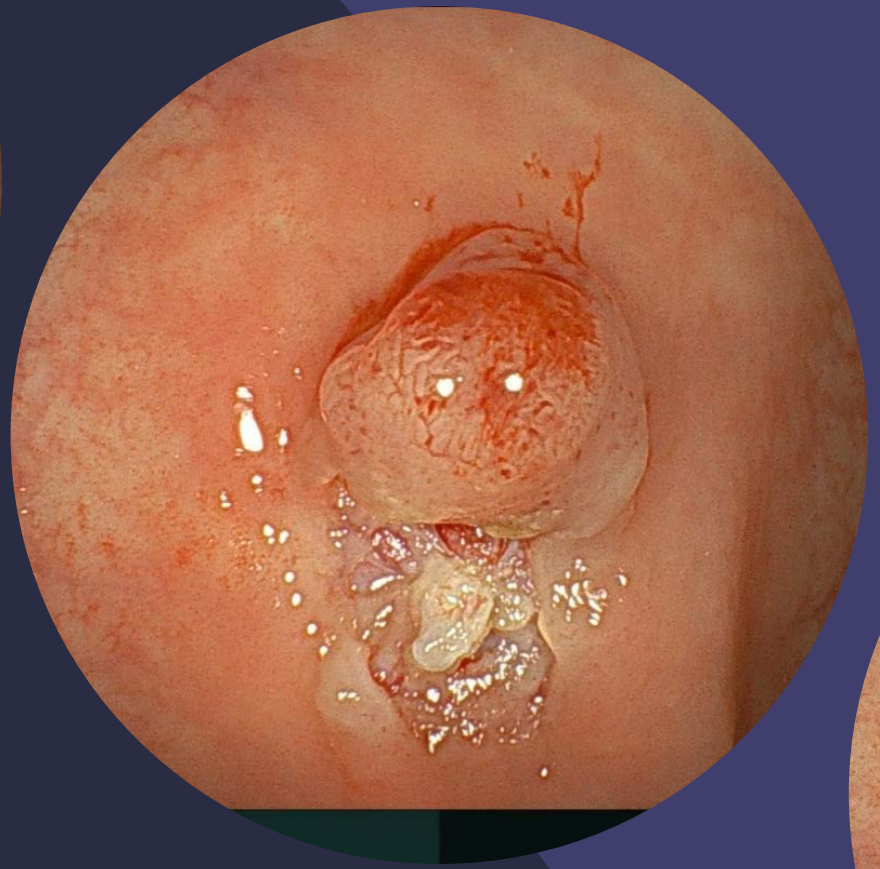
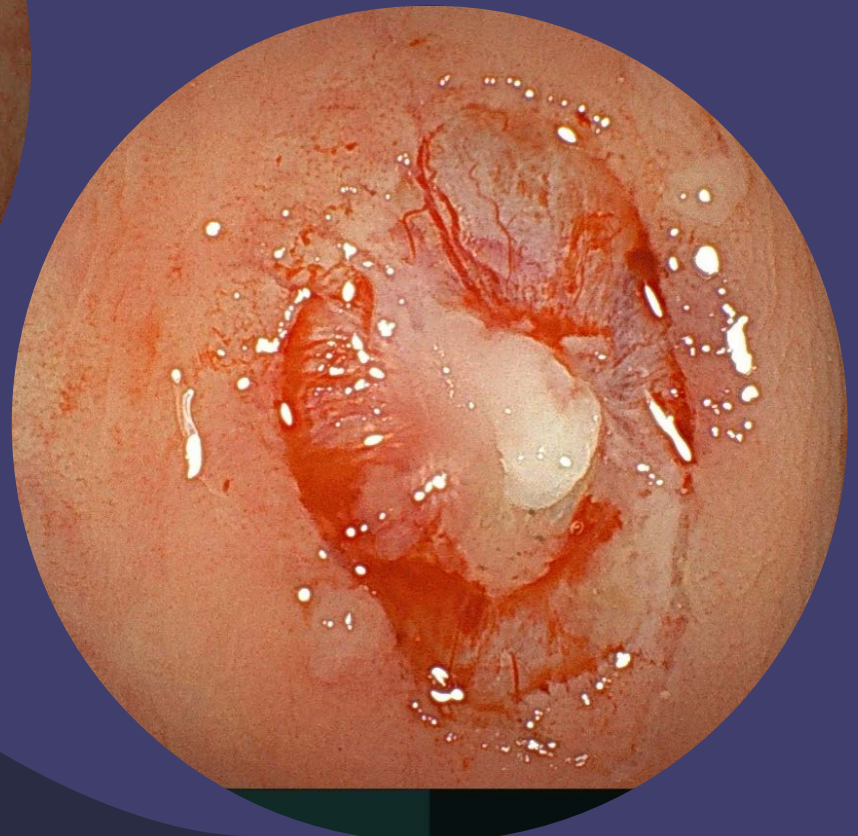
Strength of recommendation: 1

Evidence level: B

Based on the above, the indication for CSP includes preoperatively diagnosed adenomas <10 mm. The use of image-enhanced endoscopy with magnification is recommended for a highly accurate preoperative diagnosis of colorectal lesion prior to cold polypectomy.

Considering its technical facility and reliable polyp retrieval, CFP is acceptable for the removal of polyps ≤3 mm in size.[14] For such cases, the use of large forceps with a larger cup diameter, rather than standard biopsy forceps, is recommended.[15]

60 ANOS ARQUIVOS DE GASTROENTEROLOGIA

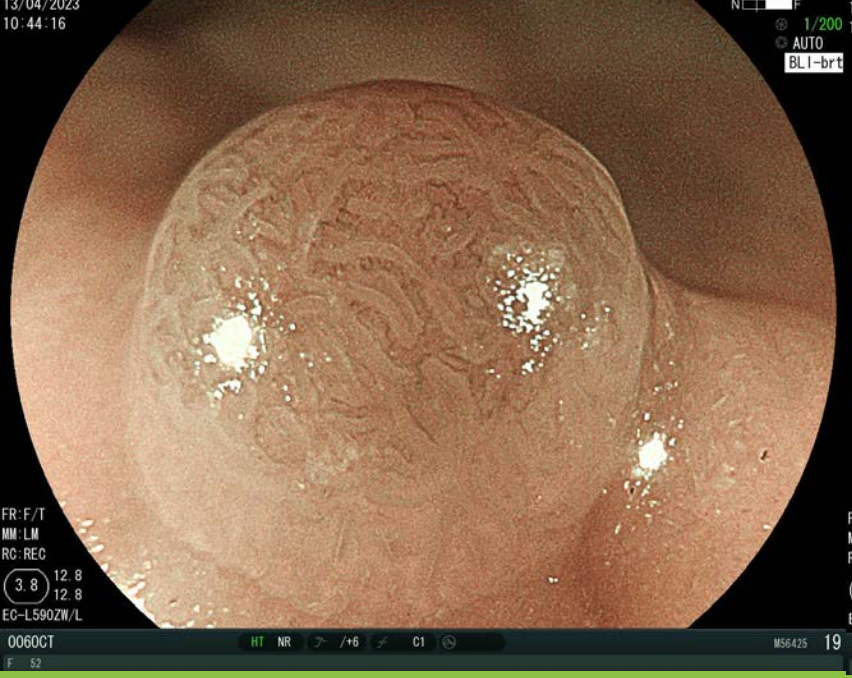
ORIGINAL ARTICLE

doi.org/10.1590/S0004-2803.23042023-115

Cold snare polypectomy: a safe procedure for removing small non-pedunculated colorectal lesions

Carlos Eduardo Oliveira Dos **SANTOS**[1,2], Daniele **MALAMAN**[1], Ivan David Arciniegas **SANMARTIN**[3], Ari Ben-Hur Stefani **LEÃO**[2], Isadora Zanotelli **BOMBASSARO**[4] and Júlio Carlos **PEREIRA-LIMA**[4]

tients by an inexperienced endoscopist. **Results** – A total of 476 polyps (99.4%) were resected en bloc. A negative margin (classified as CPR) was observed in 435 polyps (90.8%). An unclear or positive margin (classified as IPR) was observed in 43 cases (9.0%) and 1 case (0.2%), respectively, for an overall IPR rate of 9.2% (44/479). The IPR rate was 12.2% in the first half of cases and 5.9% in the second half (P=0.02). Dividing into tertiles, the IPR rate was 15.0% in the first tertile, 6.9% in the second tertile, and 5.7% in the third tertile (P=0.01). Dividing into quartiles, the IPR rate was 15.8% in the first quartile and 5.9% in the fourth quartile (P=0.03). The IPR rate was 6.3% for type 0-IIa lesions and 14.1% for type 0-Is lesions (P=0.01). For serrated and adenomatous lesions, the IPR rate was 9.2%. Specimen retrieval failed in 3.6% of cases. Immediate bleeding (>30 s) occurred in 1 case (0.2%), treated with argon plasma coagulation. No delayed bleeding or perforation occurred. **Conclusion** – CSP is a safe technique that provides good results for the resection of small non-pedunculated polyps, with a short learning curve.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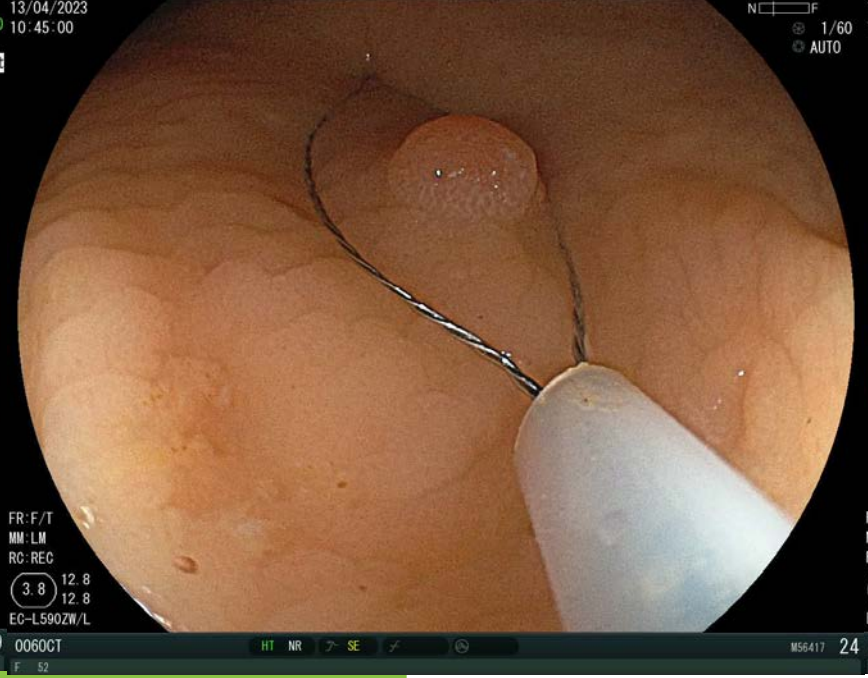
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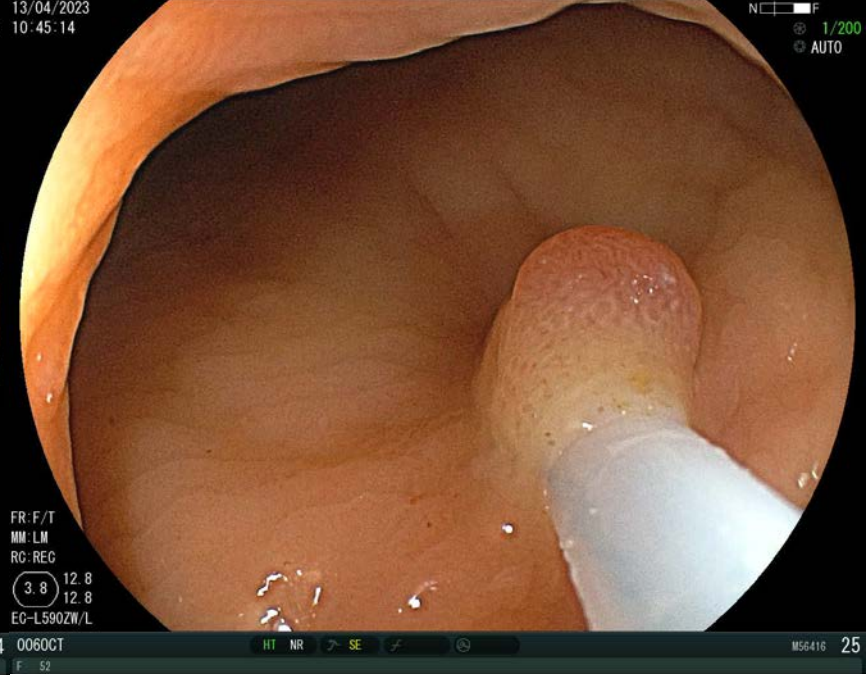
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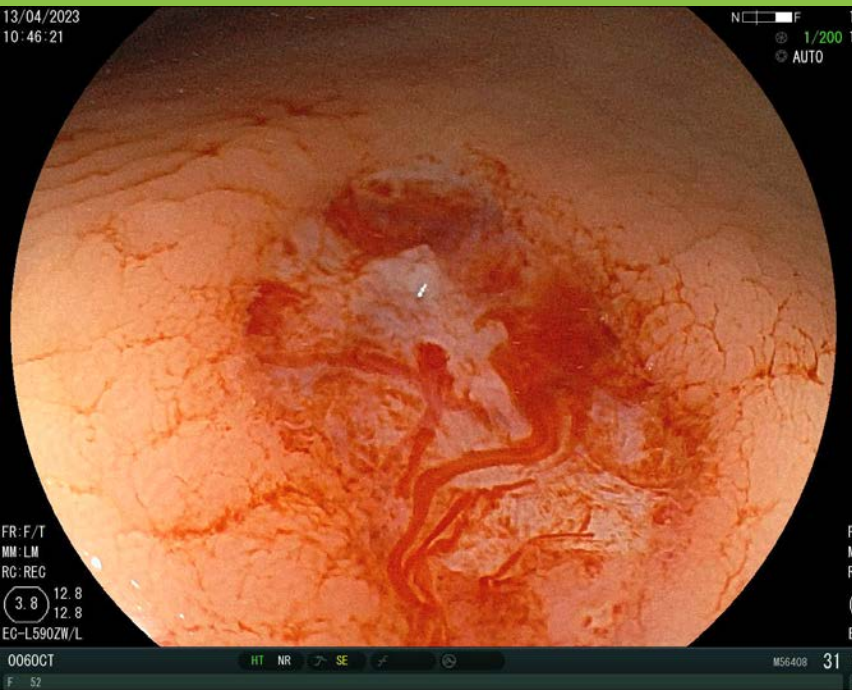
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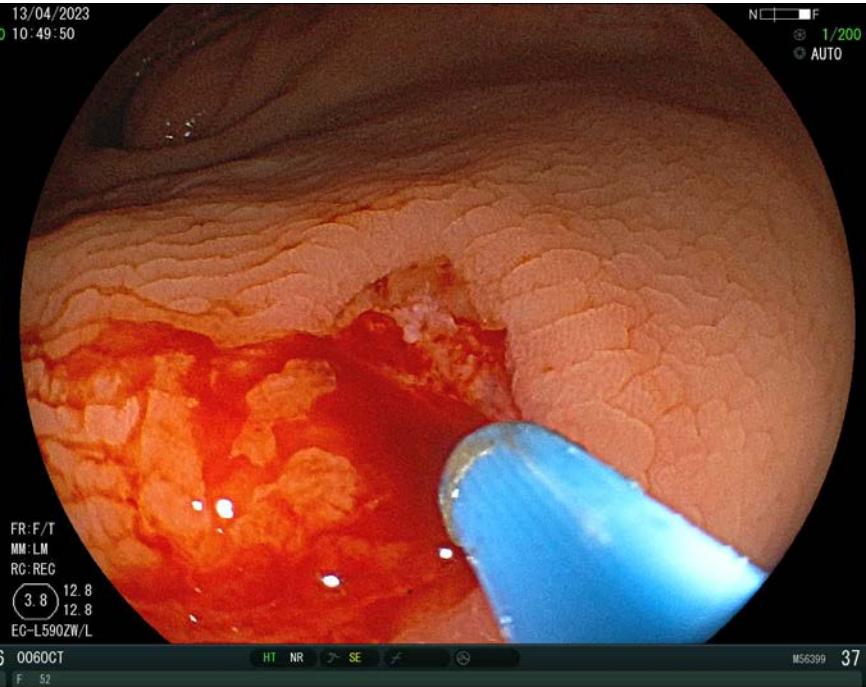
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Endoscopic Removal of Colorectal Lesions—Recommendations by the US Multi-Society Task Force on Colorectal Cancer

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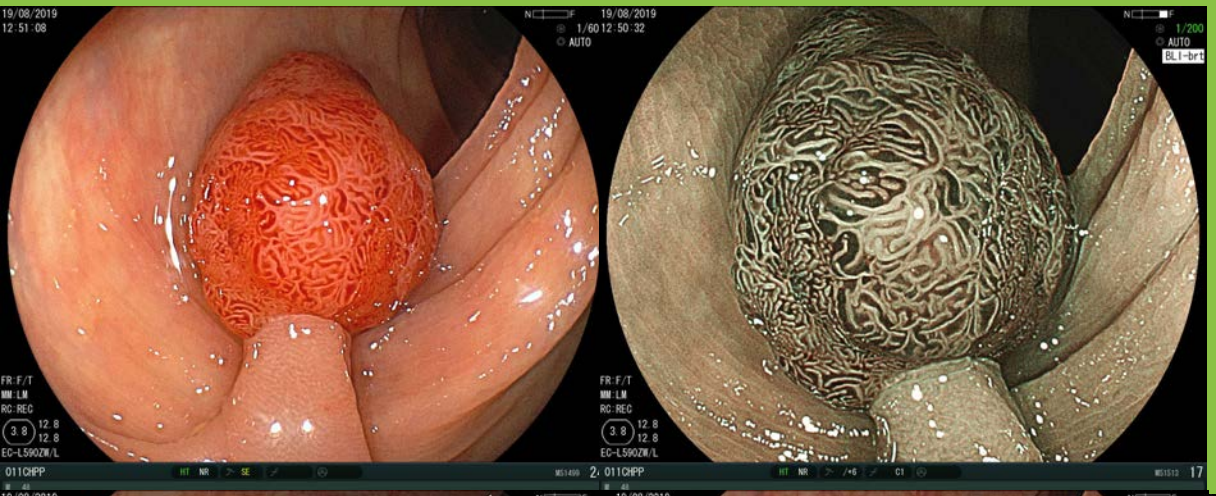
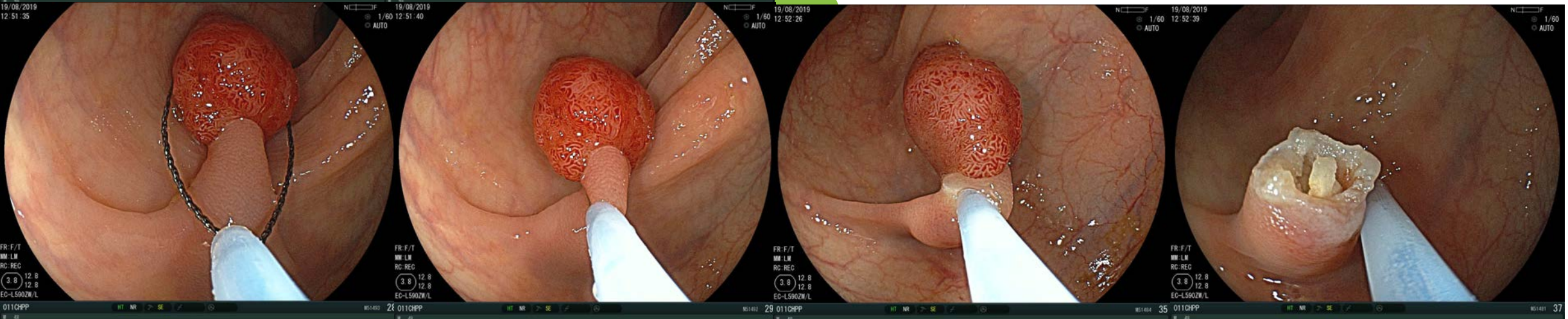
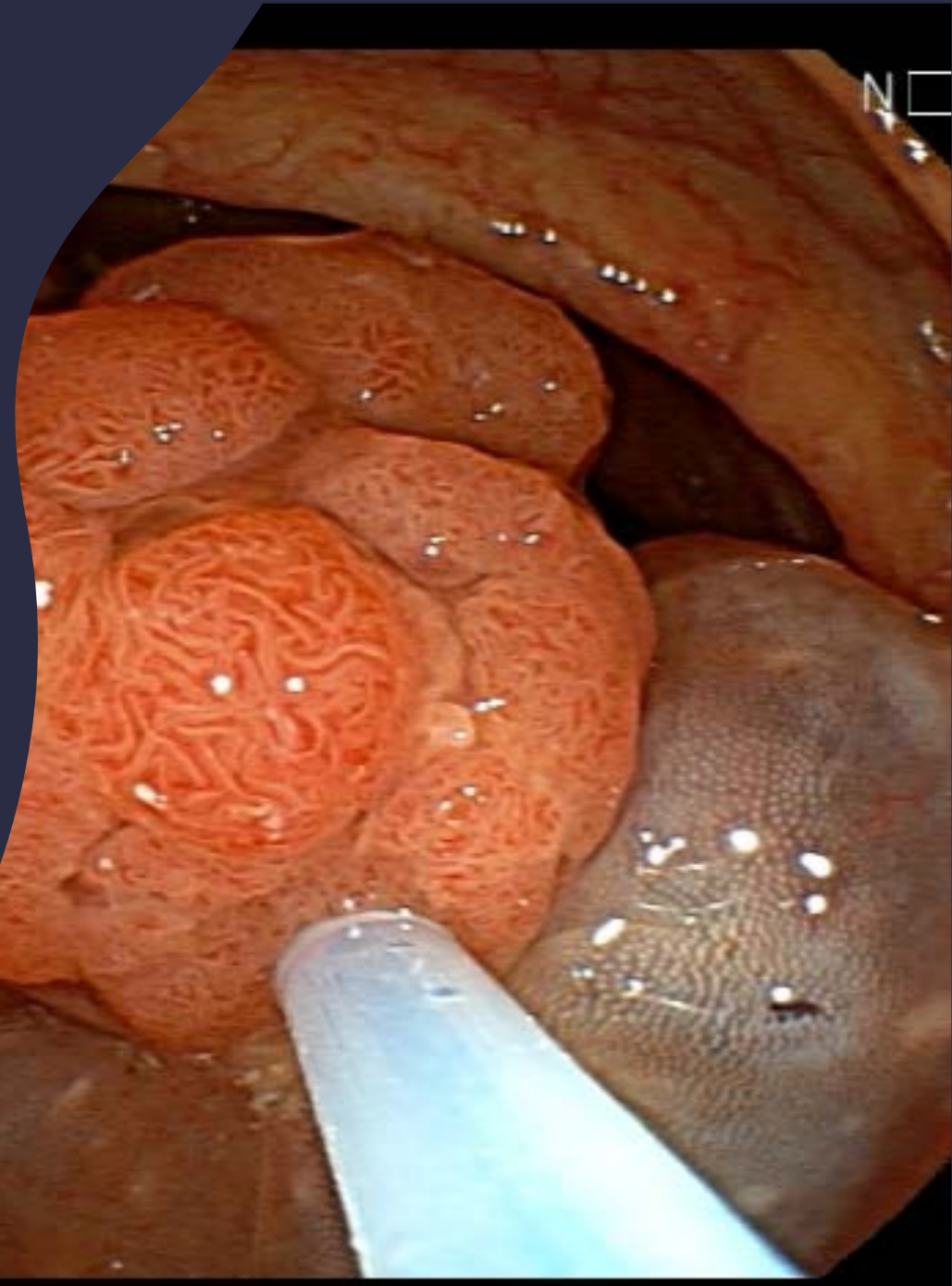


2e: pedunculated lesions

- We recommend hot snare polypectomy to remove pedunculated lesions ≥10 mm (Strong recommendation, moderate-quality evidence)
- We recommend prophylactic mechanical ligation of the stalk with a detachable loop or clips on pedunculated lesions with head ≥20 mm or with stalk thickness ≥5 mm to reduce immediate and delayed post-polypectomy bleeding. (Strong recommendation, moderate-quality evidence)



MUCOSECTOMIA



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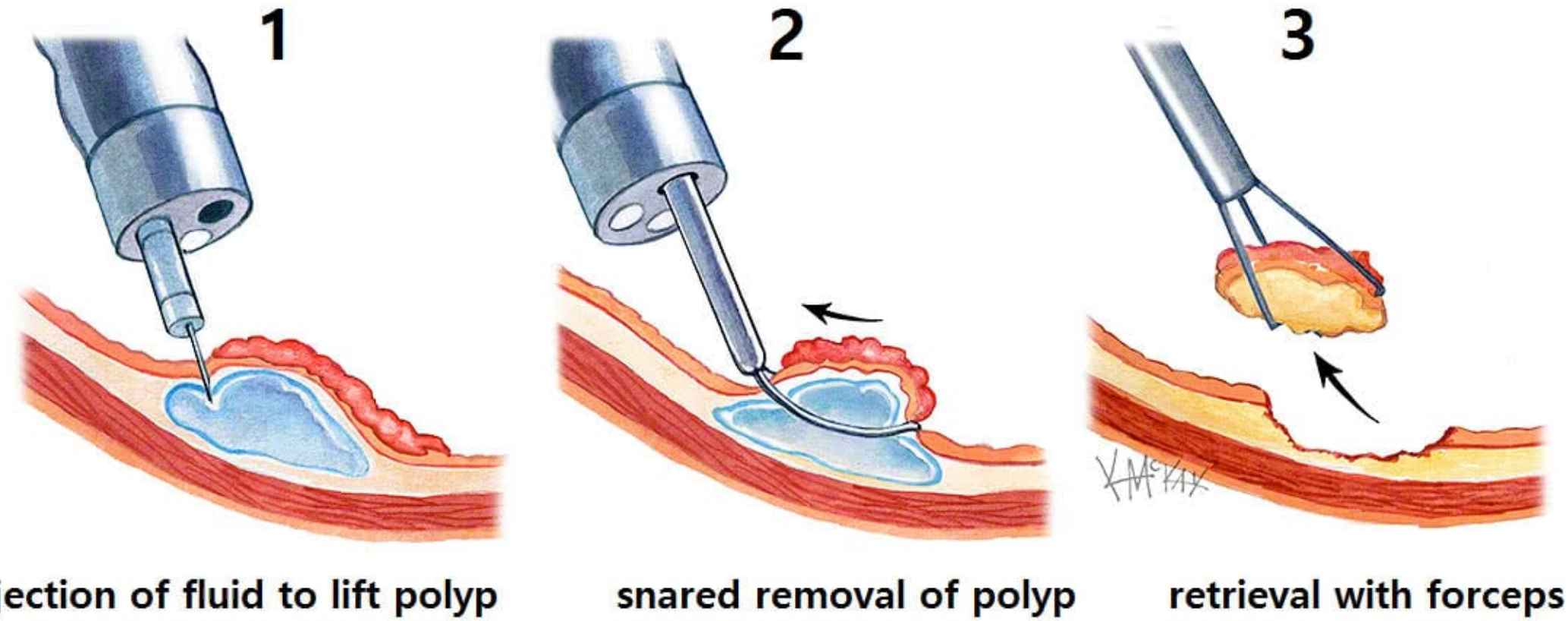
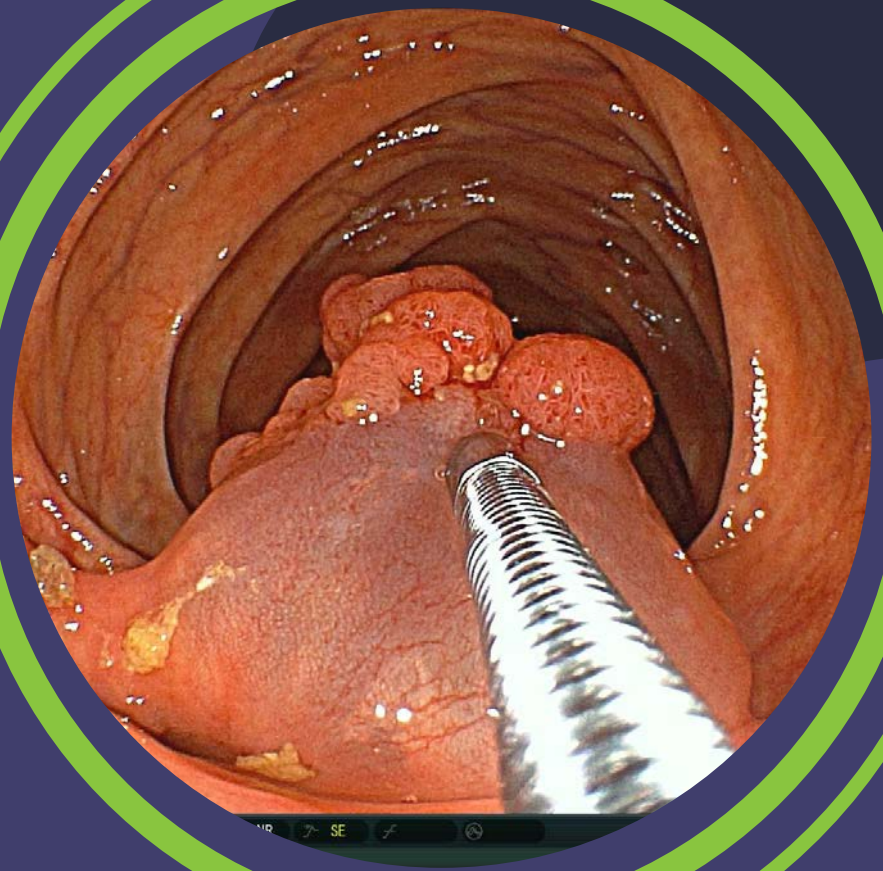


Injection of fluid to lift polyp

snared removal of polyp

retrieval with forceps



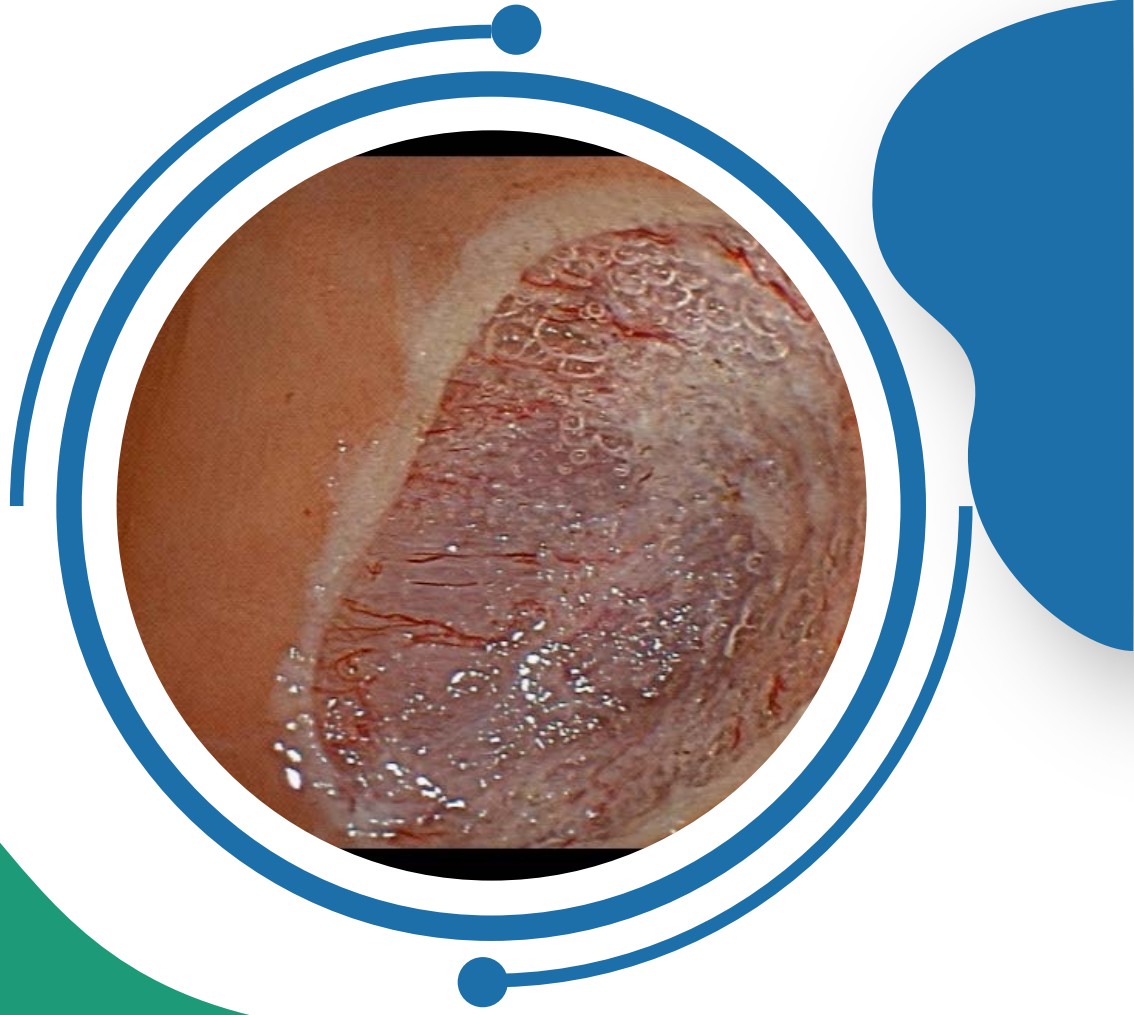
SOLUCIONES

- SOLUCIÓN SALINA
- SOLUCIÓN SALINA HIPERTÓNICA
- MANITOL
- GLICEROL
- HPMC
- ÁCIDO HIALURÓNICO (Blue Eye)
- SIC-8000 (Eleview)
- ORISE GEL

Review > Gastrointest Endosc. 2017 Apr;85(4):693-699. doi: 10.1016/j.gie.2016.12.003.
Epub 2016 Dec 8.

Normal saline solution versus other viscous solutions for submucosal injection during endoscopic mucosal resection: a systematic review and meta-analysis

Harathi Yandrapu [1], Madhav Desai [2], Sameer Siddique [3], Prashanth Vennalganti [2], Sreekar Vennalaganti [1], Sravanthi Parasa [2], Tarun Rai [2], Vijay Kanakadandi [2], Ajay Bansal [1], Mohammad Titi [1], Alessandro Repici [4], Matthew L Bechtold [3], Prateek Sharma [5], Abhishek Choudhary [1]



Soluciones viscosas

✓> resección en bloque (OR, 1.91; 95% CI, 1.11 – 3.29; p = 0.02)

✓< lesiones residuales (OR, 0.54; 95% CI, 0.32 – 0.91; p = 0.02)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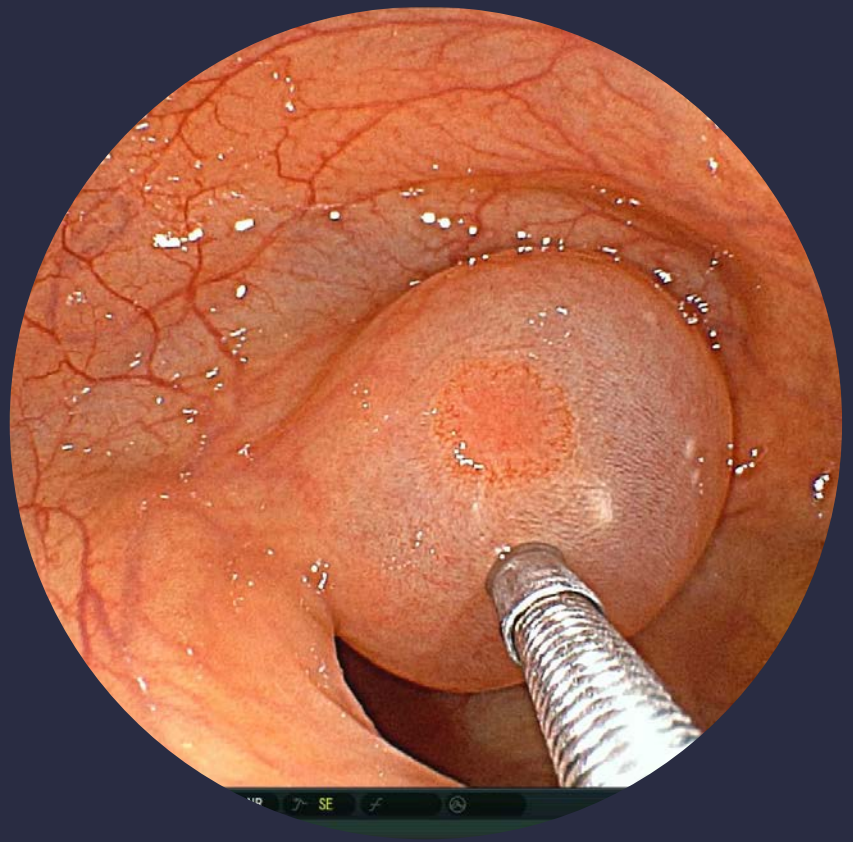
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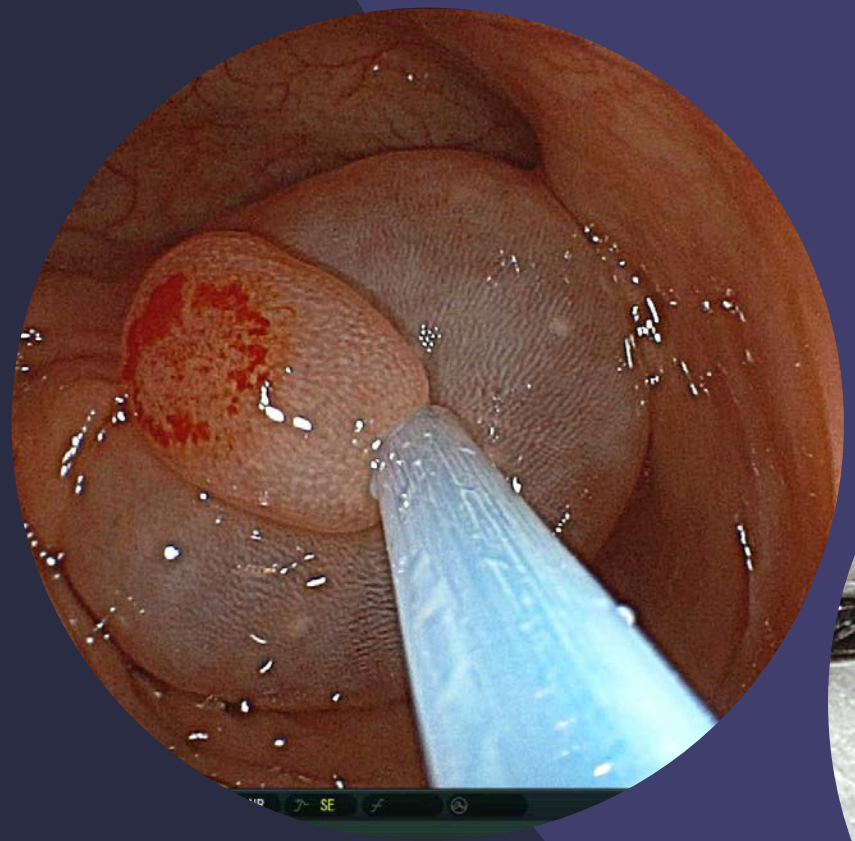
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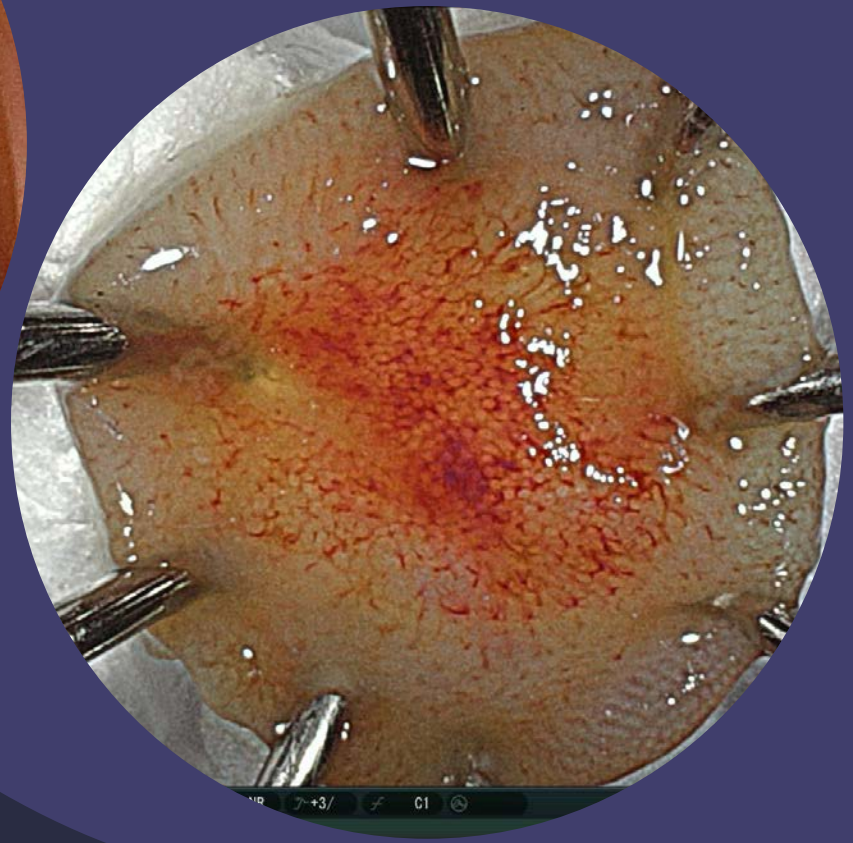
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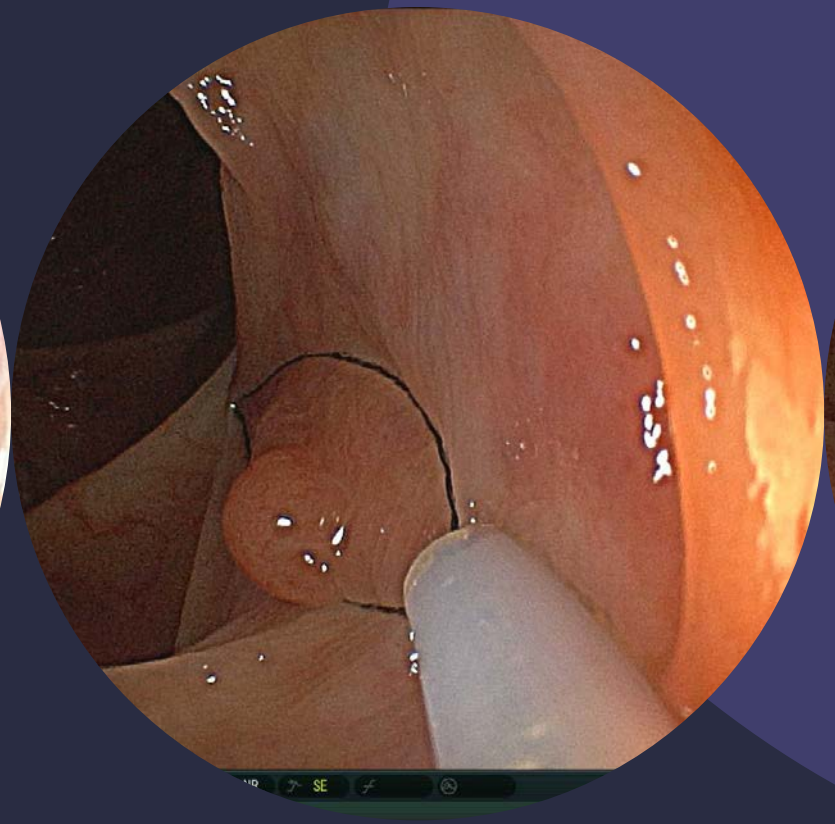
Guideline

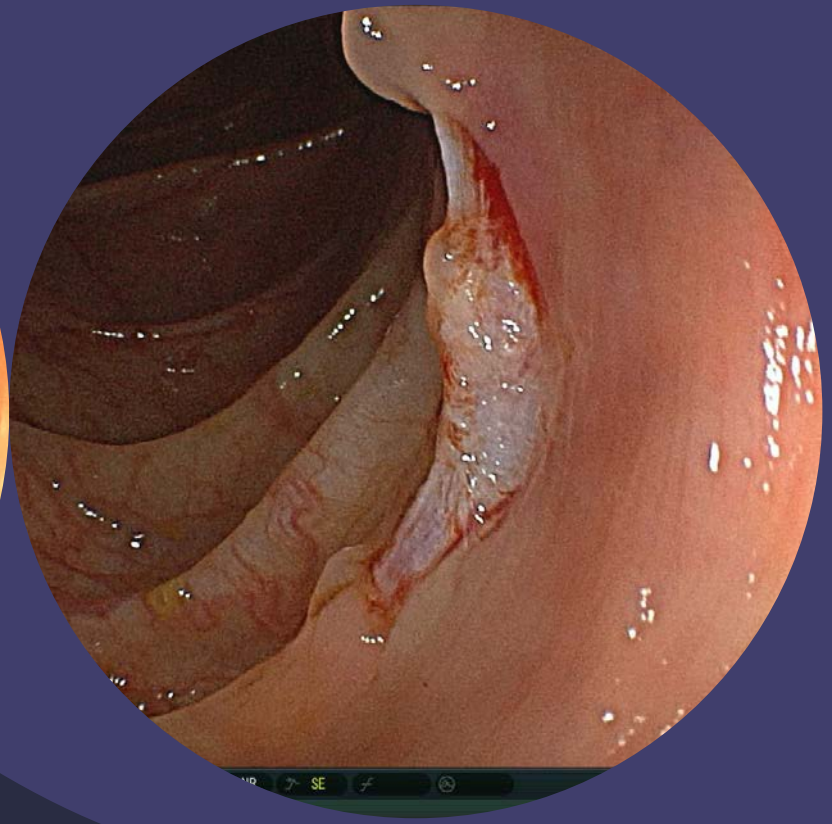
Thieme

Colorectal polypectomy and endoscopic mucosal resection: European Society of Gastrointestinal Endoscopy (ESGE) Guideline – Update 2024

ESGE

9 ESGE recommends (piecemeal) cold snare polypectomy or cold EMR for SSLs of all sizes without suspected dysplasia. Strong recommendation, moderate quality of evidence.





Clinical and endoscopic predictors of cytological dysplasia or cancer in a prospective multicentre study of large sessile serrated adenomas/polyps

Nicholas G Burgess,[1,2] Maria Pellise,[1] Kavinderjit S Nanda,[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] Heok P'Ng,[11] Duncan McLeod,[11] Michael J Bourke[1,2]

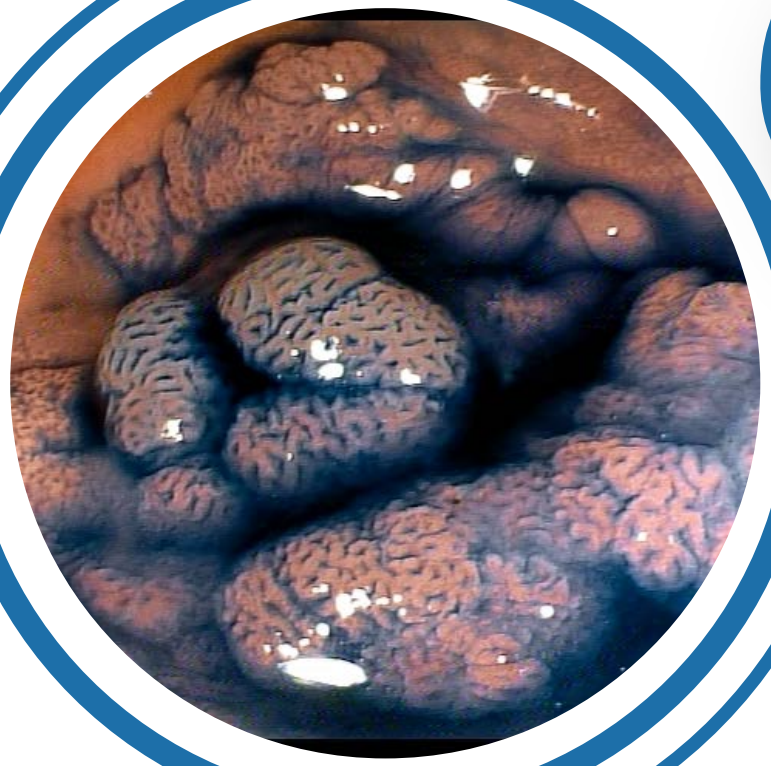


Table 2 Univariable analysis and best fitting multiple logistic regression model for factors associated with sessile serrated adenomas with cytological dysplasia (SSA-D)

			Univariable analysis	Best fitting multiple logistic regression model	
	SSA/P-ND	SSA/P-D	p Value	Adjusted OR (95% CI)	p Value
Paris classification* (n, %)					
No 0-Is component	125 (89.3%)	45 (67.2%)	<0.001	1	0.021
Any 0-Is component	15 (10.7%)	22 (32.8%)		3.10 (1.19 to 8.12)	
Highest Kudo classification* (n, %)†					
Kudo I and II	98 (72.6%)	22 (33.3%)	<0.001	1	<0.001
Kudo III, IV, V	37 (27.4%)	44 (66.7%)		3.98 (1.94 to 8.15)	

Guideline

Thieme

Colorectal polypectomy and endoscopic mucosal resection: European Society of Gastrointestinal Endoscopy (ESGE) Guideline – Update 2024

RECOMMENDATION

ESGE recommends hot snare polypectomy for the removal of SSLs with dysplasia and en bloc excision of the dysplastic component.

Weak recommendation, low quality of evidence.

RECOMMENDATION

A suspected area of dysplasia within a large SSL should be resected en bloc by hot EMR.

Strong recommendation, moderate quality of evidence.

US MULTI-SOCIETY TASK FORCE

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

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Guideline

Thieme

Colorectal polypectomy and endoscopic mucosal resection: European Society of Gastrointestinal Endoscopy (ESGE) Guideline – Update 2024

ESGE

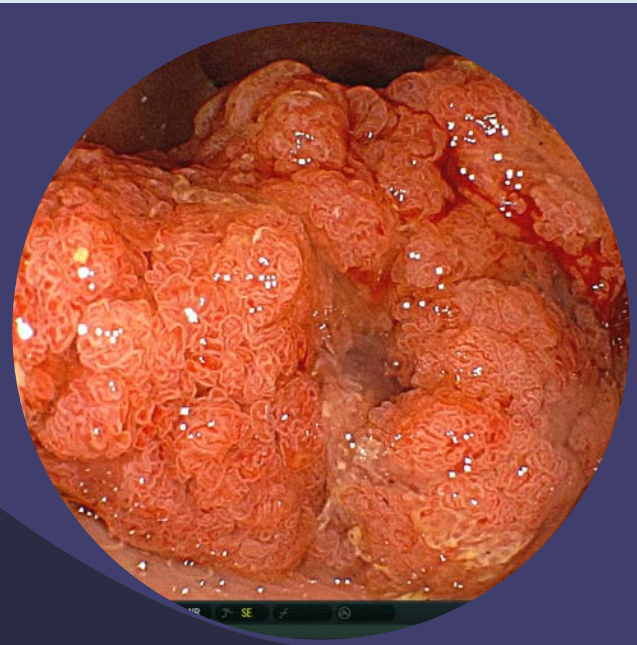
2d: Non-pedunculated (≥20 mm) lesions

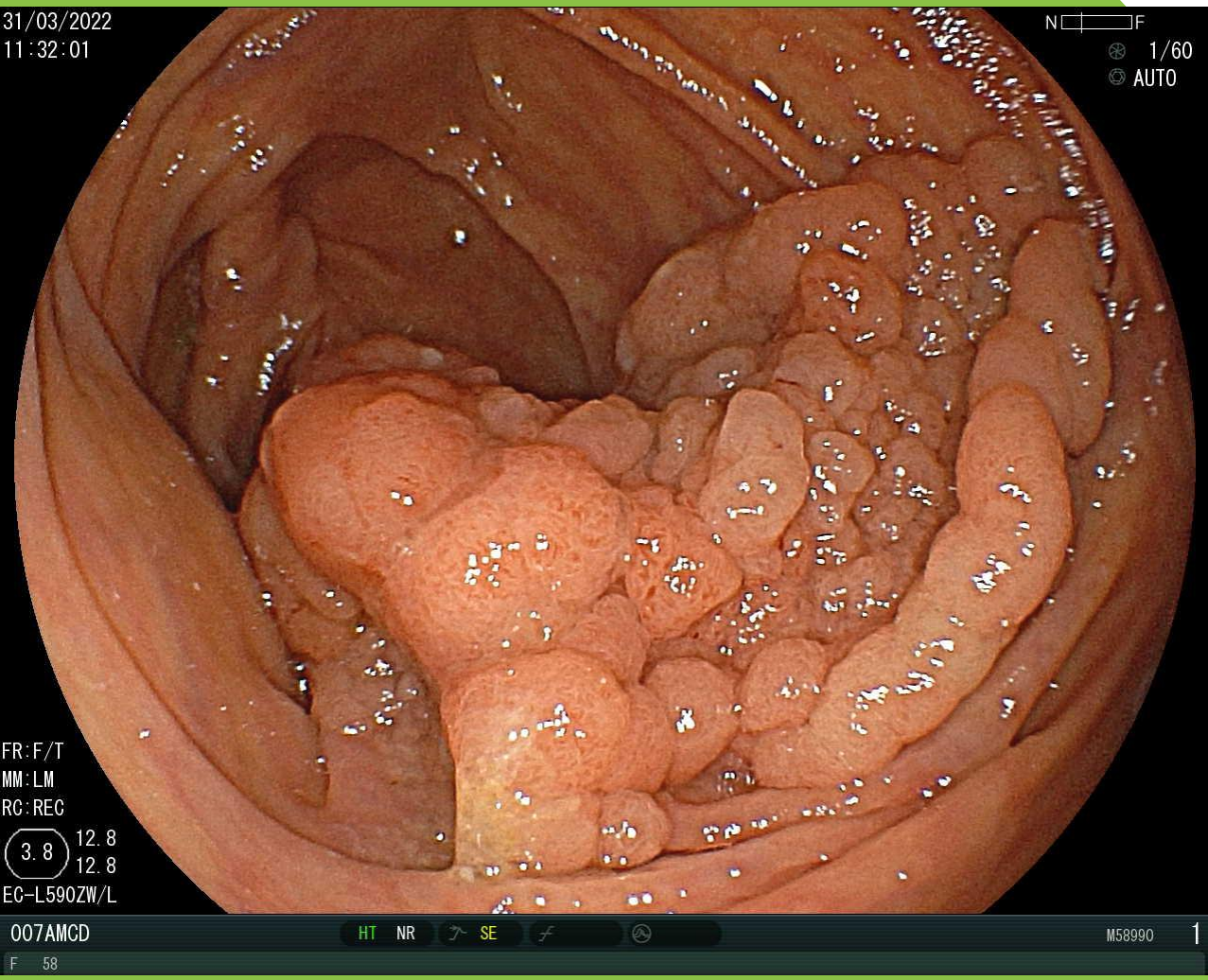
- We recommend EMR as the preferred treatment method of large (≥20 mm) non-pedunculated colorectal lesions. Endoscopic resection can provide complete resection and obviate the higher morbidity, mortality, and cost associated with alternative surgical treatment. (Strong recommendation, moderate-quality evidence)
- We recommend an endoscopist experienced in advanced polypectomy to manage large (≥20 mm) non-pedunculated colorectal lesions. (Strong recommendation, low-quality evidence)

RECOMMENDATION

Large (≥20 mm) sessile and laterally spreading or complex polyps should be removed by an appropriately trained and experienced endoscopist, in an appropriately resourced endoscopy center.

Strong recommendation, moderate quality of evidence.

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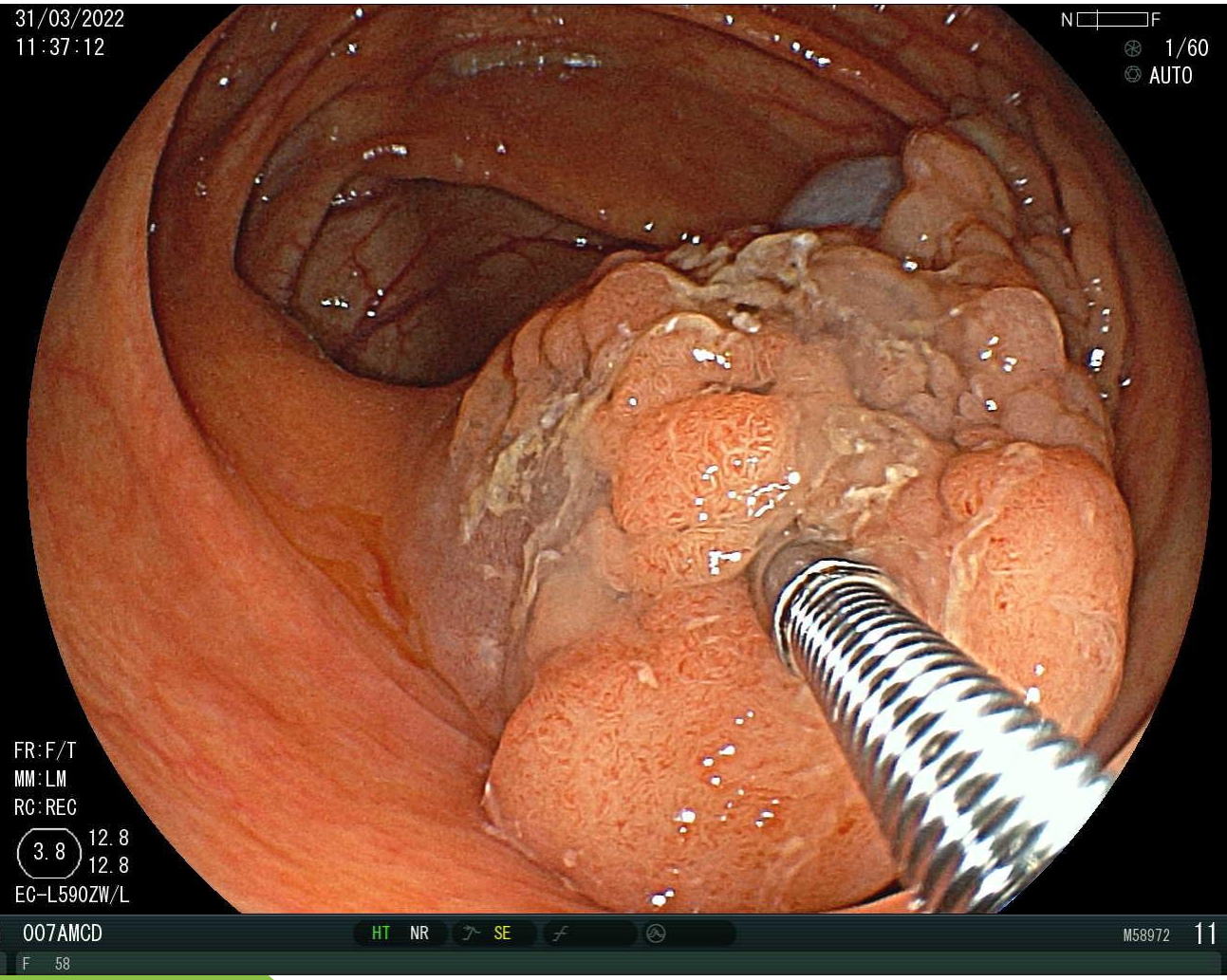
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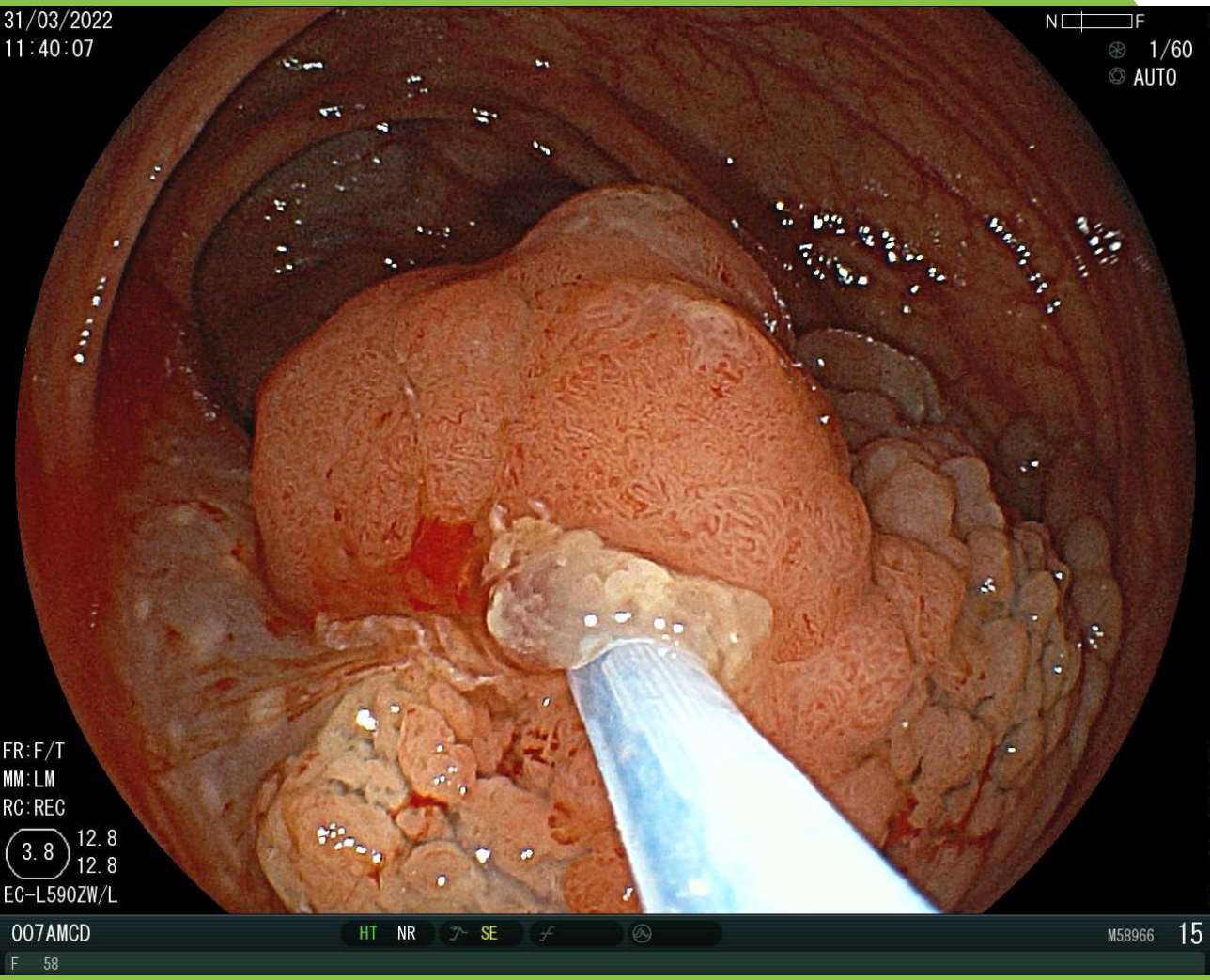
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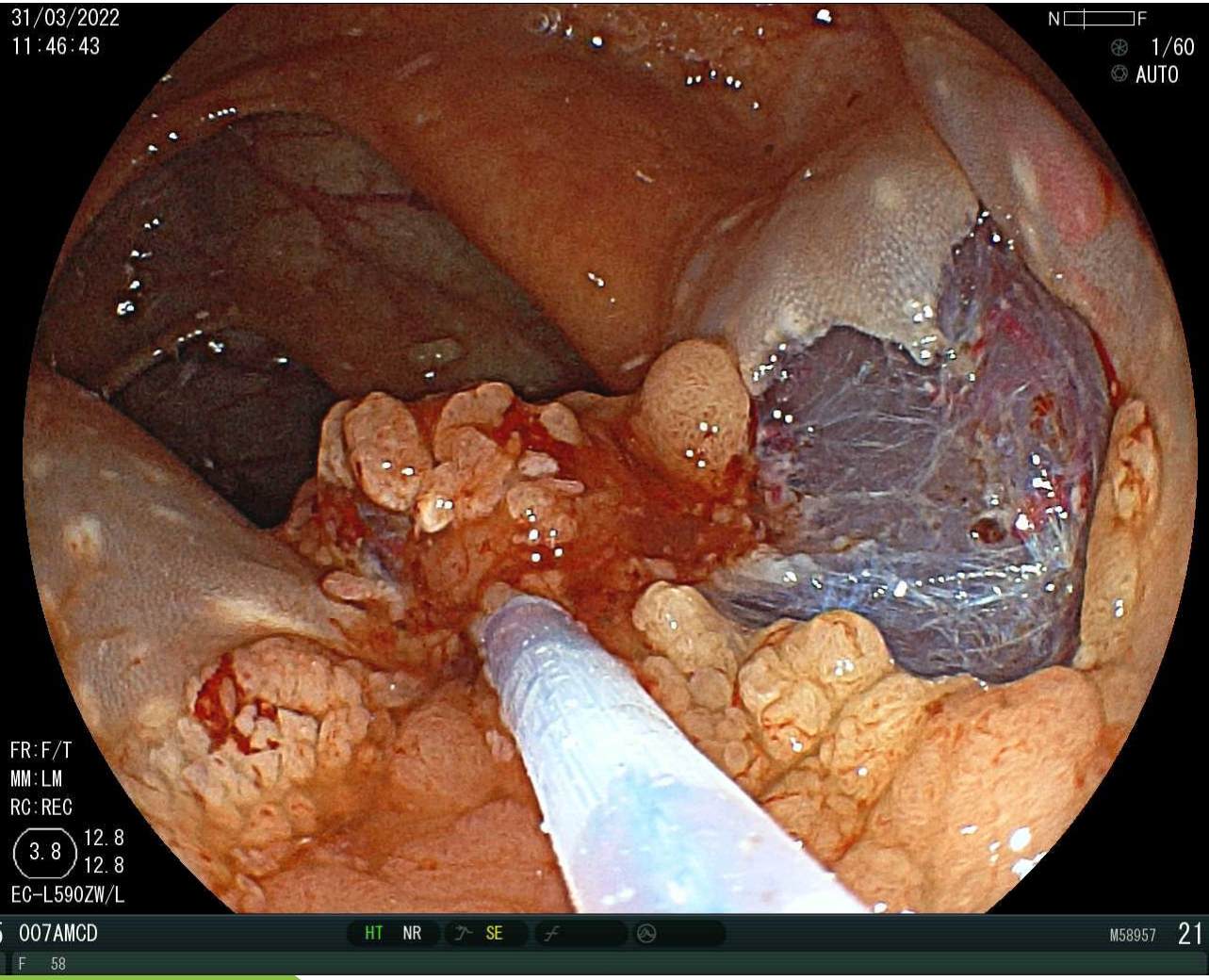
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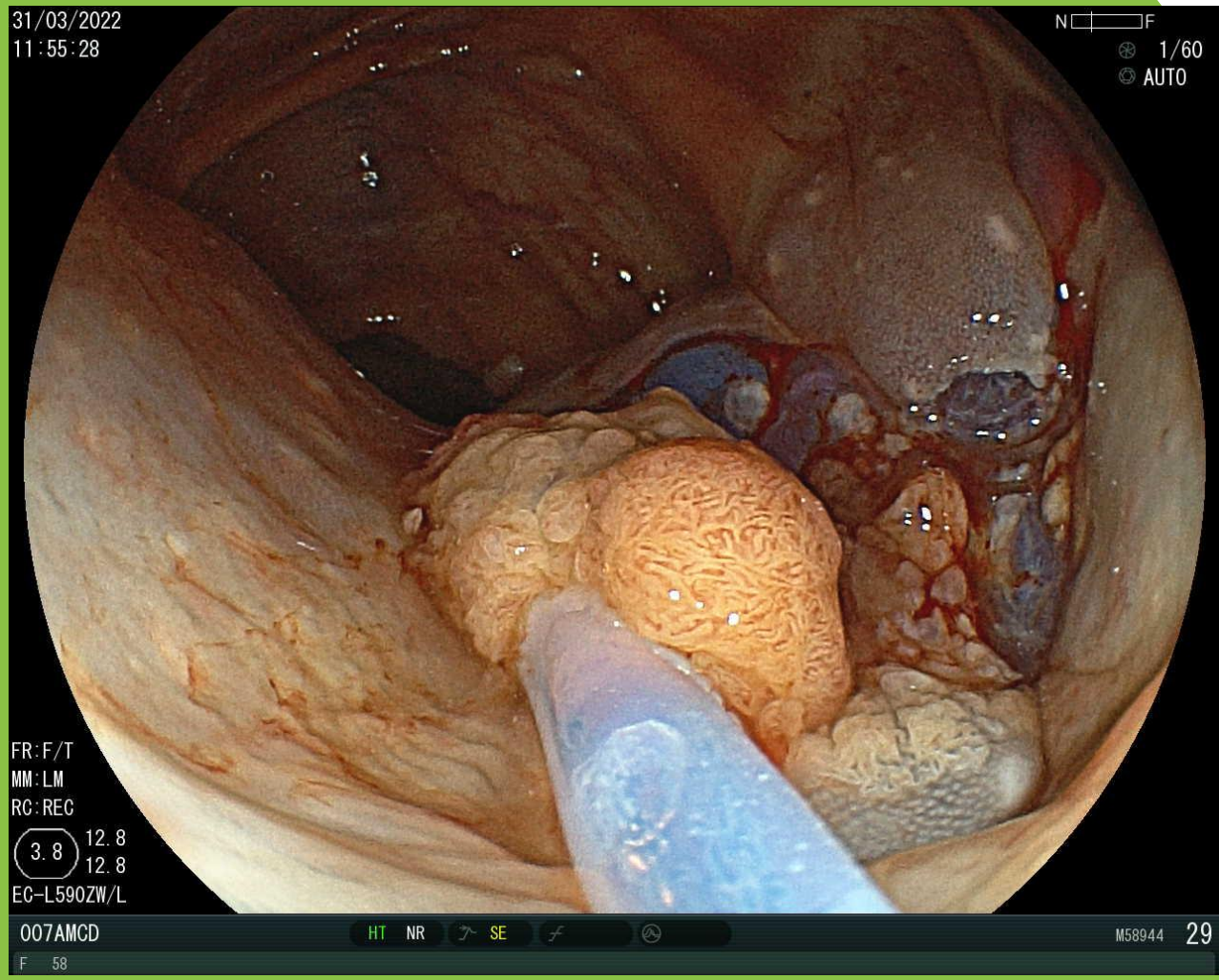
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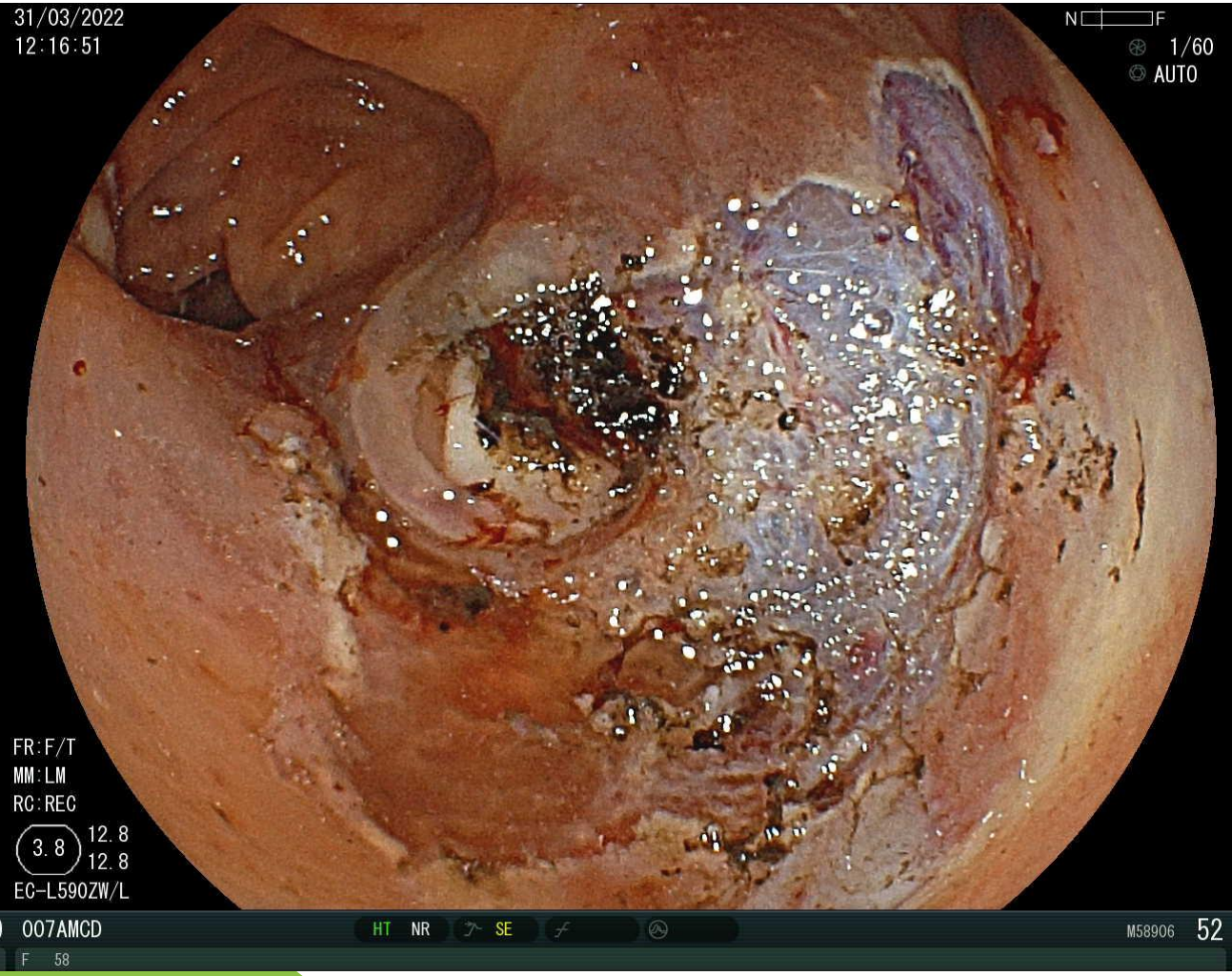
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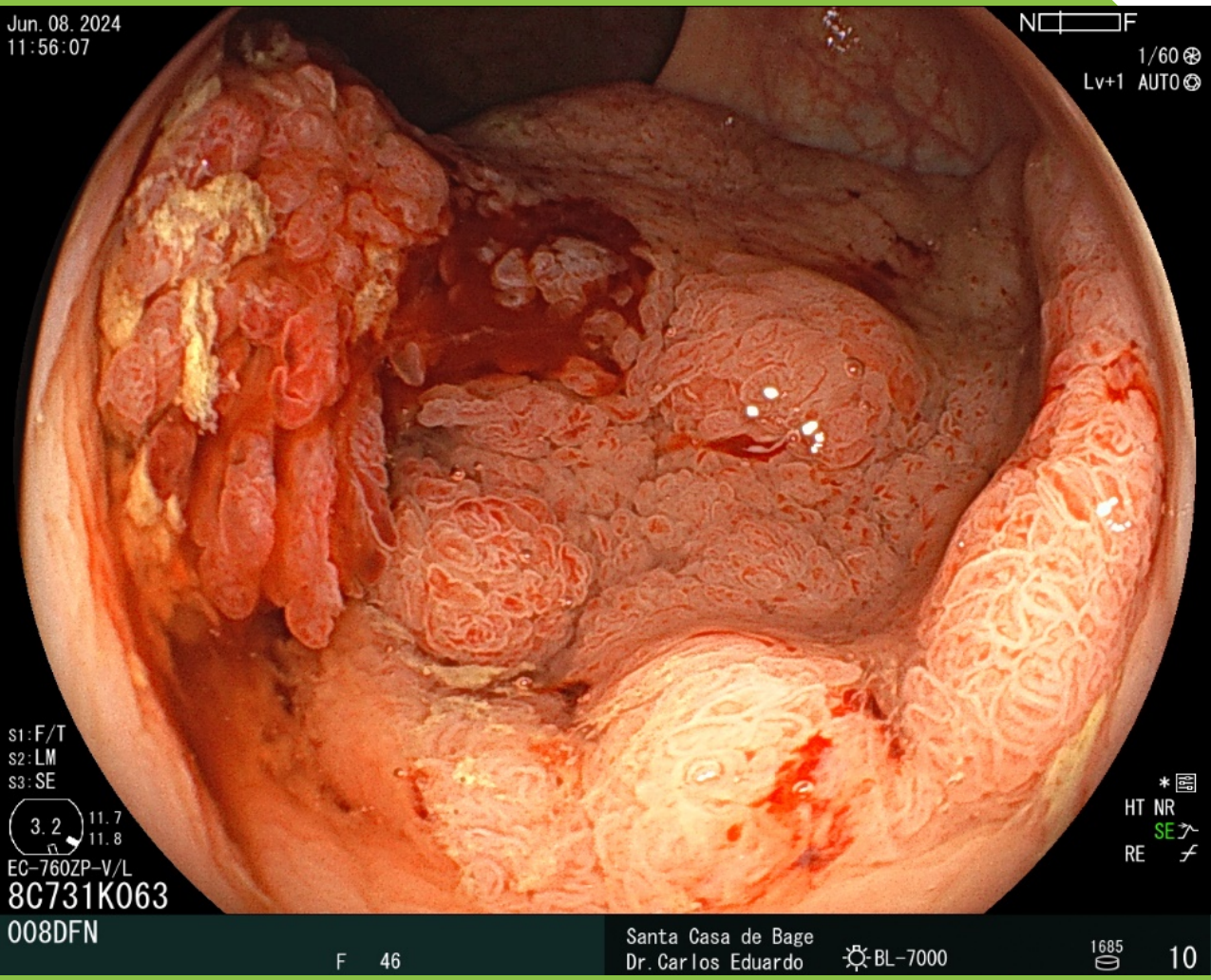
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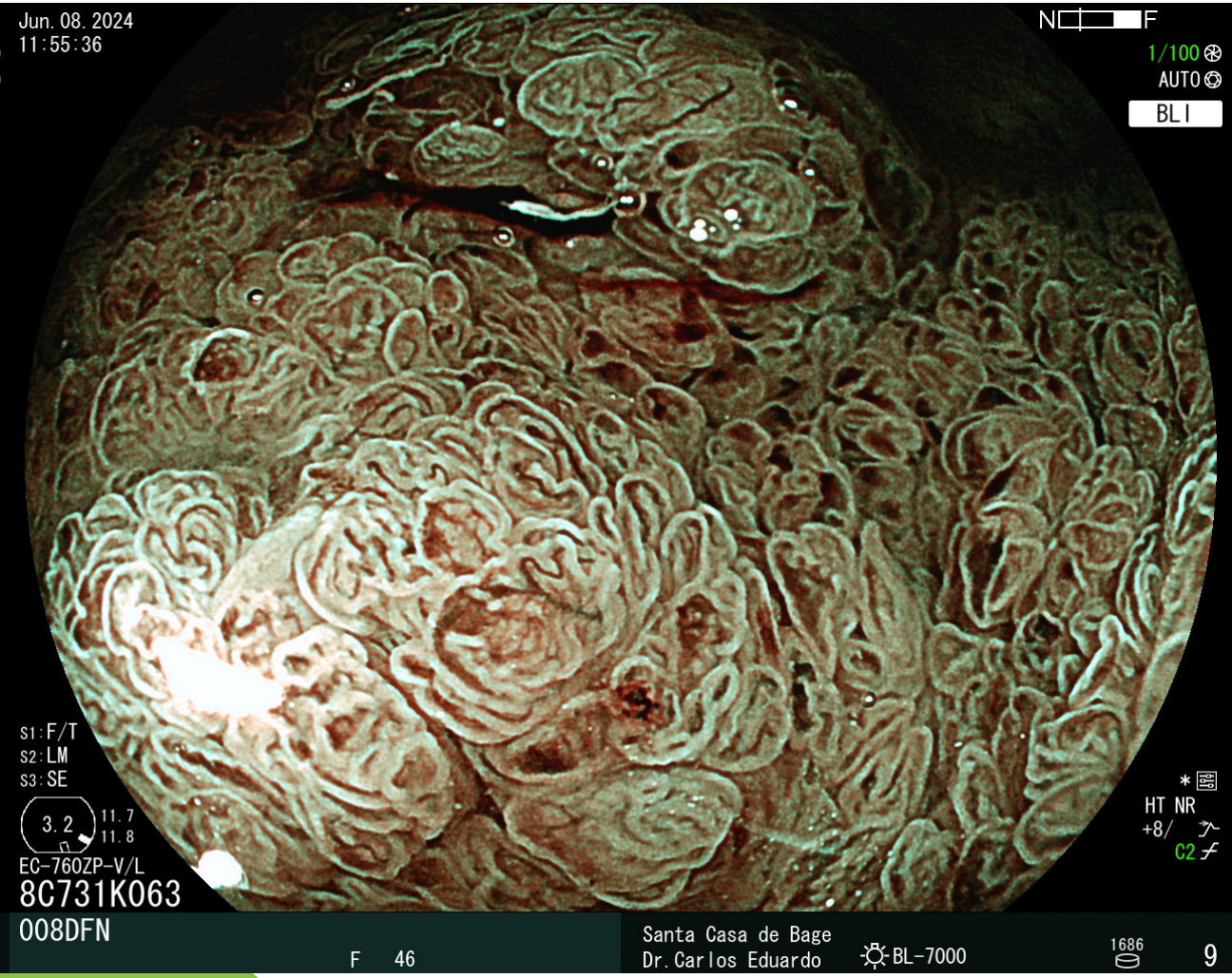
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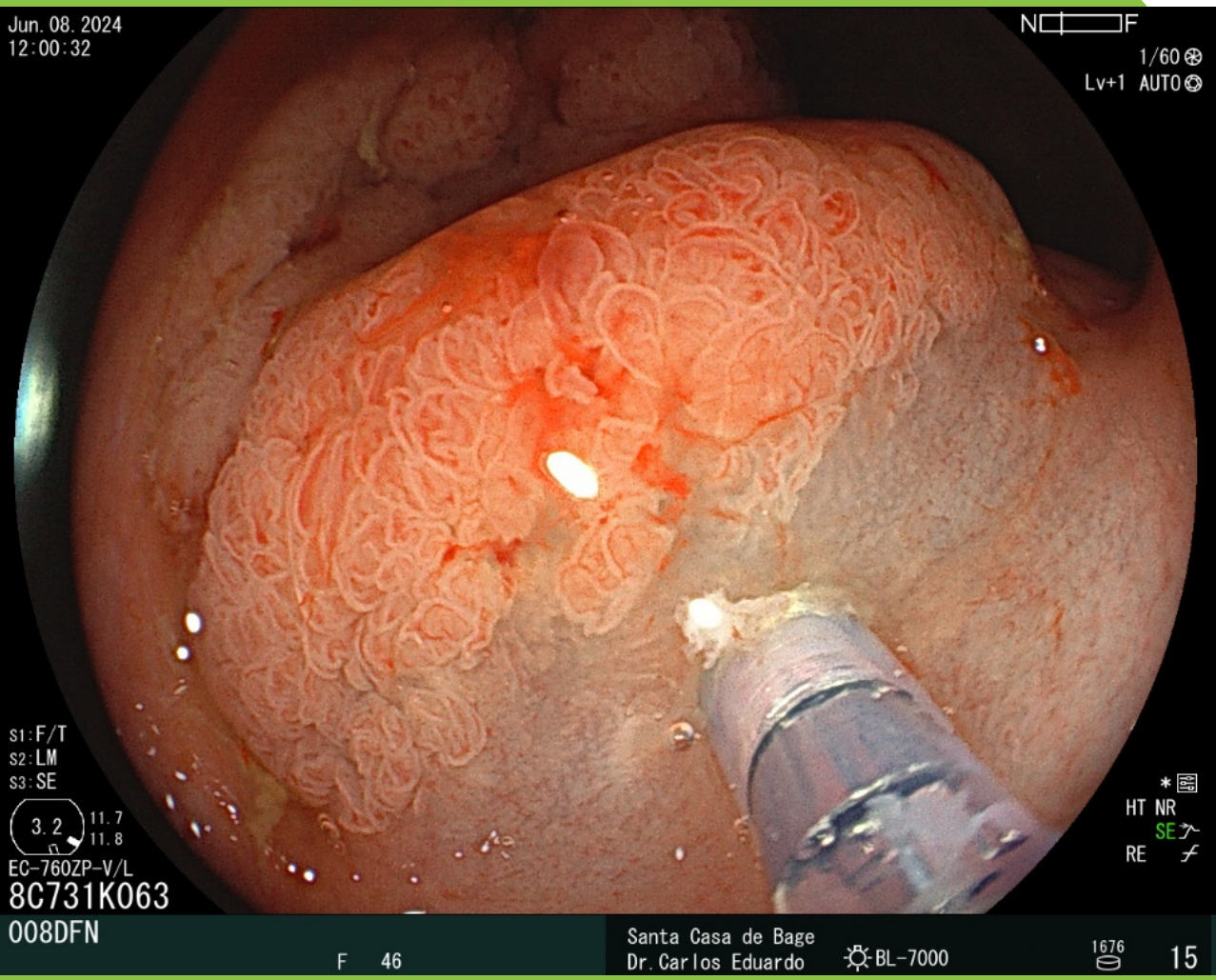
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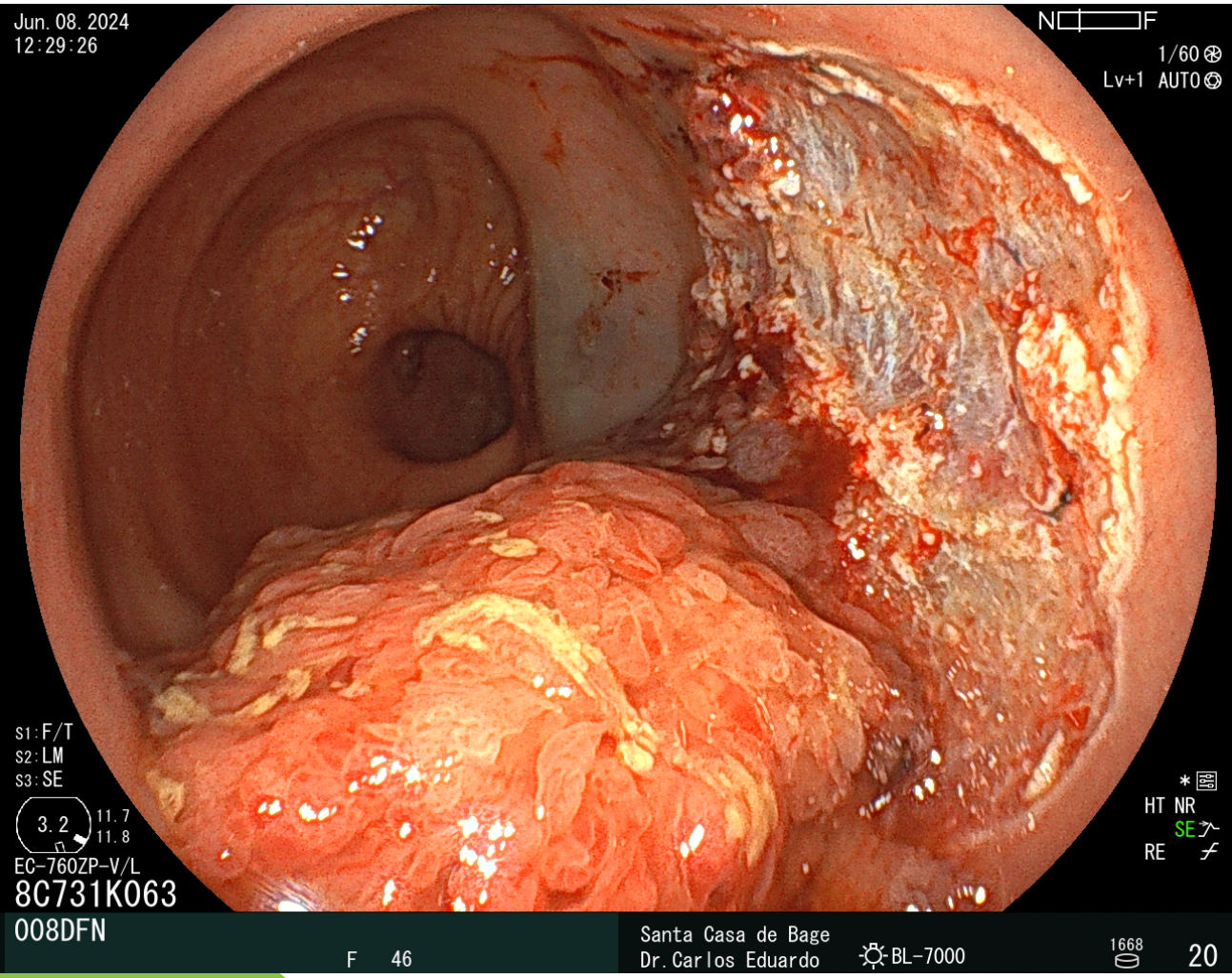
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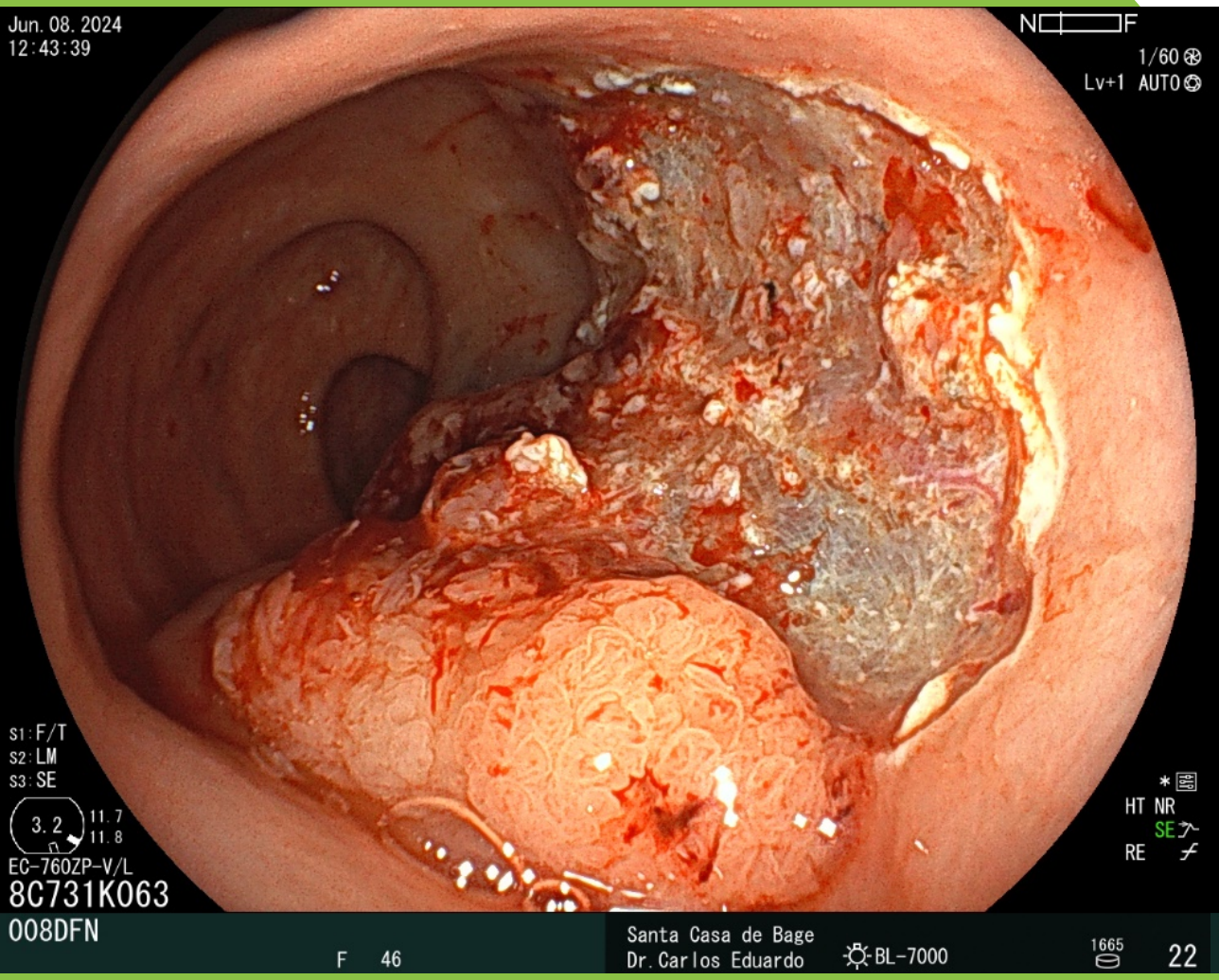
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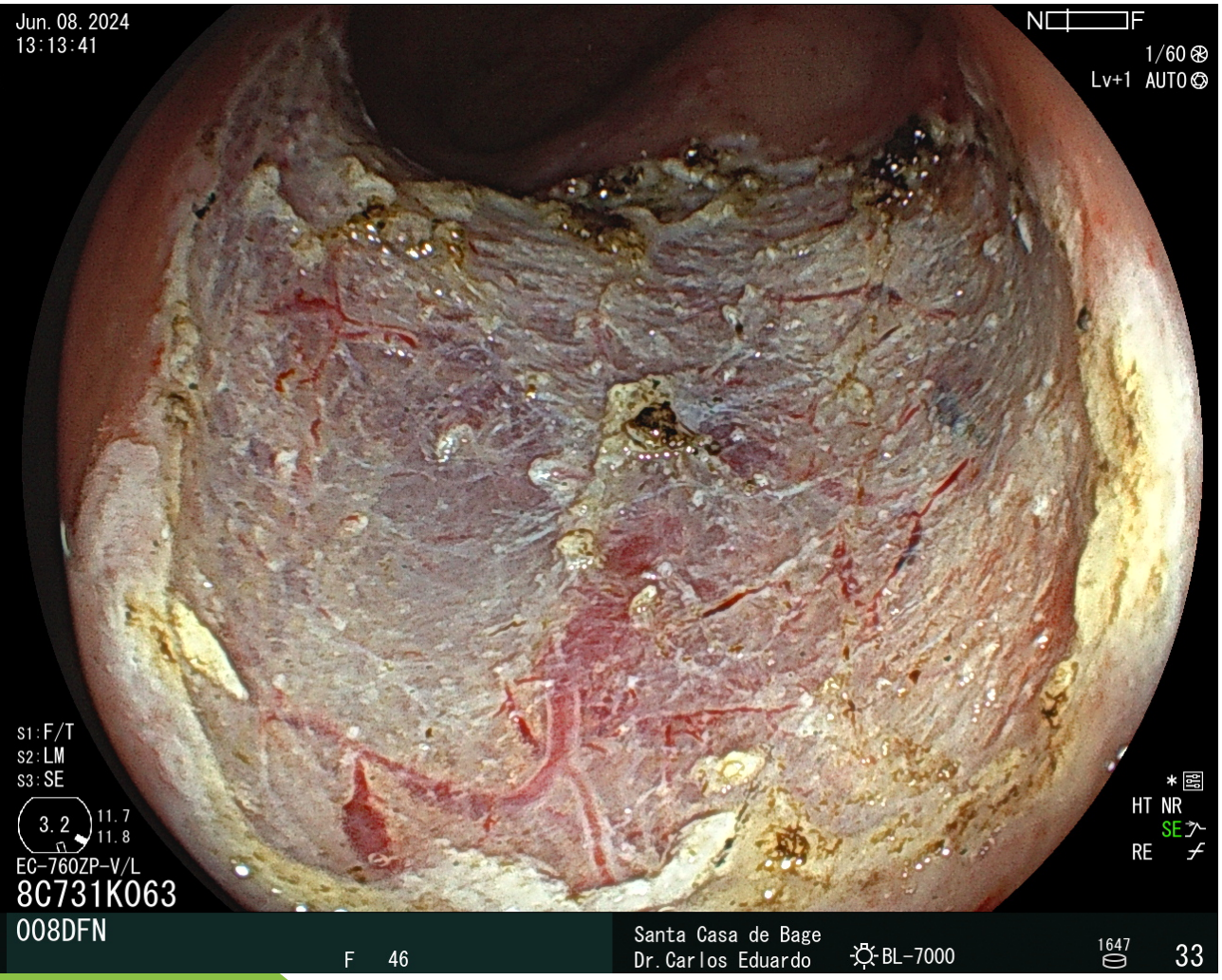
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Guideline

Thieme

Colorectal polypectomy and endoscopic mucosal resection: European Society of Gastrointestinal Endoscopy (ESGE) Guideline – Update 2024

ESGE

RECOMMENDATION

ESGE recommends the use of high quality photo- and/or videodocumentation in preference to biopsies to determine the most advanced pathology in LNPCPs and to inform selection of the optimal treatment strategy or facilitate tertiary referral. Where deep submucosal invasion is suspected, biopsies are indicated.

Strong recommendation, high quality of evidence.

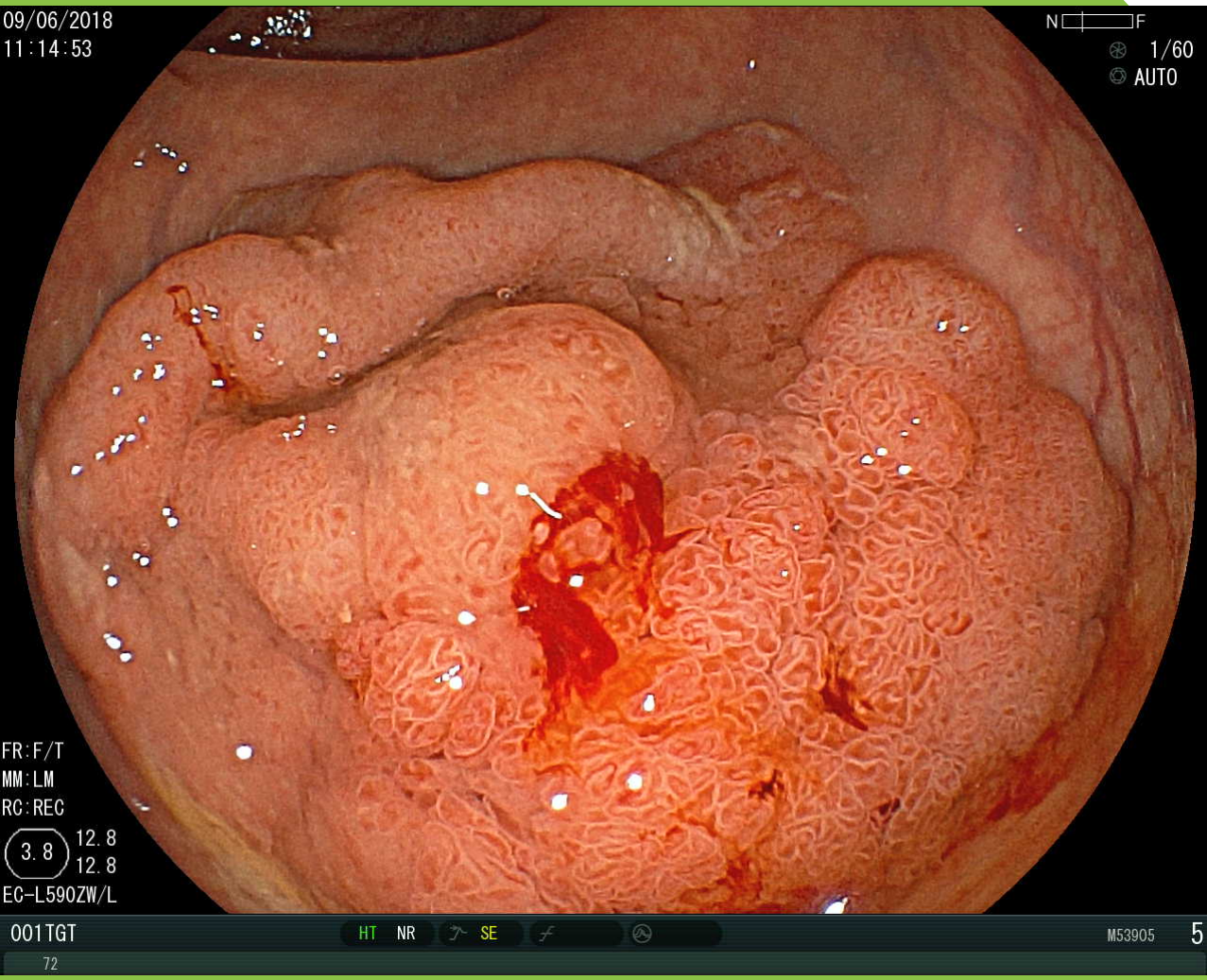
Digestive Endoscopy 2020; **32**: 219–239 doi: 10.1111/den.13545

Guidelines

Japan Gastroenterological Endoscopy Society guidelines for colorectal endoscopic submucosal dissection/endoscopic mucosal resection

Shinji Tanaka,[1,2,3,4] Hiroshi Kashida,[1] Yutaka Saito,[1,2] Naohisa Yahagi,[1] Hiroo Yamano,[1] Shoichi Saito,[1] Takashi Hisabe,[1] Takashi Yao,[2] Masahiko Watanabe,[2,3] Masahiro Yoshida,[1,4] Yusuke Saitoh,[1] Osamu Tsuruta,[1] Ken-ichi Sugihara,[2] Masahiro Igarashi,[1] Takashi Toyonaga,[1] Yoichi Ajioka,[2] Masato Kusunoki,[3] Kazuhiko Koike,[4] Kazuma Fujimoto[1] and Hisao Tajiri[1]

carcinoma cases.[81–87] In addition, biopsy should not be done in principle for qualitative diagnosis (strength of recommendation: 2, level of evidence: C). In cases of superficial-type lesions, because biopsy as a preoperative diagnosis may cause fibrosis in the SM layer and lead to a positive nonlifting sign, subsequent endoscopic treatment will be difficult.[81] For large lesions such as LST-G,[54] which, in several cases are "carcinoma in adenoma", a simple biopsy may not show an accurate yield as a qualitative diagnosis. Therefore, a diagnosis based on image enhancement/magnifying endoscopic observation as an optical biopsy (histological diagnosis by endoscopic imaging without forceps biopsy) is more effective.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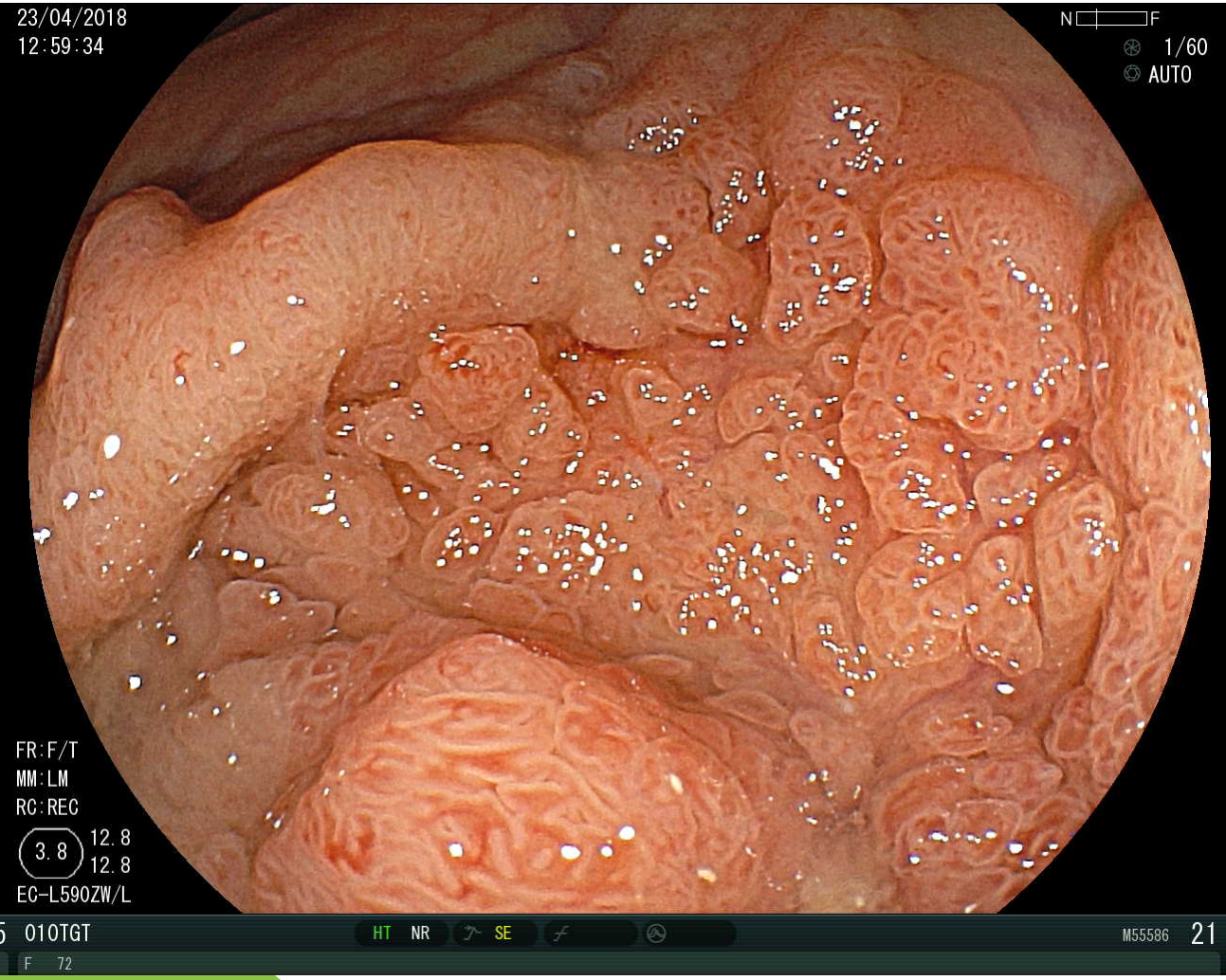
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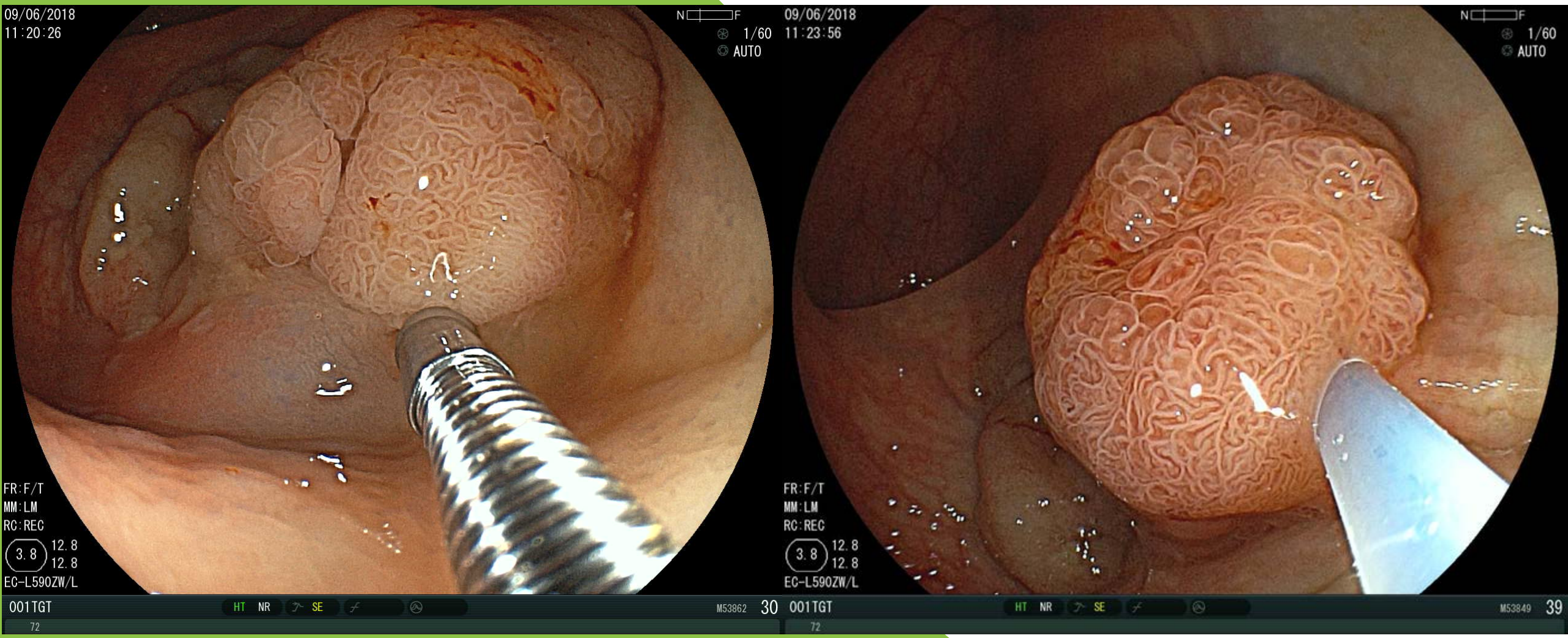
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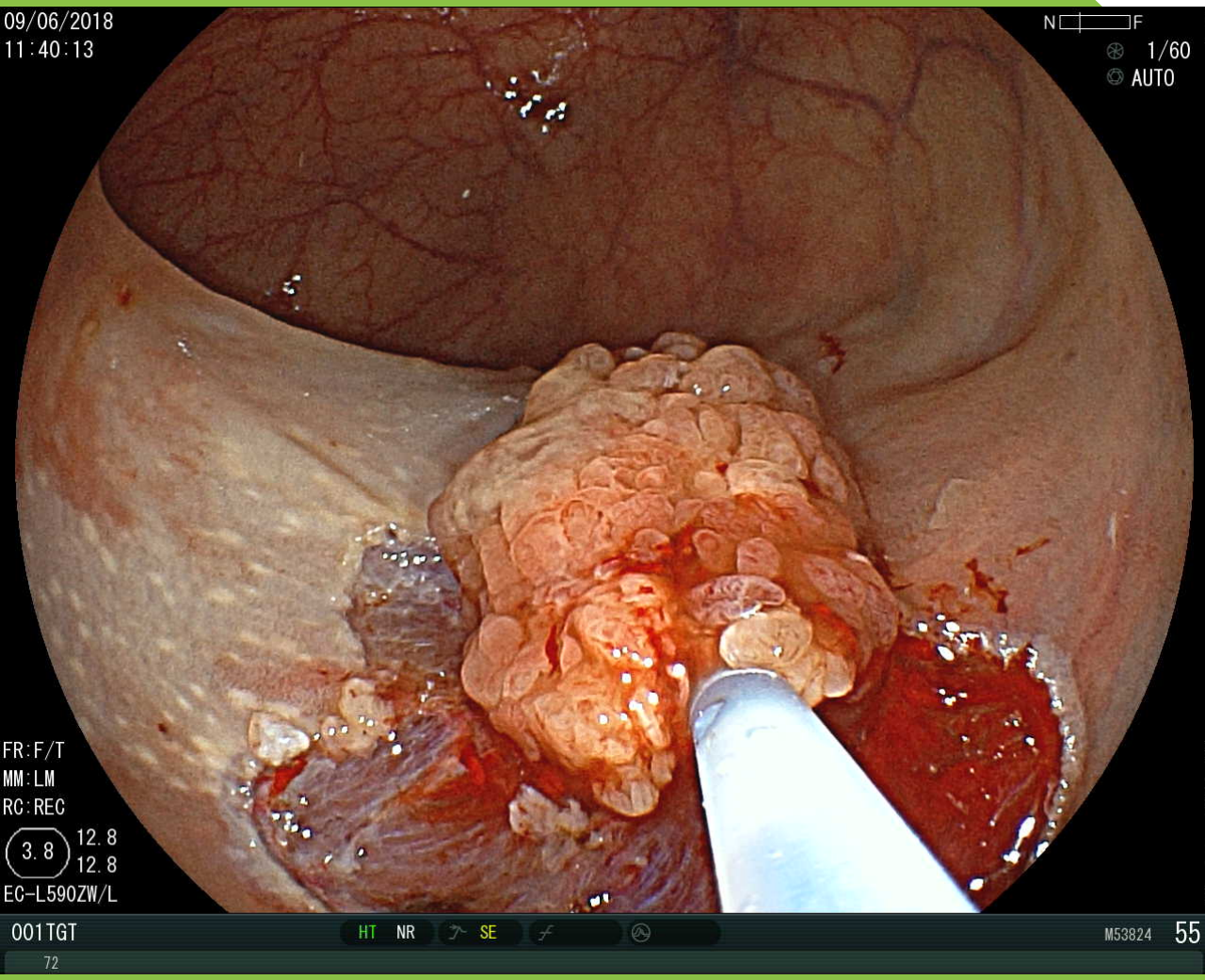
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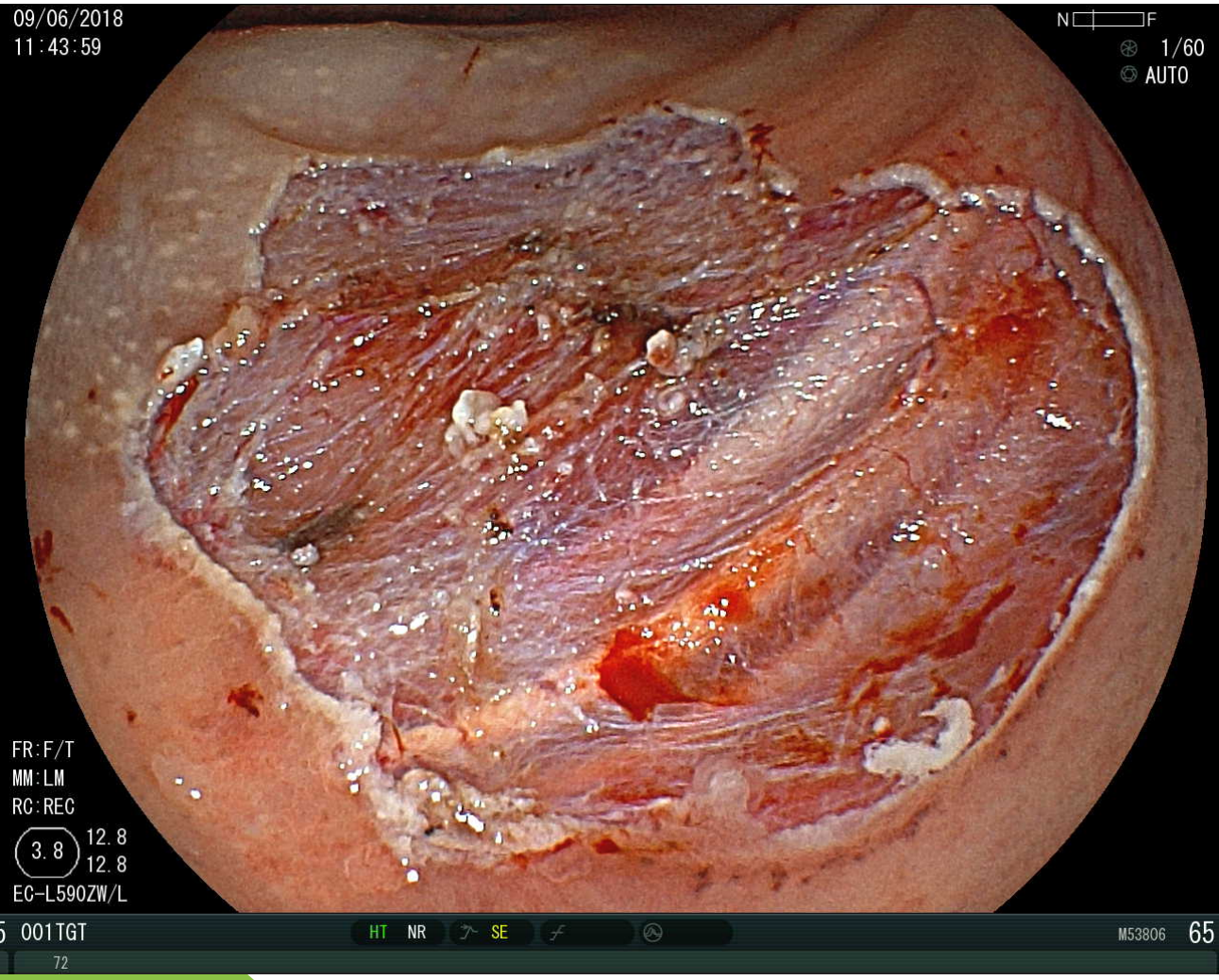
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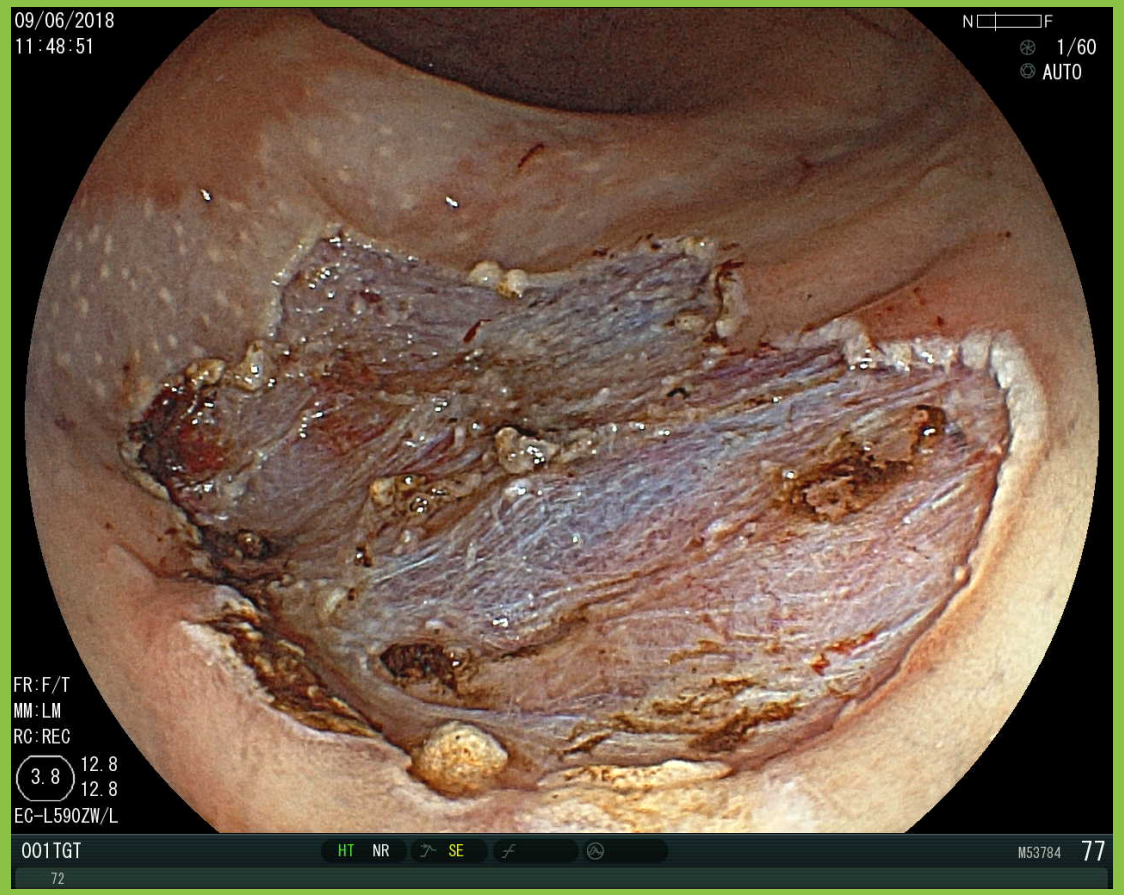
US MULTI-SOCIETY TASK FORCE

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]



Guideline

Thieme

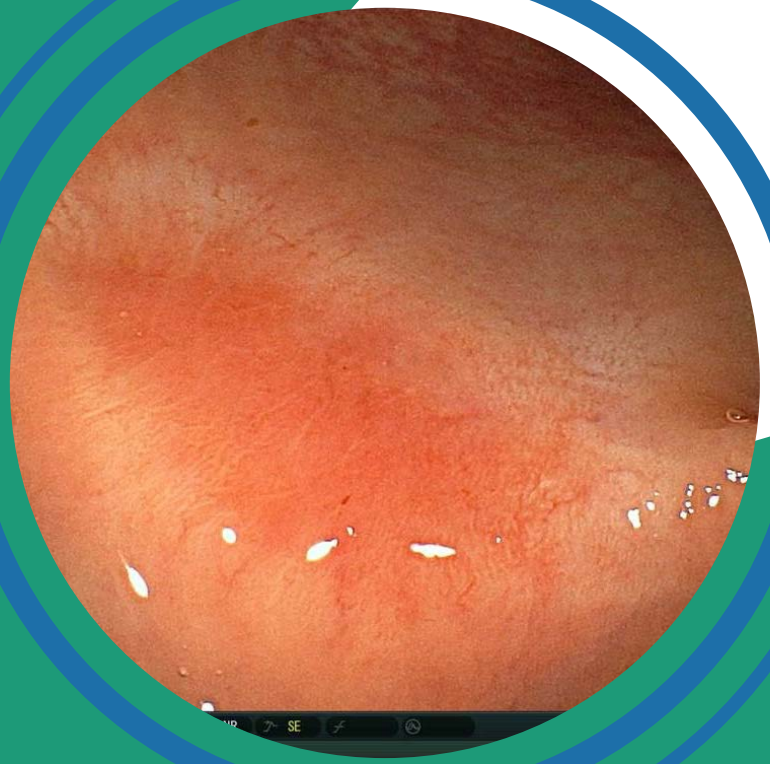
Colorectal polypectomy and endoscopic mucosal resection: European Society of Gastrointestinal Endoscopy (ESGE) Guideline – Update 2024

ESGE

RECOMMENDATION

ESGE recommends that, after piecemeal EMR of LNPCPs, the resection margins should be treated by thermal ablation using snare-tip soft coagulation (STSC) to prevent adenoma recurrence.
Strong recommendation, high quality of 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)



Guideline

Thieme

Colorectal polypectomy and endoscopic mucosal resection: European Society of Gastrointestinal Endoscopy (ESGE) Guideline – Update 2024

ESGE

RECOMMENDATION

ESGE recommends that successful EMR should be defined by: the lack of endoscopically visible remnant neoplastic tissue at the mucosectomy site; histologic assessment of the specimen; and the absence of recurrence at the first surveillance colonoscopy at 6 months.

Strong recommendation, moderate quality of evidence.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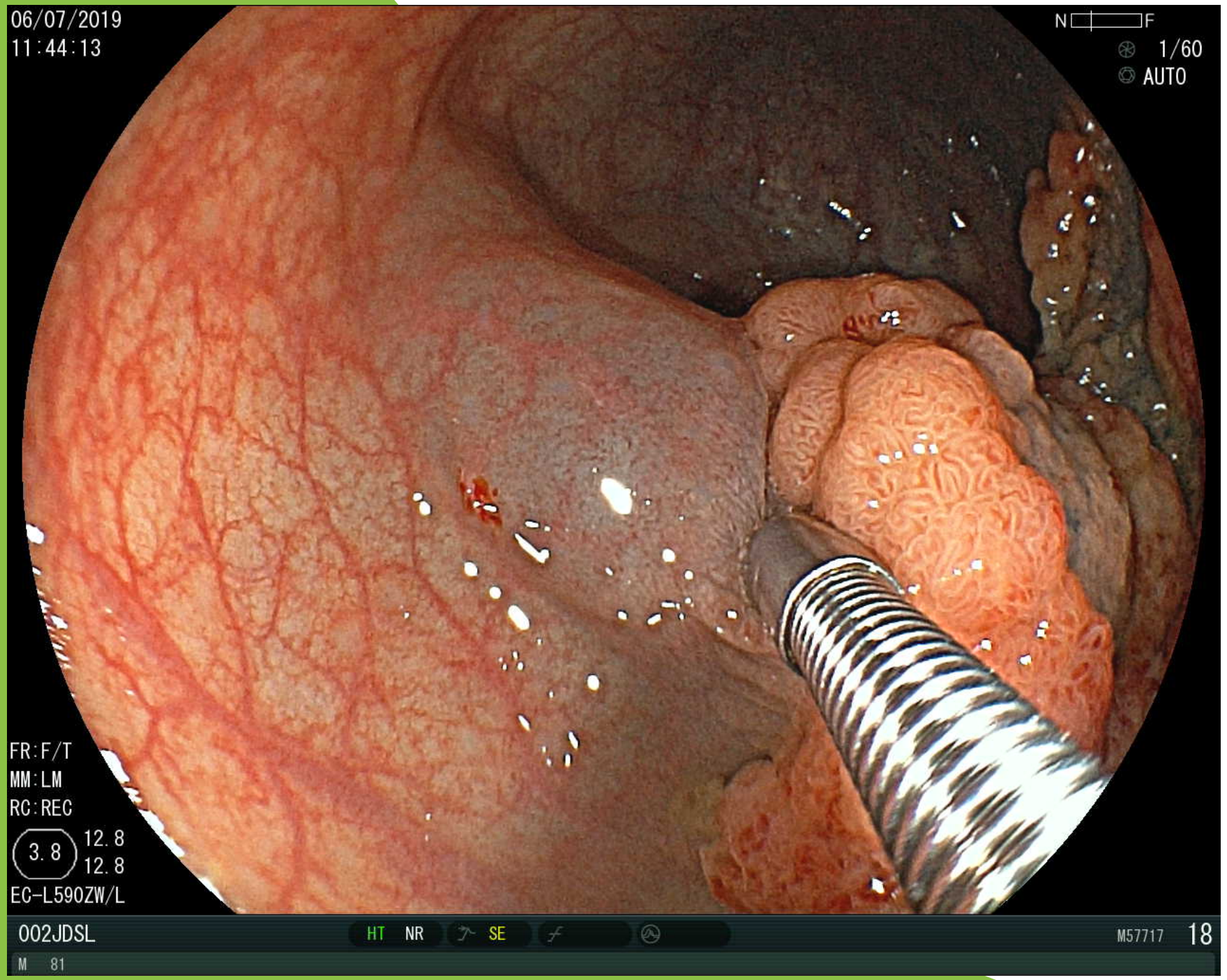
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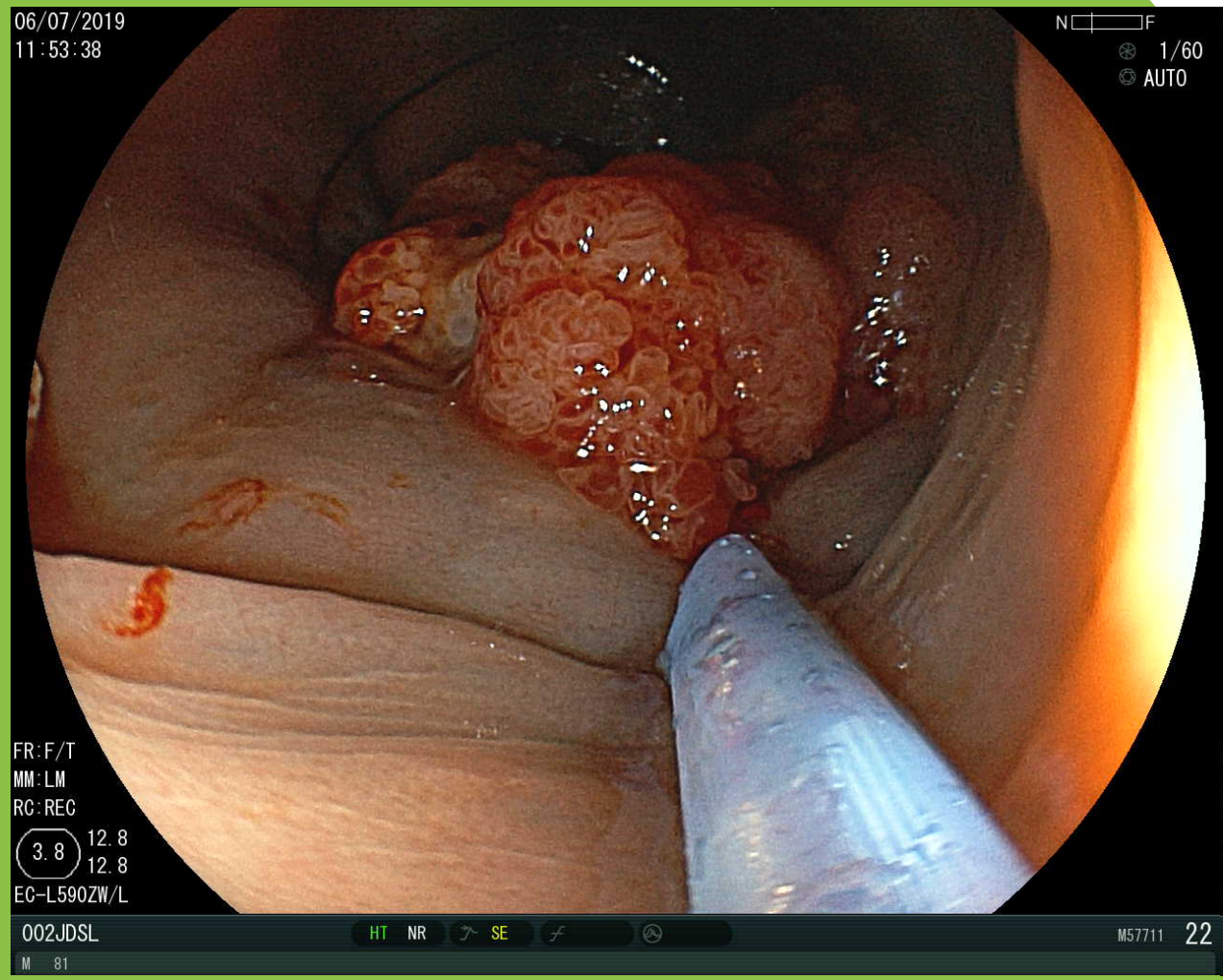
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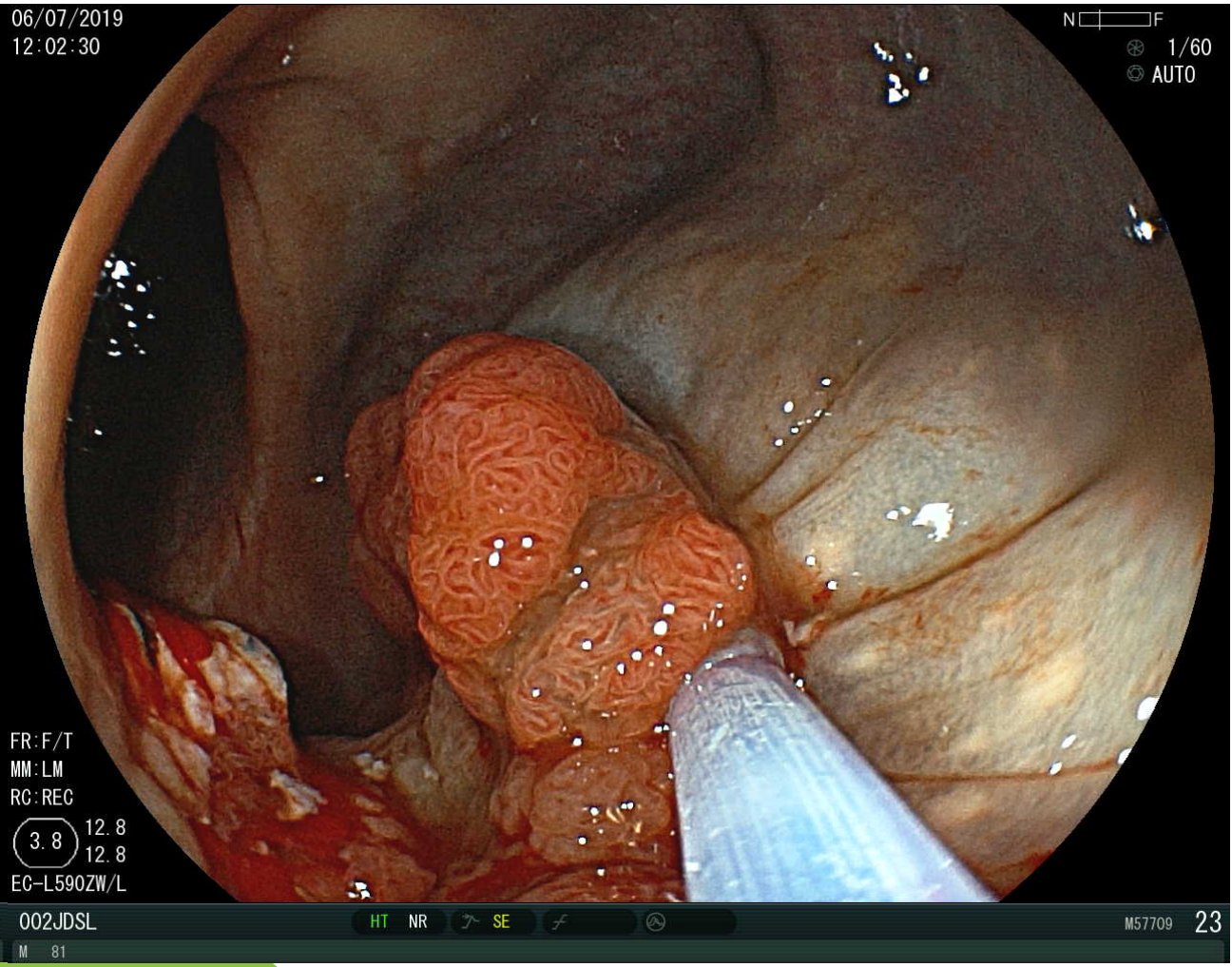
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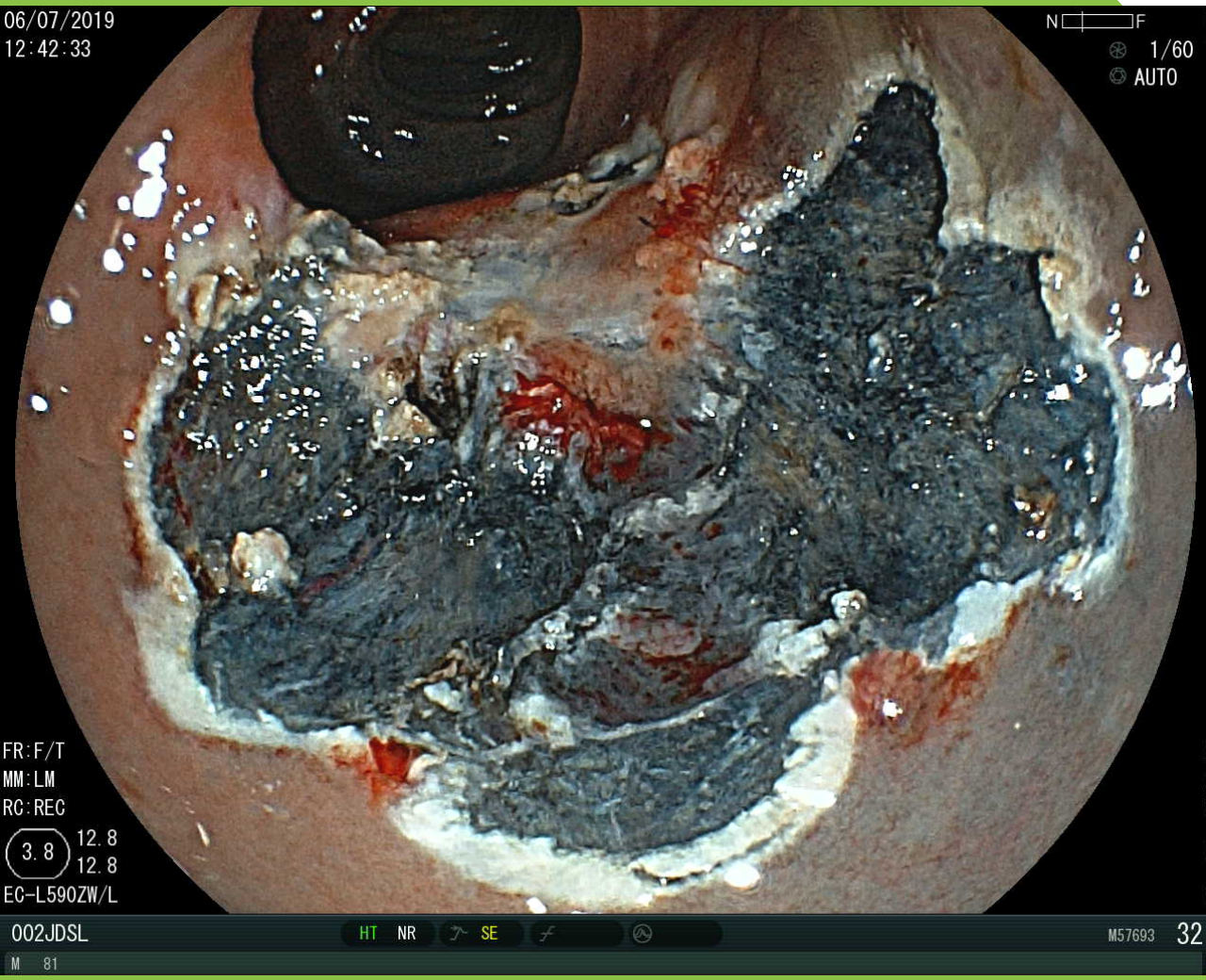
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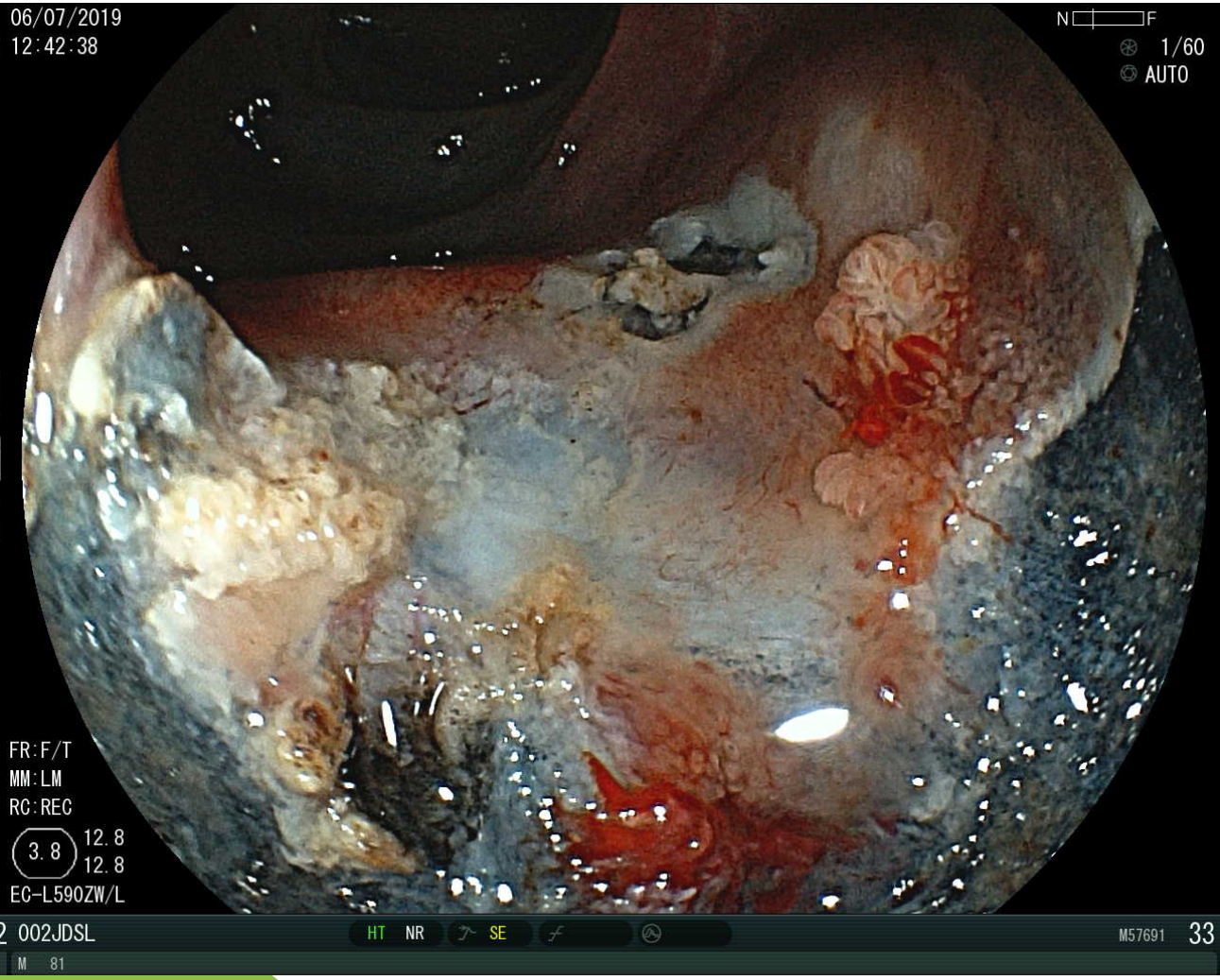
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Guideline

Thieme

Colorectal polypectomy and endoscopic mucosal resection: European Society of Gastrointestinal Endoscopy (ESGE) Guideline – Update 2024

ESGE

RECOMMENDATION

ESGE recommends that, in addition to conventional EMR, adjunctive techniques including hot or cold avulsion (CAST) be considered as treatment options in the management of nonlifting areas within LNPCPs.

Strong recommendation, moderate quality of evidence.


SE

Digestive Endoscopy 2020; **32**: 219–239 doi: 10.1111/den.13545

Guidelines

Japan Gastroenterological Endoscopy Society guidelines for colorectal endoscopic submucosal dissection/endoscopic mucosal resection

Shinji Tanaka,[1,2,3,4] Hiroshi Kashida,[1] Yutaka Saito,[1,2] Naohisa Yahagi,[1] Hiroo Yamano,[1] Shoichi Saito,[1] Takashi Hisabe,[1] Takashi Yao,[2] Masahiko Watanabe,[2,3] Masahiro Yoshida,[1,4] Yusuke Saitoh,[1] Osamu Tsuruta,[1] Ken-ichi Sugihara,[2] Masahiro Igarashi,[1] Takashi Toyonaga,[1] Yoichi Ajioka,[2] Masato Kusunoki,[3] Kazuhiko Koike,[4] Kazuma Fujimoto[1] and Hisao Tajiri[1]

Table 4 Local recurrence rate between *en bloc* and piecemeal resection

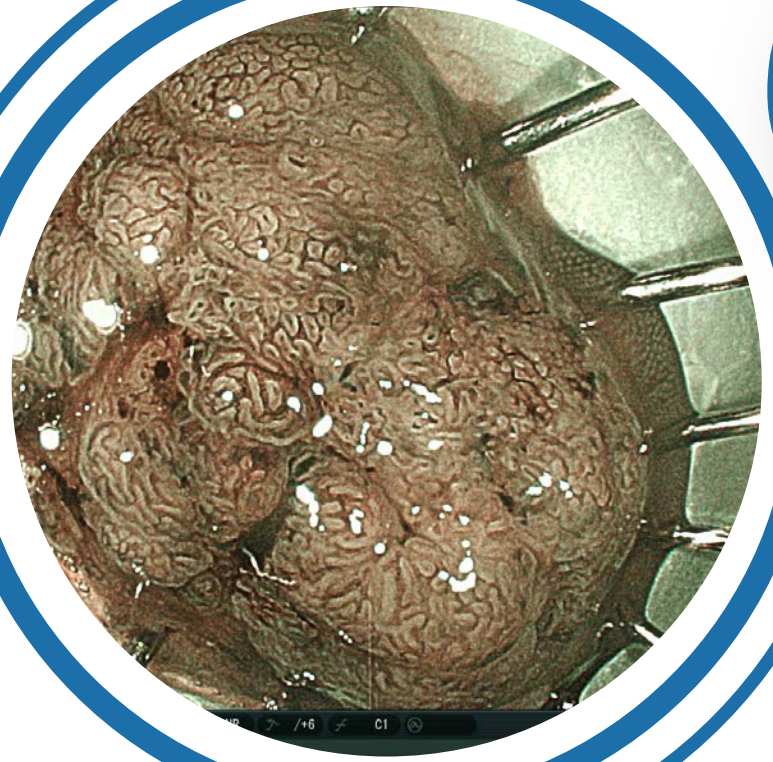
Resection method		Author
En bloc	Piecemeal	
2.7%	20.1%	Saito *et al*. (2010)[47]
0–3%	10–23%	Hotta *et al*. (2010)[49]
—	19%	Sakamoto *et al*. (2012)[50]
1.4%	6.8%	Oka *et al*. (2015)[53]
0.7%	23.5%	Hotta *et al*. (2009)[119]
1.2%	15.4%	Tajika *et al*. (2011)[148]

ORIGINAL ARTICLE

AG-2021-71
doi.org/10.1590/S0004-2803.202200001-04

Small as well as large colorectal lesions are effectively managed by endoscopic mucosal resection technique

Carlos Eduardo Oliveira dos **SANTOS**[1,2], Lysandro Alsina **NADER**[3], Cintia **SCHERER**[3], Rafaelle Gaglioto **FURLAN**[1], Ivan David Arciniegas **SANMARTIN**[4] and Júlio Carlos **PEREIRA-LIMA**[5]

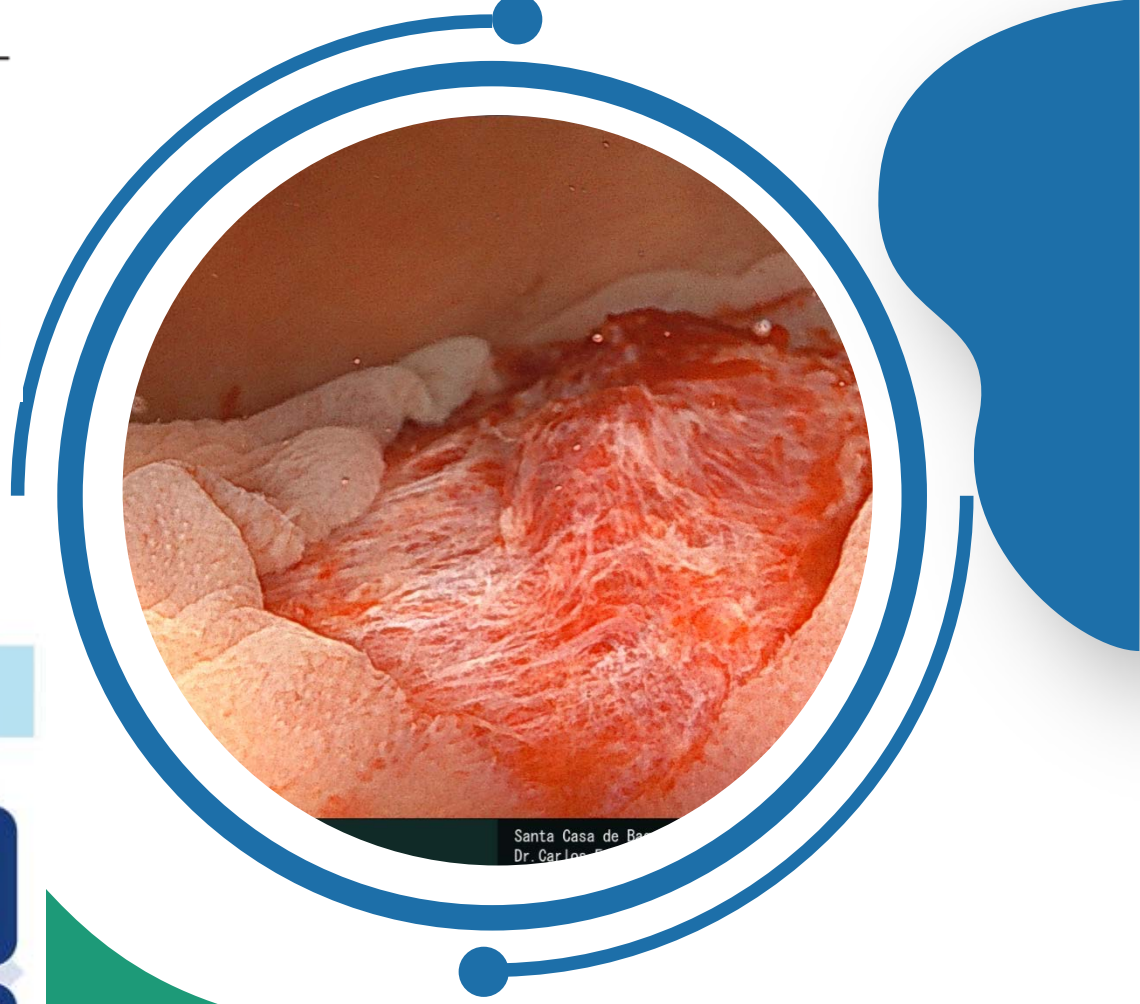


ABSTRACT – **Background** – Endoscopic mucosal resection (EMR) is an easy-to-use treatment option for superficial colorectal lesions, including lesions ≥20 mm. **Objective** – To evaluate the effectiveness of EMR. **Methods** – We evaluated 430 lesions removed by EMR in 404 patients. The lesions were analyzed according to their morphology, size, location, and histology. Lesions <20 mm were resected en bloc, whereas lesions ≥20 mm were removed by piecemeal EMR (p-EMR). Adverse events and recurrence were assessed. **Results** – Regarding morphology, 145 (33.7%) were depressed lesions, 157 (36.5%) were polypoid lesions and 128 (29.8%) were laterally spreading lesions, with 361 (84%) lesions <20 mm and 69 (16%) ≥20 mm. Regarding histology, 413 (96%) lesions were classified as neoplastic lesions. Overall, 14 (3.3%) adverse reactions occurred, most commonly in lesions removed by p-EMR (P<0.001) and associated with advanced histology (P=0.008). Recurrence occurred in 14 (5.2%) cases, more commonly in lesions removed by p-EMR (P<0.001). **Conclusion** – EMR is an effective technique for the treatment of superficial colorectal lesions, even of large lesions.

Thieme

Cold snare endoscopic mucosal resection for colon polyps: a systematic review and meta-analysis

Authors
Mohamed Abdallah[1], Khalid Ahmed[2], Daniyal Abbas[3], Mouhand F. H. Mohamed[4], Gaurav Suryawanshi[1], Nicholas McDonald[1], Natalie Wilson[1], Shifa Umar[5], Aasma Shaukat[6], Mohammad Bilal[1]



Cold snare endoscopic mucosal resection for colon polyps: a systematic review and meta-analysis

Cold snare endoscopic mucosal resection (CS-EMR)

Data on recurrence rates and adverse events for CS-EMR of colon polyps are mixed

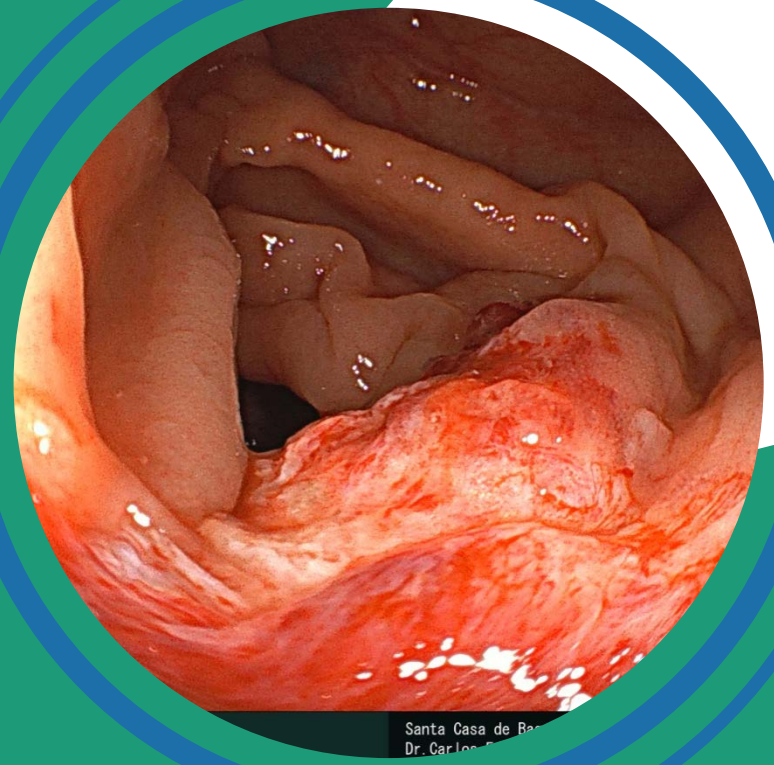
16 studies
- 5 retrospective
- 7 prospective
- 4 RCTs

2592 colon polyps

1922 patients

Recurrence rate 6.7% 95%CI 2.4%-17.4%	Intraprocedural bleeding rate 2.6% 95%CI 1.5%-4.5%
Delayed bleeding rate 1.5% 95%CI 0.8%-2.7%	Technical success rate 97.2% 95%CI 91.8%-99.1%

Endoscopy



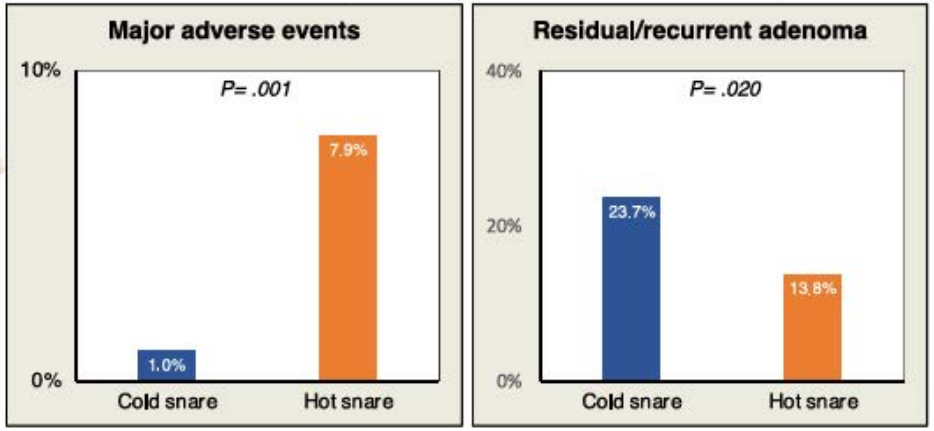
Cold Versus Hot Snare Endoscopic Resection of Large Nonpedunculated Colorectal Polyps: Randomized Controlled German CHRONICLE Trial

Ingo Steinbrück,[1] Alanna Ebigbo,[2] Armin Kuellmer,[3] Arthur Schmidt,[3,4] Konstantinos Kouladouros,[5] Markus Brand,[6] Teresa Koenen,[7] Viktor Rempel,[8] Andreas Wannhoff,[9] Siegbert Faiss,[10] Oliver Pech,[11] Oliver Möschler,[12] Franz Ludwig Dumoulin,[13] Martha M. Kirstein,[14] Thomas von Hahn,[15] Hans-Dieter Allescher,[16] Stefan K. Gölder,[17] Martin Götz,[18] Stephan Hollerbach,[19] Björn Lewerenz,[20] Alexander Meining,[6] Helmut Messmann,[2] Thomas Rösch,[21] and Hans-Peter Allgaier[1]

Gastroenterology 2024;167:764–777

Cold versus Hot Snare Endoscopic Resection of Large Non-Pedunculated Colorectal Polyps (Randomized-controlled German CHRONICLE-trial)

Major adverse events are a relevant problem of hot snare-EMR of non-pedunculated colorectal polyps ≥ 2cm.



Cold snare-EMR appears safer than hot snare-EMR with an almost complete elimination of major adverse events, but results in a higher rate of residual adenoma at the first endoscopic follow-up.

Gastroenterology

"Underwater" EMR without submucosal injection for large sessile colorectal polyps (with video)

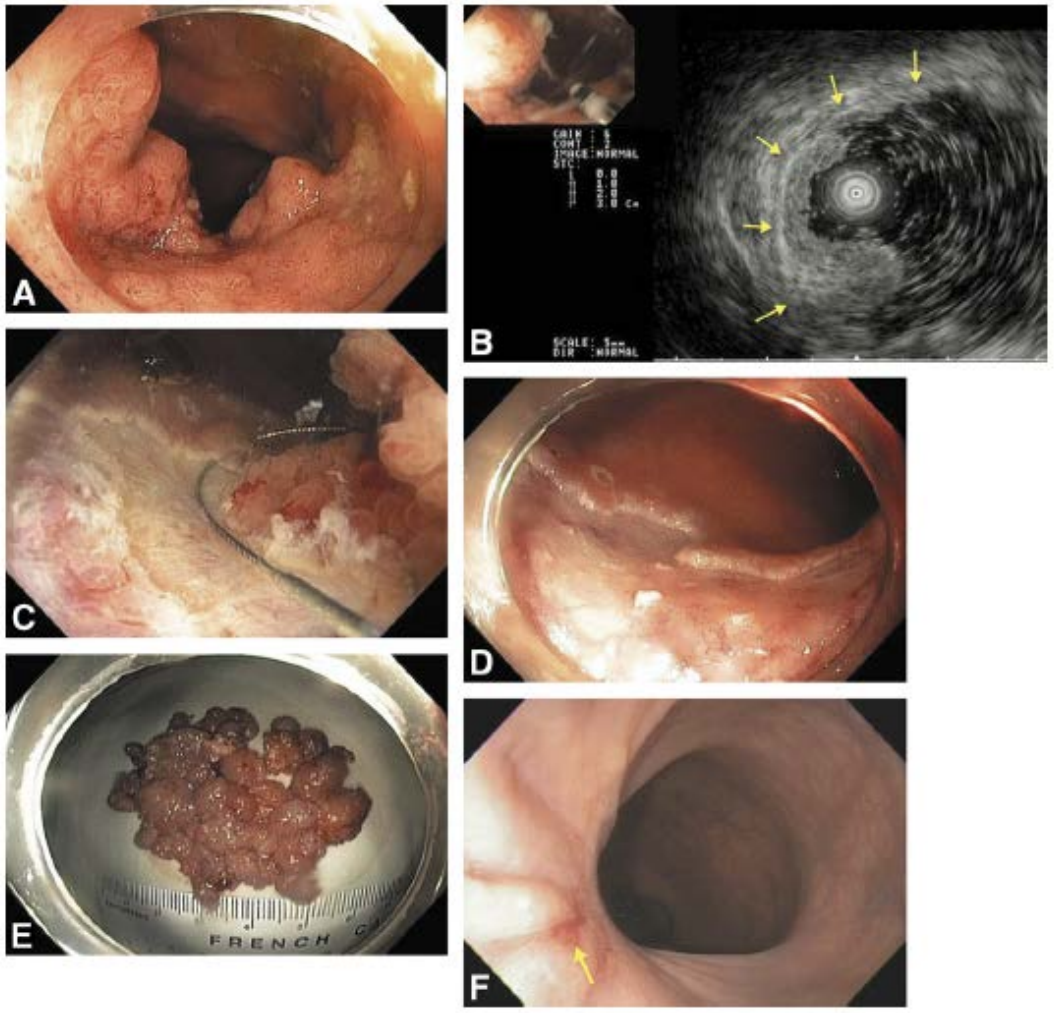
Kenneth F. Binmoeller, MD, Frank Weilert, MD, Janak Shah, MD, Yasser Bhat, MD, Steve Kane

San Francisco, California, USA

RECOMMENDATION

ESGE suggests that underwater EMR can be considered an alternative to conventional hot EMR for the treatment of adenomatous LNPCPs.

Weak recommendation, moderate quality of evidence.

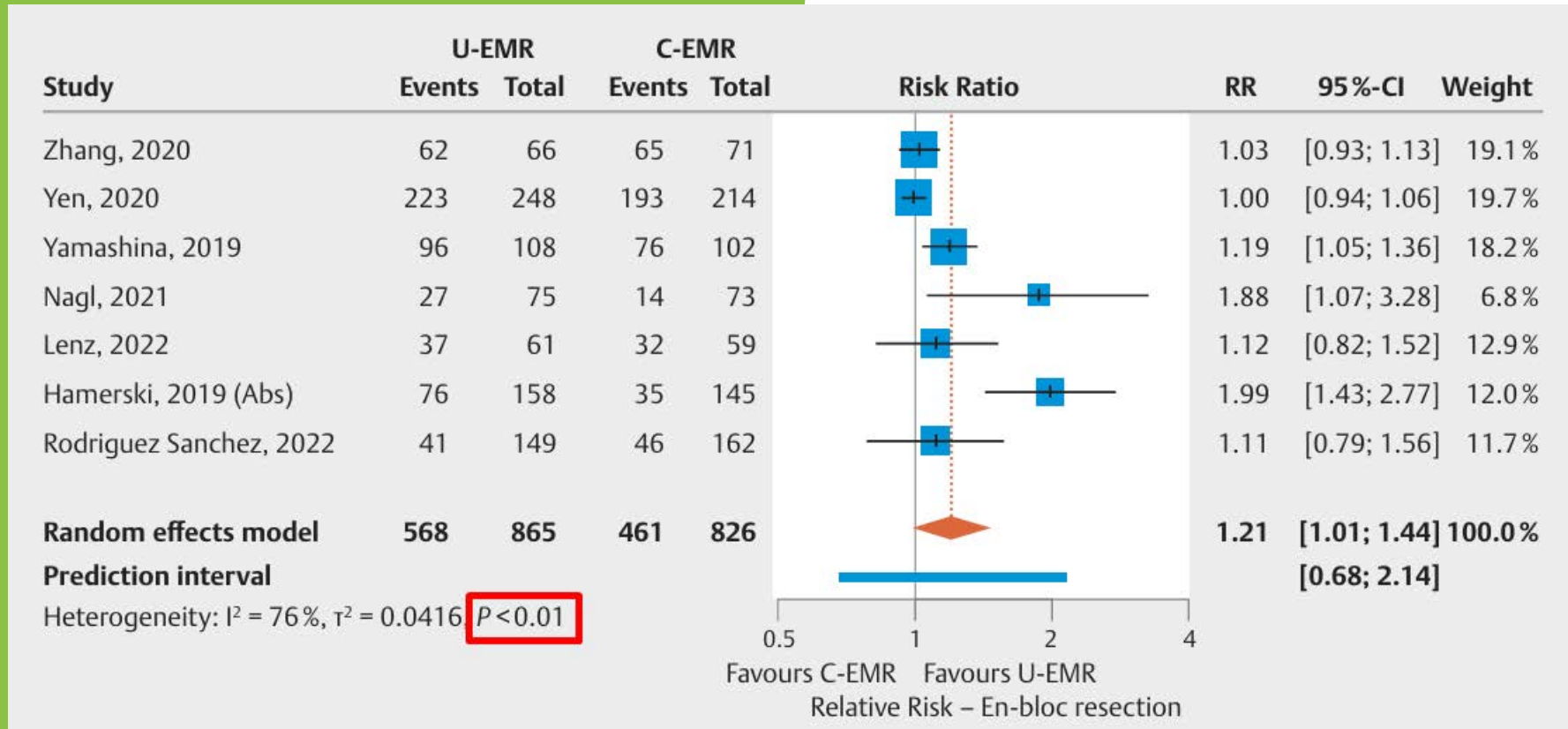


Thieme

Safety and efficacy of underwater versus conventional endoscopic mucosal resection for colorectal polyps: Systematic review and meta-analysis of RCTs

OPEN ACCESS

Authors
Saurabh Chandan[1], Jay Bapaye[2], Shahab R. Khan[3], Babu P. Mohan[4], Daryl Ramai[4], Dushyant S. Dahiya[5], Mohammad Bilal[6], Peter V. Draganov[7], Mohamed O. Othman[8], Joaquin Rodriguez Sánchez[9], Gursimran S. Kochhar[10]

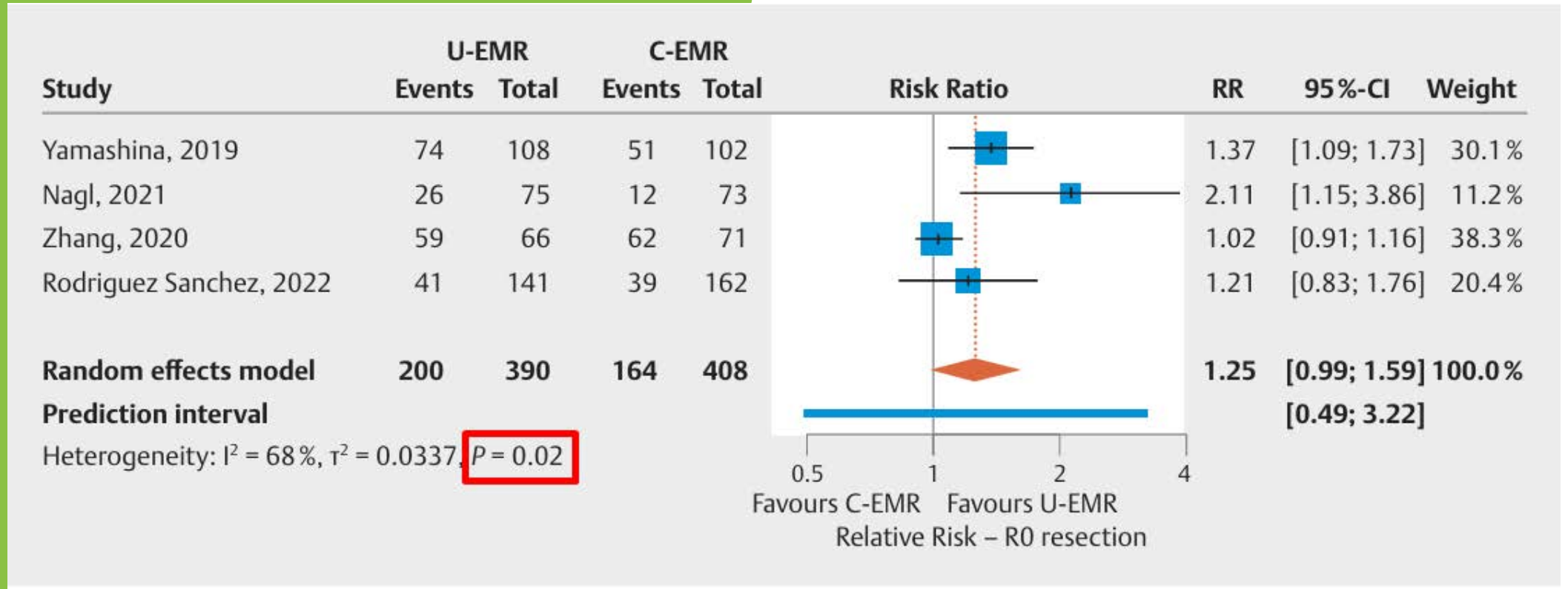


▶ **Fig. 2** Forest plot, RR, en-bloc resection.

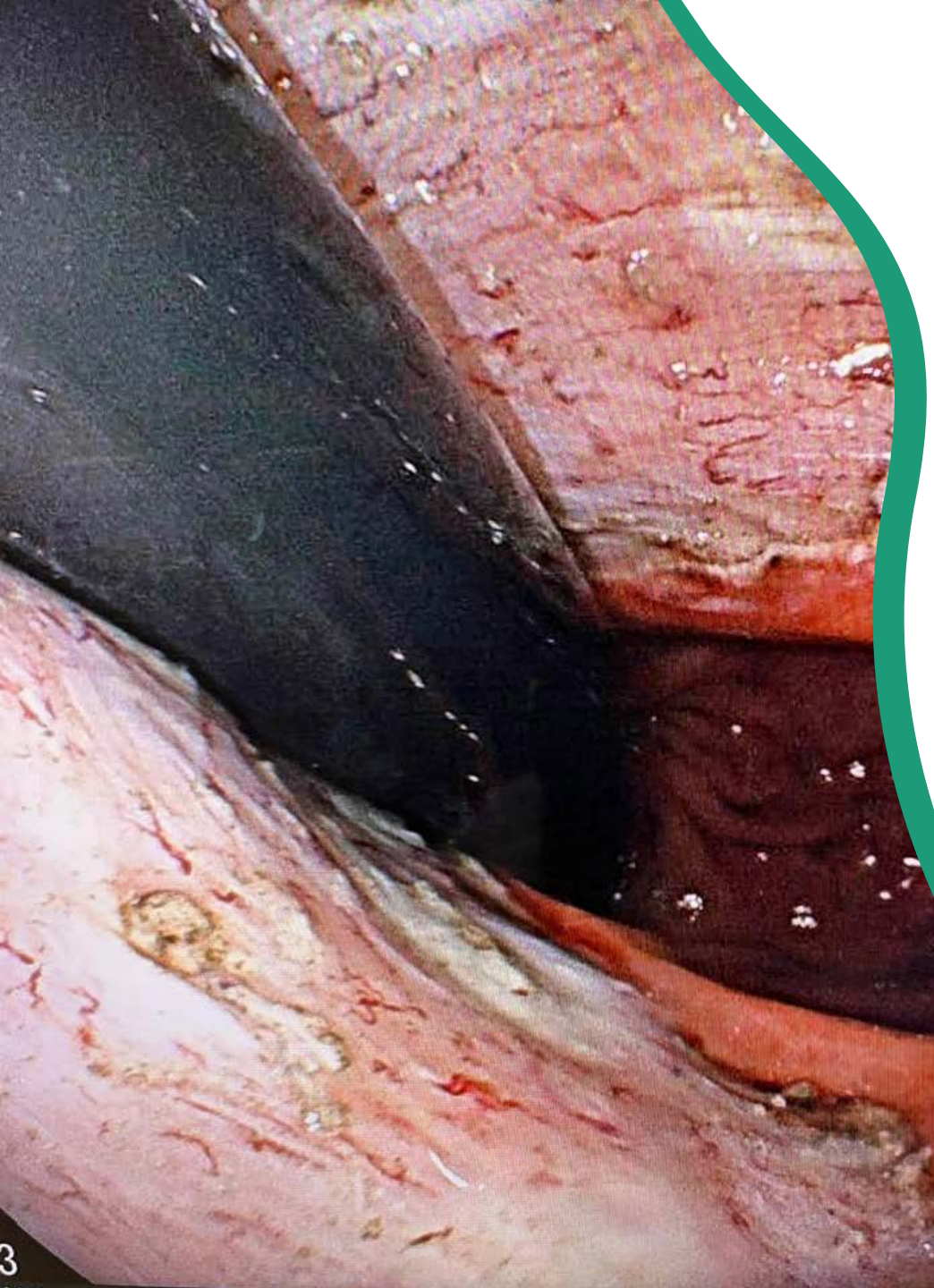
Safety and efficacy of underwater versus conventional endoscopic mucosal resection for colorectal polyps: Systematic review and meta-analysis of RCTs

OPEN ACCESS

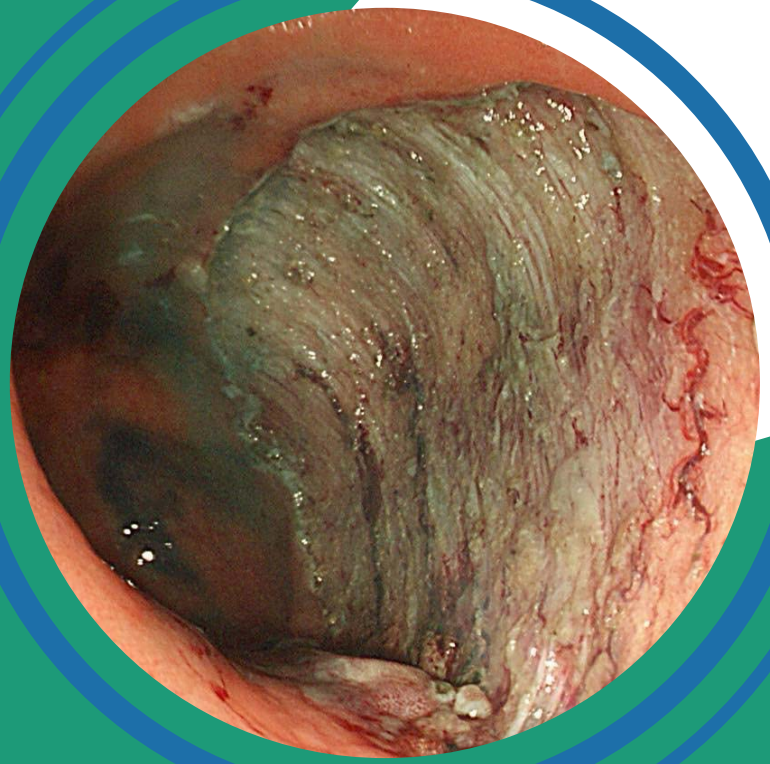
Authors
Saurabh Chandan[1], Jay Bapaye[2], Shahab R. Khan[3], Babu P. Mohan[4], Daryl Ramai[4], Dushyant S. Dahiya[5], Mohammad Bilal[6], Peter V. Draganov[7], Mohamed O. Othman[8], Joaquin Rodriguez Sánchez[9], Gursimran S. Kochhar[10]



▶ **Fig. 1** Forest plot, RR, R0 resection.



ESD



Guideline

Thieme

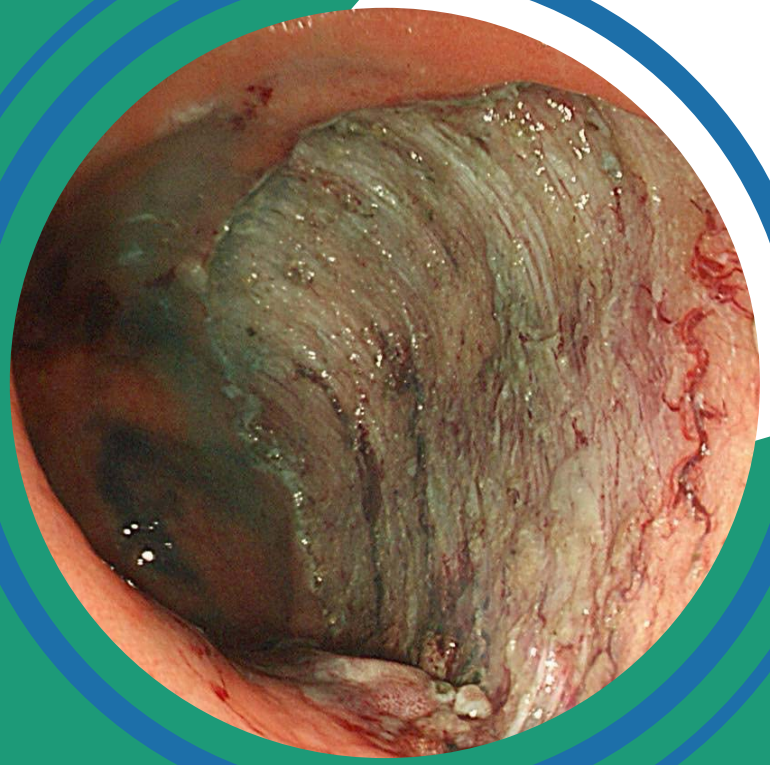
Colorectal polypectomy and endoscopic mucosal resection: European Society of Gastrointestinal Endoscopy (ESGE) Guideline – Update 2024

ESGE

RECOMMENDATION

Endoscopic submucosal dissection may also be suggested as an alternative for removal of LNPCPs of ≥ 20 mm in selected cases and in high-volume centers.

Weak recommendation, low quality of evidence.



Digestive Endoscopy 2020; **32**: 219–239 doi: 10.1111/den.13545

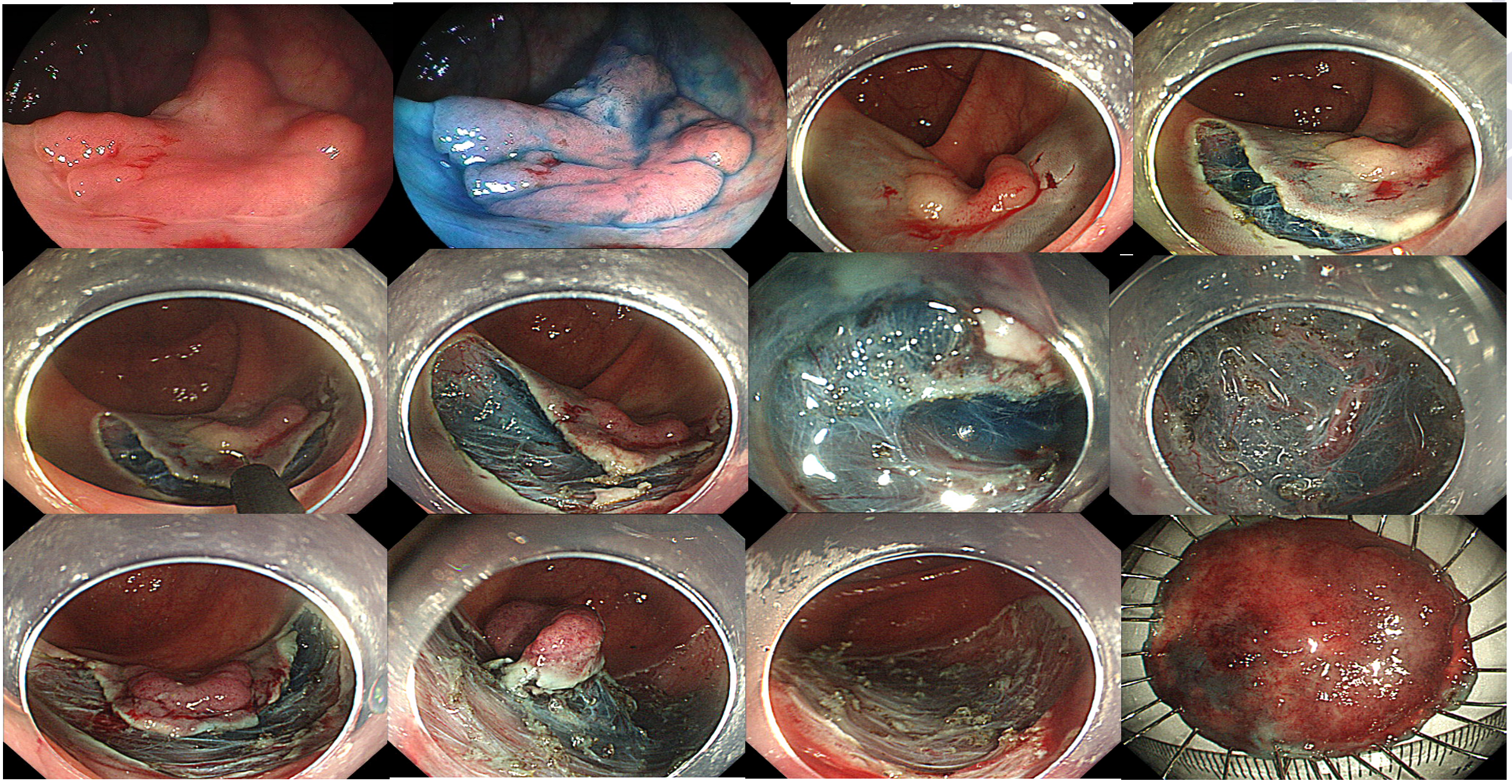
Guidelines

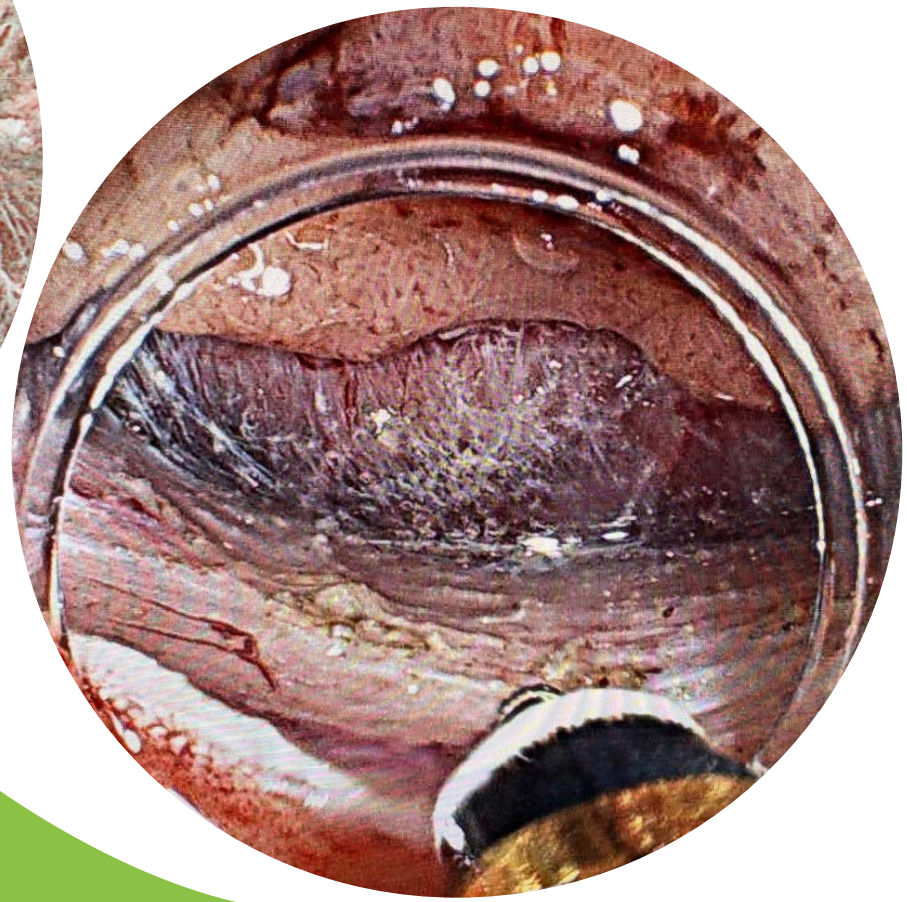
Japan Gastroenterological Endoscopy Society guidelines for colorectal endoscopic submucosal dissection/endoscopic mucosal resection

Shinji Tanaka,[1,2,3,4] Hiroshi Kashida,[1] Yutaka Saito,[1,2] Naohisa Yahagi,[1] Hiroo Yamano,[1] Shoichi Saito,[1] Takashi Hisabe,[1] Takashi Yao,[2] Masahiko Watanabe,[2,3] Masahiro Yoshida,[1,4] Yusuke Saitoh,[1] Osamu Tsuruta,[1] Ken-ichi Sugihara,[2] Masahiro Igarashi,[1] Takashi Toyonaga,[1] Yoichi Ajioka,[2] Masato Kusunoki,[3] Kazuhiko Koike,[4] Kazuma Fujimoto[1] and Hisao Tajiri[1]

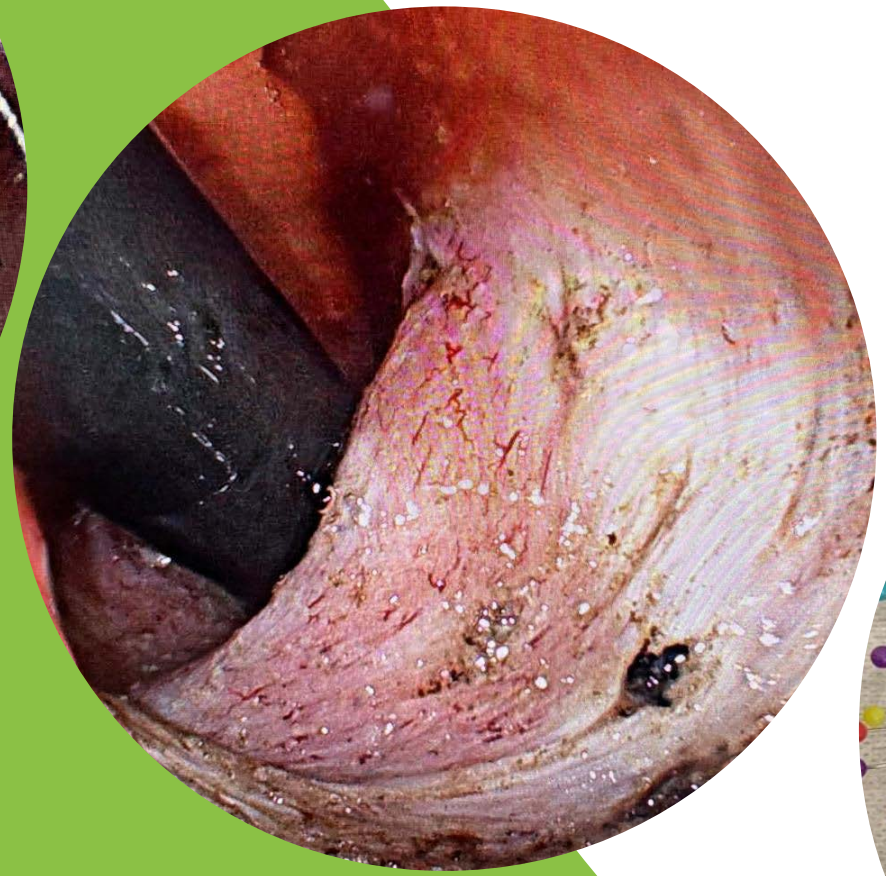
Table 2 Indications for endoscopic submucosal dissection of colorectal tumors

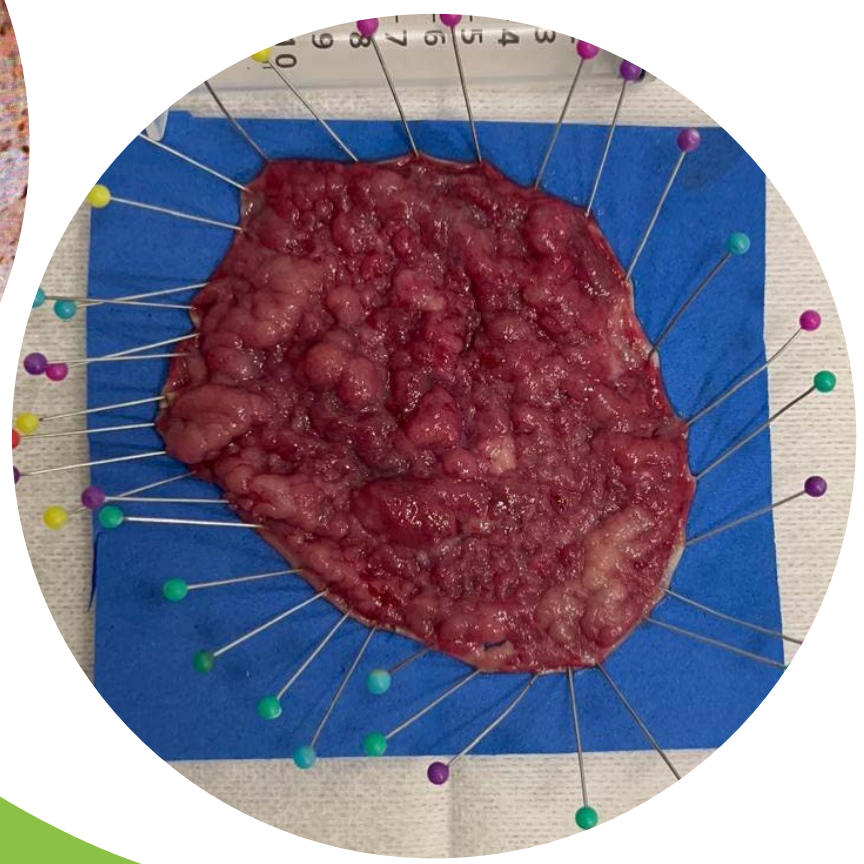
Lesions for which endoscopic en bloc resection is required
1) Lesions for which en bloc resection with snare EMR is difficult to apply
LST-NG, particularly LST-NG (PD)
Lesions showing a VI-type pit pattern
Carcinoma with shallow T1 (SM) invasion
Large depressed-type tumors
Large protruded-type lesions suspected to be carcinoma†
2) Mucosal tumors with submucosal fibrosis‡
3) Sporadic tumors in conditions of chronic inflammation such as ulcerative colitis
4) Local residual or recurrent early carcinomas after endoscopic resection





Cortesia de Rafael Castilho Pinto





Cortesia de Rafael Castilho Pinto

Digestive Endoscopy 2020; **32**: 219–239 doi: 10.1111/den.13545

Guidelines

Japan Gastroenterological Endoscopy Society guidelines for colorectal endoscopic submucosal dissection/endoscopic mucosal resection

Shinji Tanaka,[1,2,3,4] Hiroshi Kashida,[1] Yutaka Saito,[1,2] Naohisa Yahagi,[1] Hiroo Yamano,[1] Shoichi Saito,[1] Takashi Hisabe,[1] Takashi Yao,[2] Masahiko Watanabe,[2,3] Masahiro Yoshida,[1,4] Yusuke Saitoh,[1] Osamu Tsuruta,[1] Ken-ichi Sugihara,[2] Masahiro Igarashi,[1] Takashi Toyonaga,[1] Yoichi Ajioka,[2] Masato Kusunoki,[3] Kazuhiko Koike,[4] Kazuma Fujimoto[1] and Hisao Tajiri[1]

Table 3 Perforation rate during procedure in accordance with resection technique

Perforation rate			Author
Polypectomy	EMR	ESD	
—	0%	10.7%	Kobayashi *et al*. (2012)[48]
—	0.8%	2.0%	Nakajima *et al*. (2013)[111]
0%	0.78%	—	Wada *et al*. (2015)[131]
—	—	5.5%	Fujishiro *et al*. (2007)[132]
—	—	8.2%	Isomoto *et al*. (2009)[133]

—, no data.
EMR, endoscopic mucosal resection; ESD, endoscopic submucosal dissection.

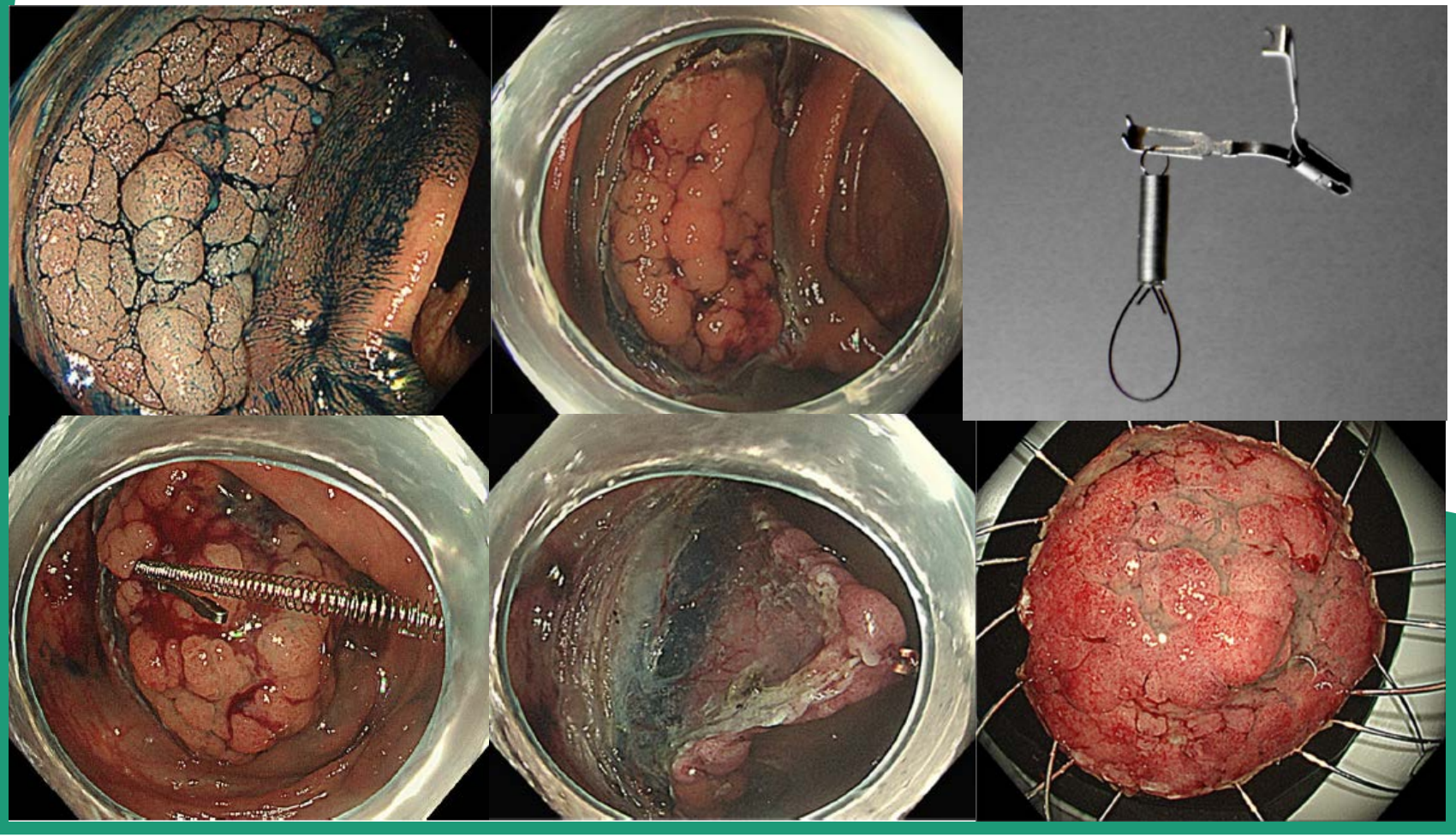
Journal of
Clinical Medicine

MDPI

Article

Effectiveness of S-O Clip-Assisted Colorectal Endoscopic Submucosal Dissection

Haruka Fujinami [1,*], Akira Teramoto [2], Saeko Takahashi [2], Takayuki Ando [2], Shinya Kajiura [3] and Ichiro Yasuda [2]



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Article

Effectiveness of S-O Clip-Assisted Colorectal Endoscopic Submucosal Dissection

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Table 2. Overall outcomes.

	CO Group (n = 47)	SO Group (n = 80)	p-Value
Surgery duration, mean ± SD (range), min	73.9 ± 43.5 (31–226)	52.3 ± 21.8 (16–113)	0.0006 *
Lesion area, mean ± SD (range), mm^2	616.8 ± 576.8 (235.6–1507.9)	660.6 ± 333.6 (259.2–1696.4)	0.227
Dissection time, mean ± SD (range), min	49.7 ± 37.1 (17–189)	31.9 ± 16.4 (7–82)	<0.001 *
Dissection speed, mean ± SD (range), mm^2/min	14.8 ± 8.7 (4.1–50.1)	24.4 ± 12.9 (5.5–70.6)	0.0014 *
En bloc resection rate, % (n)	80.9 (38/47)	98.8 (79/80)	<0.001 *
Perforation rate, % (n)	4.3 (2/47)	1.3 (1/80)	0.554
Hemorrhage rate, % (n)	0 (0/47)	2.5 (2/80)	0.530

* A p value of < 0.05 was considered statistically significant.

Surgical Endoscopy
https://doi.org/10.1007/s00464-021-08471-5

Indications and outcomes of colorectal hybrid endoscopic submucosal dissection: a large multicenter 10-year study

Yuki Okamoto[1] · Shiro Oka[1] · Shinji Tanaka[2] · Shinji Nagata[3] · Masaki Kunihiro[4] · Toshio Kuwai[5] · Yuko Hiraga[6] · Seiji Onogawa[7] · Takeshi Mizumoto[8] · Hideharu Okanobu[9] · Morihisa Akagi[10] · Kazuaki Chayama[1]

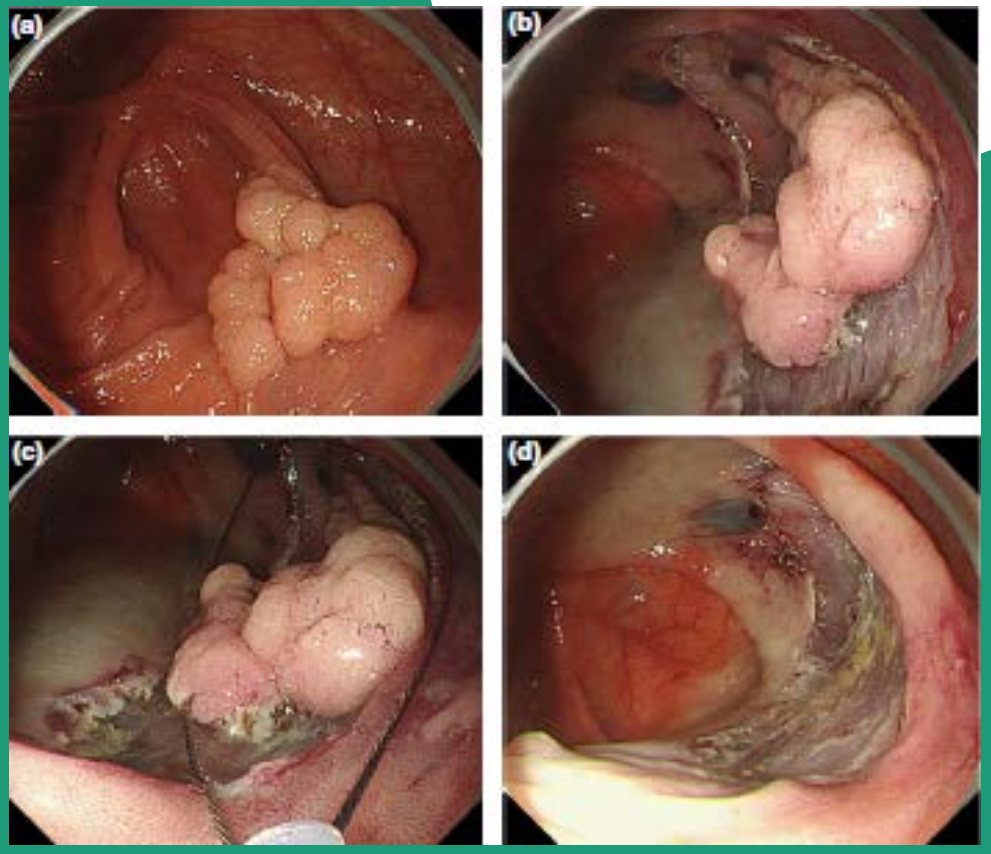


Table 2 A comparison of treatment outcomes between planned and salvage hybrid ESD

Variables		Total	Hybrid ESD		*p*-value
			Planned N = 56	Salvage N = 116	
Procedure time (min)		63.0 ± 42.7	44.5 ± 26.7	72.0 ± 46.3	< 0.01
En bloc resection		154 (89.5)	53 (94.6)	101 (87.1)	NS
Complete en bloc resection		149 (86.6)	52 (92.9)	97 (83.6)	NS
Delayed bleeding		4 (2.3)	2 (3.6)	2 (1.7)	NS
Perforation (+)		25 (14.5)	0 (0)	25 (21.6)	< 0.01
During submucosal layer dissection		23 (13.4)	0 (0)	23 (19.8)	< 0.01
During snaring		2 (1.1)	0 (0)	2 (1.8)	NS
Delayed perforation		0 (0)	0 (0)	0 (0)	–
Local recurrence		1 (0.6)*	0 (0)	1 (0.9)*	NS
Operator's experience of colorectal ESD	≥ 50 cases	113 (65.7)	34 (60.7)	79 (68.1)	NS
	< 50 cases	59 (34.3)	22 (39.3)	37 (31.9)	

*Local recurrence 2 years after treatment was curatively resected with ESD: pTis (tub1), Ly0, V0, HM0, VM0 (%). *Hybrid ESD* hybrid endoscopic submucosal dissection, *NS* not significant

EFTR

ENDOSCOPIC FULL-THICKNESS RESECTION

PADLOCK

OVESCO

Guideline

Thieme

Colorectal polypectomy and endoscopic mucosal resection: European Society of Gastrointestinal Endoscopy (ESGE) Guideline – Update 2024

ESGE

RECOMMENDATION

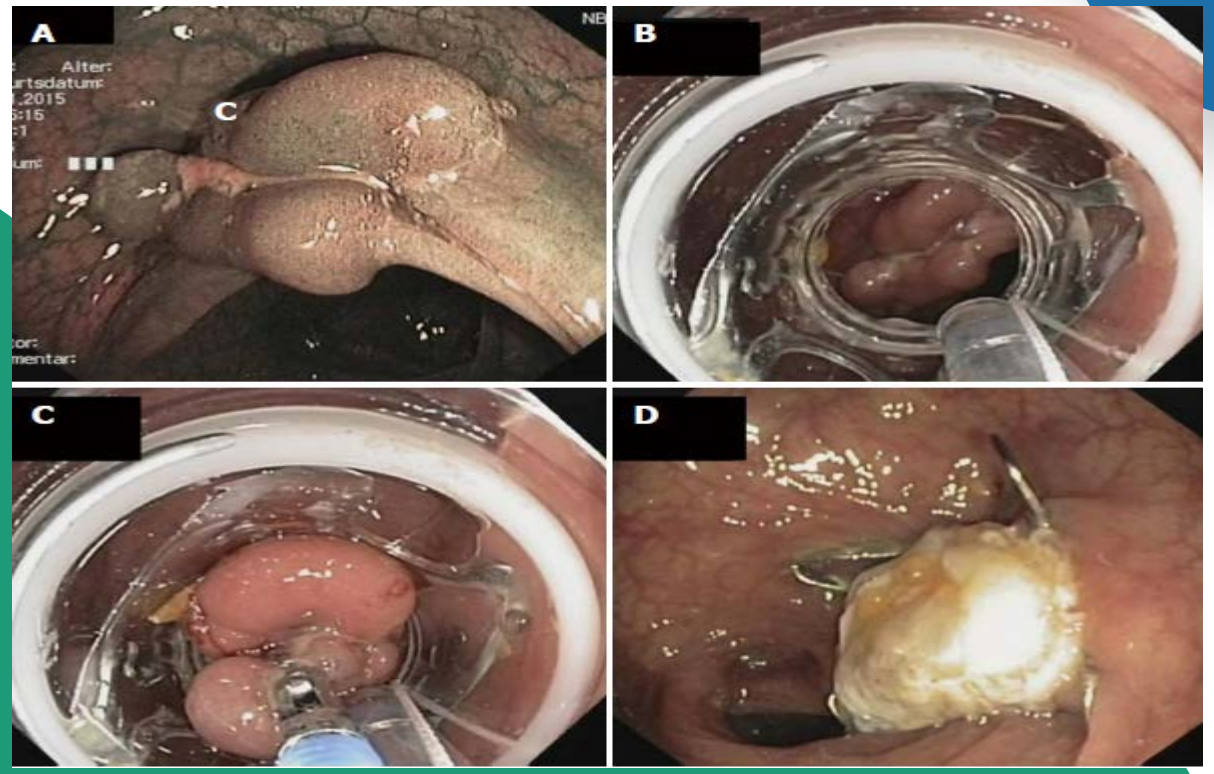
ESGE suggests that EFTR can be considered for endoscopic resection of lesions that otherwise cannot be removed by standard polypectomy, CAST, EMR, or ESD (e.g. nonlifting lesions without signs of submucosal invasion, lesions involving the appendiceal orifice or diverticula).

Weak recommendation, low quality of evidence.

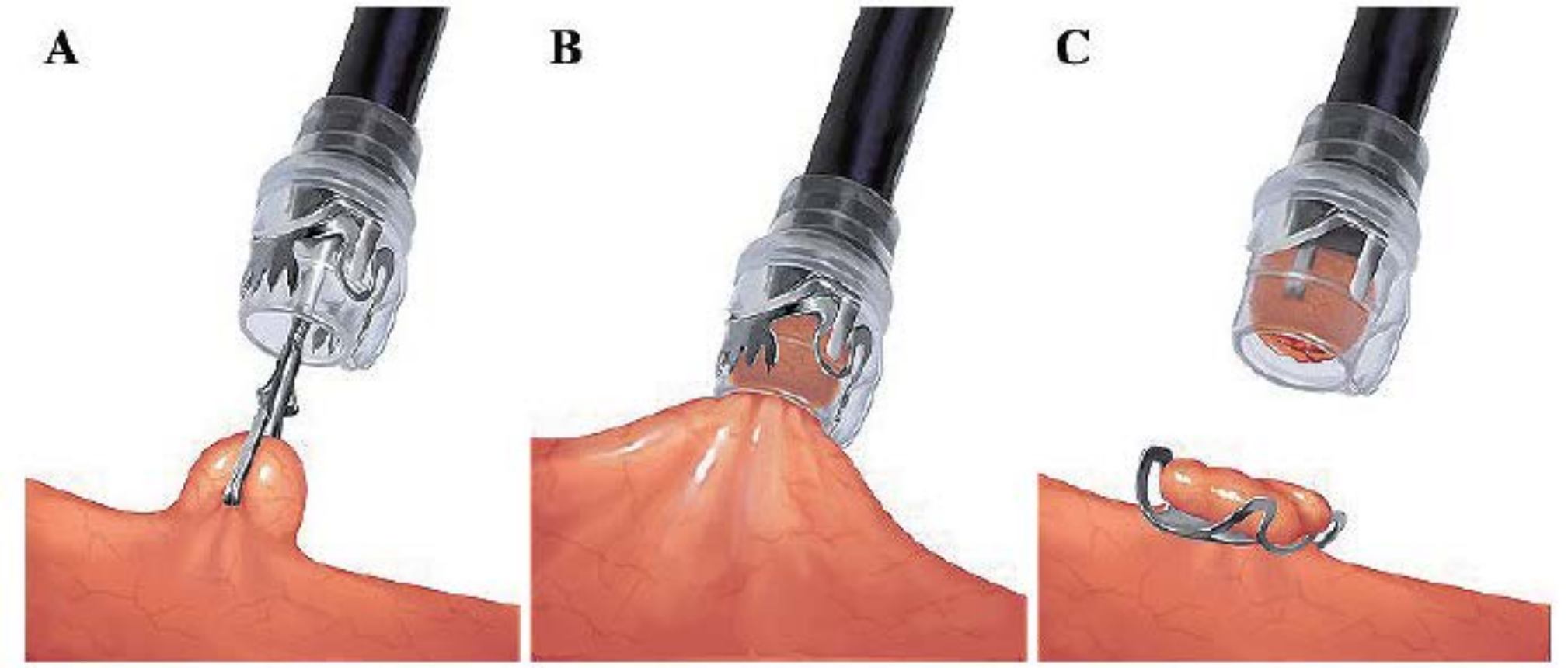
RECOMMENDATION

ESGE suggests that EFTR can be considered as a treatment option for residual/recurrent lesions after resection of superficial invasive carcinoma.

Weak recommendation, low quality of evidence.

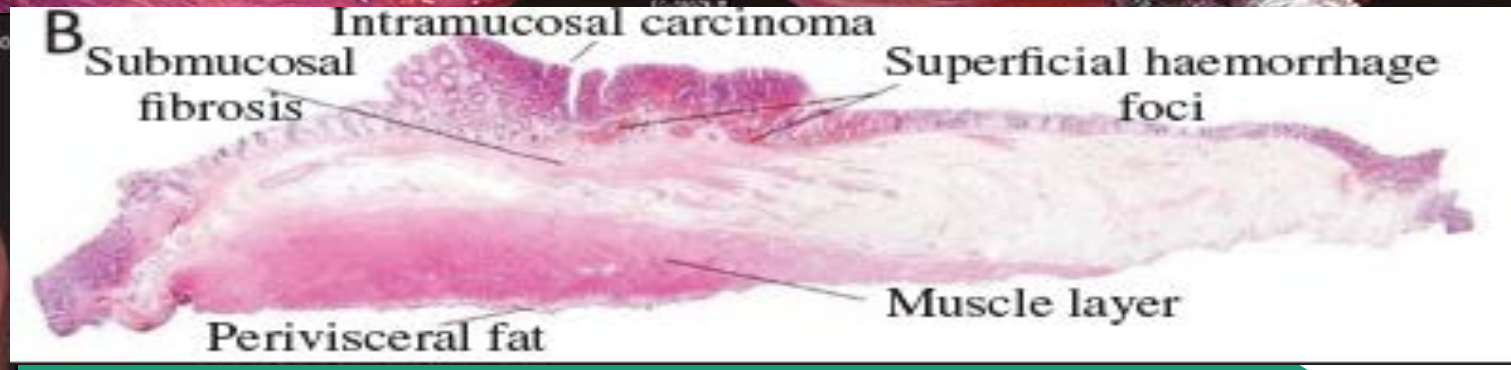


ENDOSCOPIC FULL-THICKNESS RESECTION




A
B
C


A


B
Intramucosal carcinoma
Submucosal fibrosis
Superficial haemorrhage foci
Muscle layer
Perivisceral fat

Original article

Thieme

Endoscopic full-thickness resection using a clip non-exposed method for gastrointestinal tract lesions: a meta-analysis

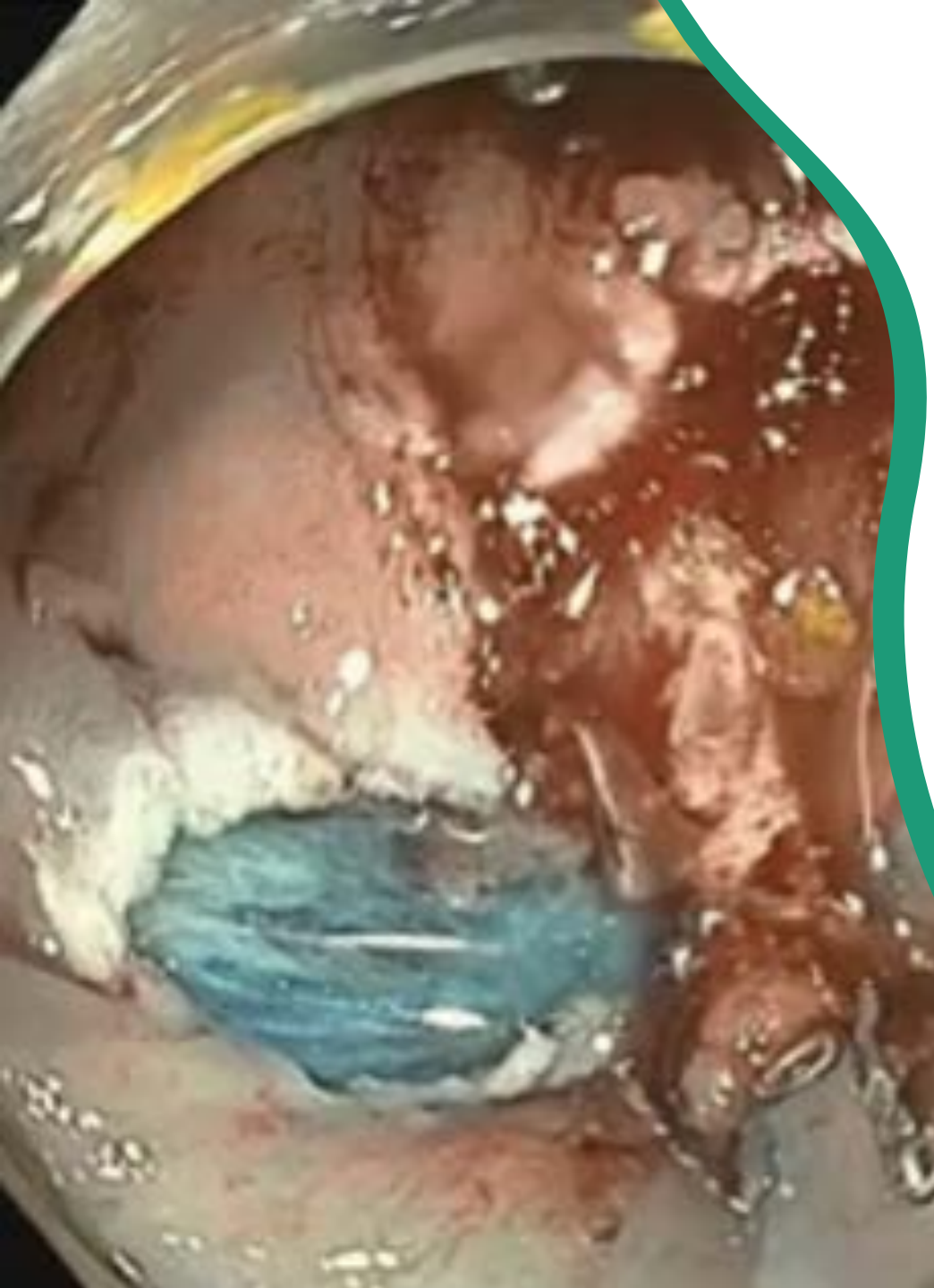
OPEN ACCESS

Authors

Olaya I. Brewer Gutierrez[1], Venkata S. Akshintala[1], Yervant Ichkhanian[1], Gala G. Brewer[1], Yuri Hanada[2], Maria P. Truskey[3], Amol Agarwal[2], Gulara Hajiyeva[2], Vivek Kumbhari[1], Anthony N. Kalloo[1], Mouen A. Khashab[1], Saowanee Ngamruengphong[1]

▶ **Table 3** Subgroup analyses for R0 resection rates.

Subgroup	Number of studies included	Number of patients	Pooled rate (95% CI)	I2	*P* value
Difficult colorectal polyps	14 [10, 11, 12, 13, 14, 17, 20–26]	324	80 (67–91)	81.83%	<0.01
Colorectal early carcinoma	7 [11, 13, 14, 17, 21, 25]	88	78 (54–95)	68.25%	<0.01
Colorectal SELs	8 [10, 12, 13, 17, 18, 20, 23, 26]	38	100 (95–100)	0	0.99
Upper GI SELs	5 [3, 10, 14, 16, 18, 24]	30	81 (58–97)	47.97%	0.09

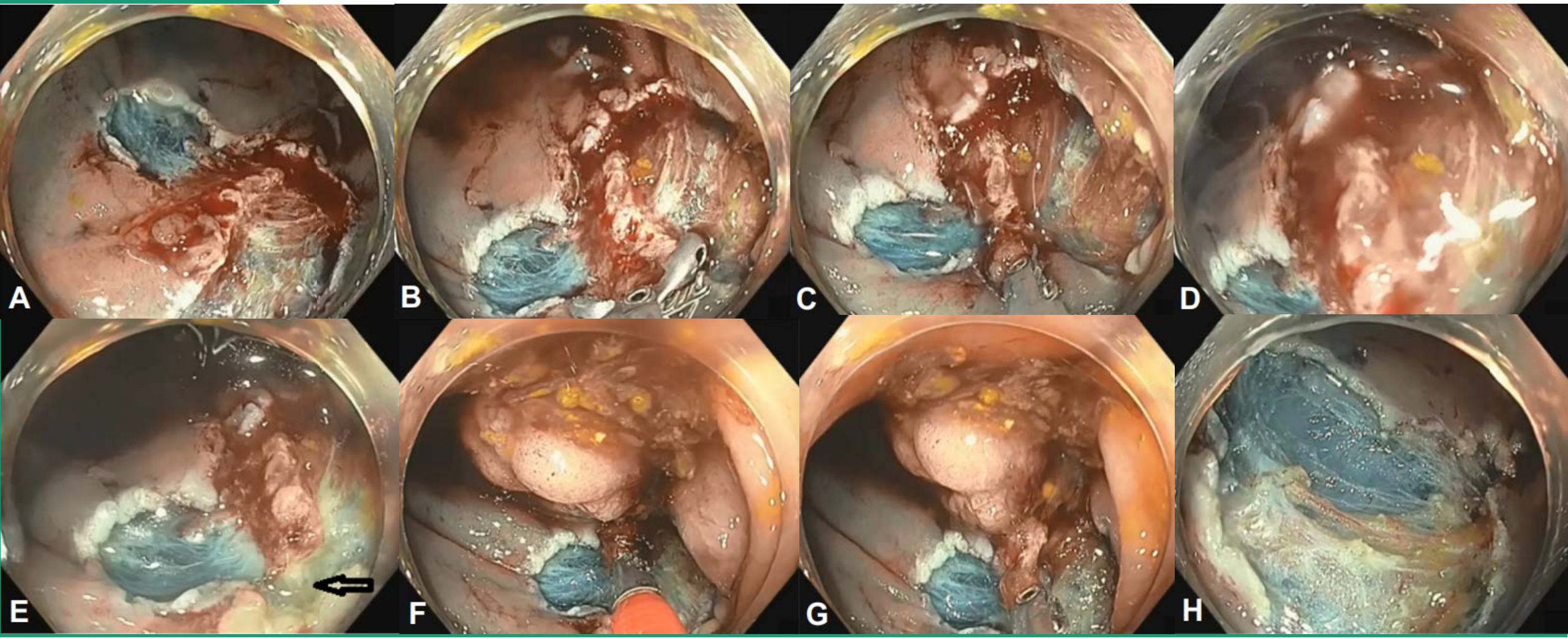


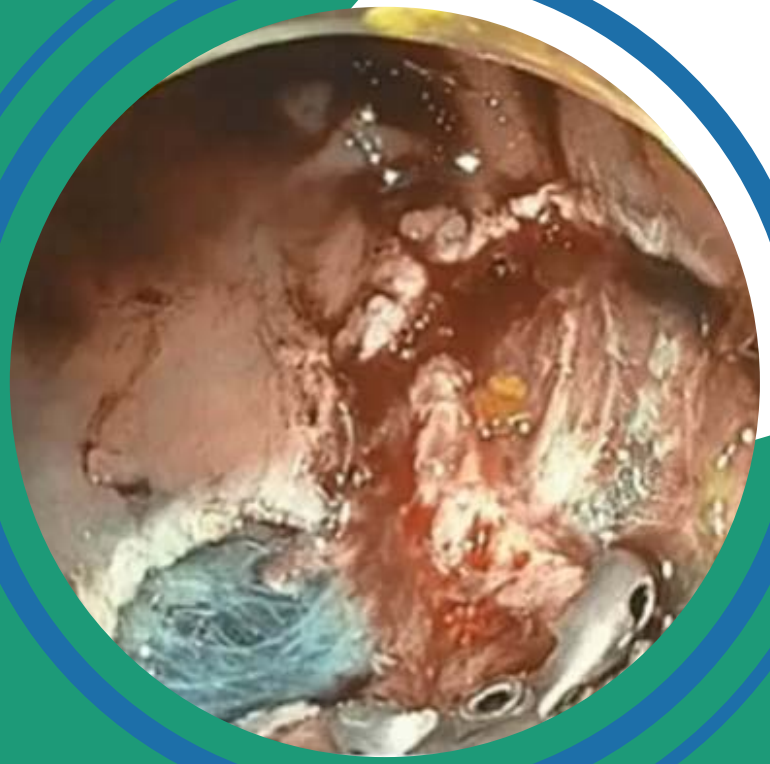
AVULSIÓN/ABLACIÓN

ORIGINAL ARTICLE

Safety and efficacy of hot avulsion as an adjunct to EMR (with videos)

Vinod Kumar, MD,[1] Heather Broadley, MS,[2] Douglas K. Rex, MD[2]





Safety and efficacy of hot avulsion as an adjunct to EMR (with videos)

Vinod Kumar, MD,[1] Heather Broadley, MS,[2] Douglas K. Rex, MD[2]

TABLE 2. Comparison of the avulsion and non-avulsion lesions

	Avulsion group	Non-avulsion group	*P* value
No. of lesions	112	425	
Size of polyp (mm), mean (±SD)	30.55 (±12.70)	24.85 (±13.11)	<.001
Location of polyps			
Right sided	98 (87.5)	341 (80.24)	
Left sided	14 (12.5)	84 (19.76)	.76
Adverse events (total)			
Number with delayed bleeding	6 (5.35)	11 (2.58)	.15
Size of polyp associated with bleeding event (mm), mean (±SD)	44.16 (±21.07)	31 (±11.57)	.2
Post-coagulation syndrome	2 (1.8)	2 (0.47)	.15
Recurrence	17/97 (17.52)	50/312 (16.02)	.76

Clinical Trial > Endoscopy. 2025 Mar 21. doi: 10.1055/a-2535-7559. Online ahead of print.

Impact of margin thermal ablation after cold-forceps avulsion with snare-tip soft coagulation for nonlifting large nonpedunculated colorectal polyps

Francesco Vito Mandarino [1], Timothy O'Sullivan [1 2], Julia L Gauci [1], Clarence Kerrison [1 2], Anthony Whitfield [1 2], Brian Lam [1], Varan Perananthan [1], Sunil Gupta [1 2], Oliver Cronin [1 2], Renato Medas [1], David J Tate [1], Eric Y Lee [1], Nicholas G Burgess [1 2], Michael J Bourke [1 2]

are however a significant limitation. We aimed to compare the outcomes of CAST plus margin thermal ablation (MTA) versus CAST alone for NL-LNPCPs.Prospective observational data on consecutive patients with NL-LNPCPs treated by EMR and CAST at a single tertiary center were retrospectively

period (July 2017-October 2023). The primary outcome was the residual/recurrent adenoma (RRA) rate at first surveillance colonoscopy (SC1). Secondary outcomes included the RRA rate at SC2 and adverse events.Over 142 months, 300 patients underwent EMR and CAST for LNPCP: 103 lesions pre-MTA and 197 with MTA. At SC1 and SC2, recurrence was lower in the MTA cohort compared with the pre-MTA cohort (5.0% vs. 18.8% and 0.8% vs. 10.0%, respectively; both $P<0.001$). Adverse events were similar between the two cohorts for deep mural injury types III-V (pre-MTA 2.9% vs. MTA 5.6%; $P=0.29$) and delayed bleeding (pre-MTA 8.7% vs. MTA 7.1%; $P=0.49$). On multivariate analysis, MTA

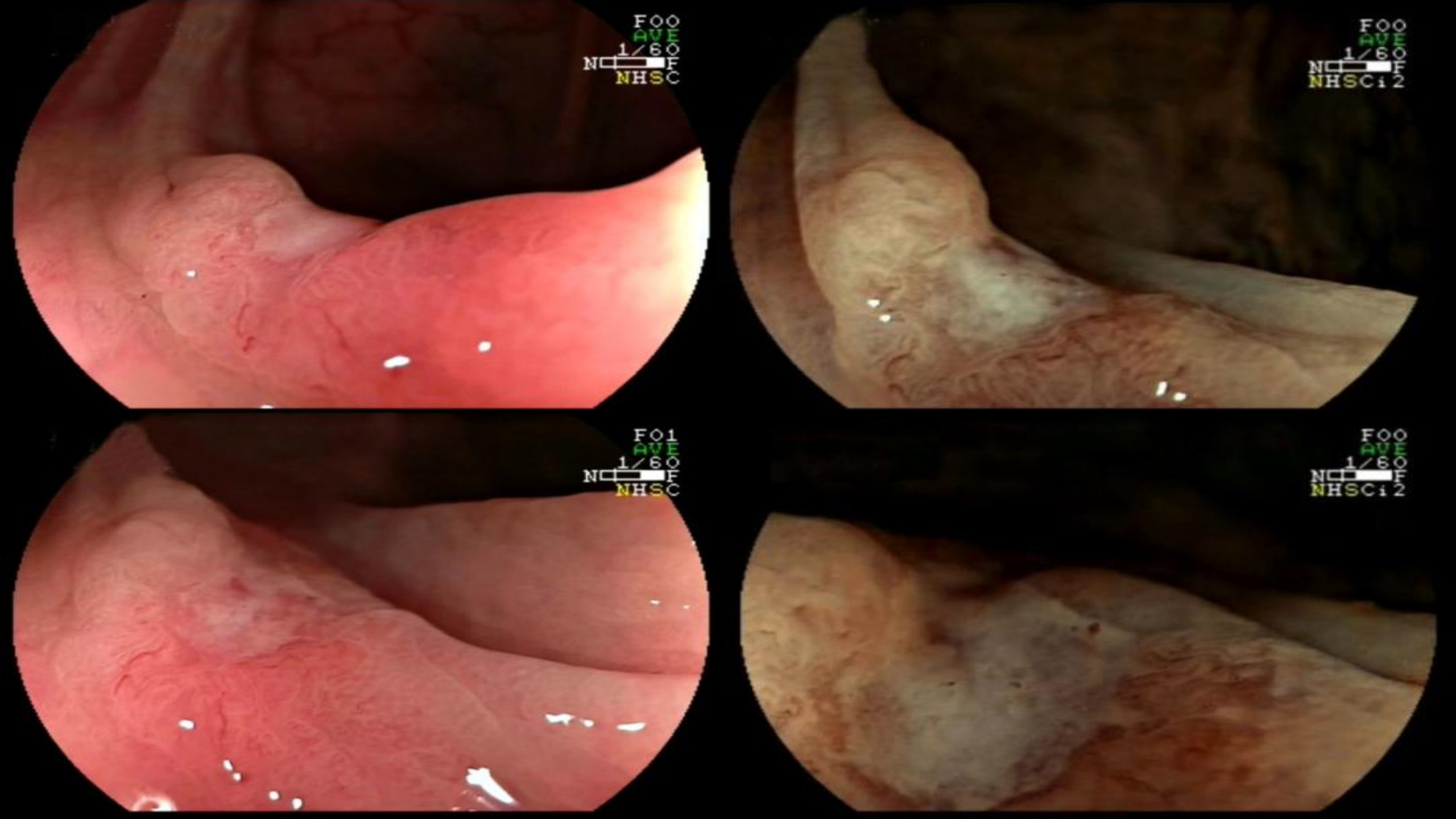
ORIGINAL ARTICLE

Efficacy and safety of endoscopic resection of large colorectal polyps: a systematic review and meta-analysis

C Hassan,[1] A Repici,[2] P Sharma,[3] L Correale,[4] A Zullo,[1] M Bretthauer,[5,6] C Senore,[7] C Spada,[8] Cristina Bellisario,[9] P Bhandari,[10] D K Rex[10]

- ✓ 50 estudios: 6442 pacientes - 6779 lesiones

- ✓ 14% de los pacientes fueron enviados directamente a cirugía sin ningún intento de resección endoscópica, debido a un aspecto endoscópico sugestivo de invasión submucosa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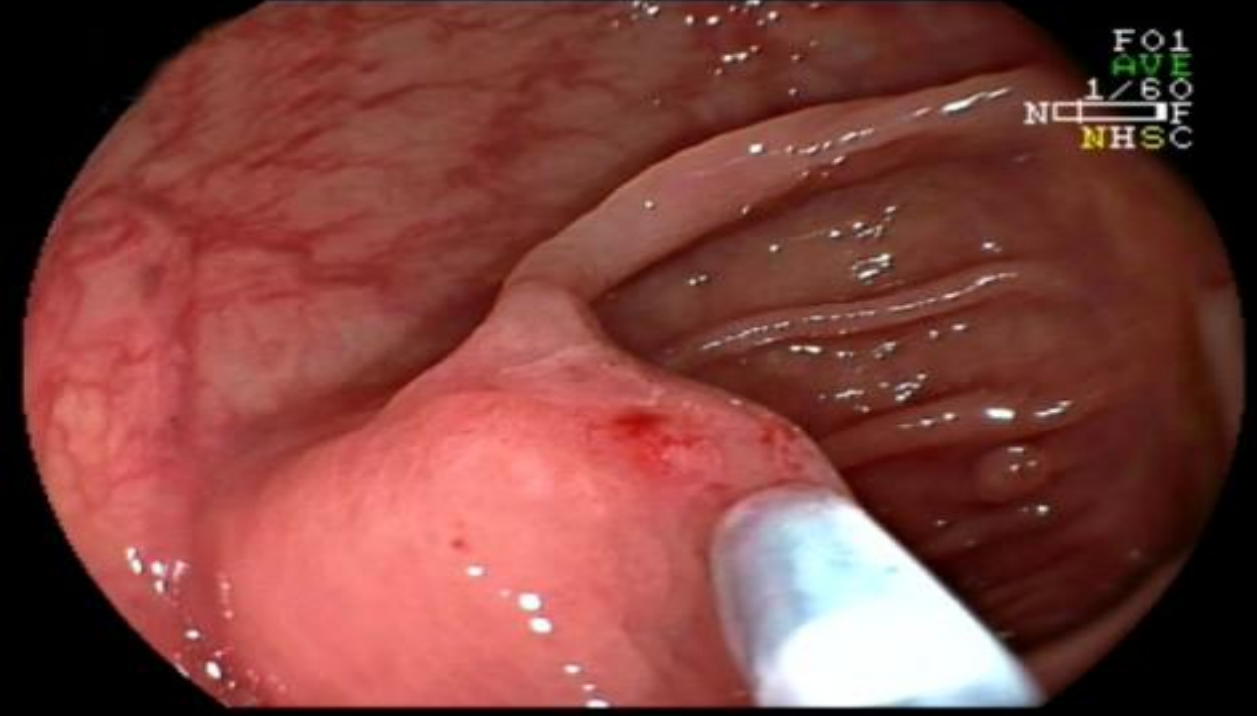
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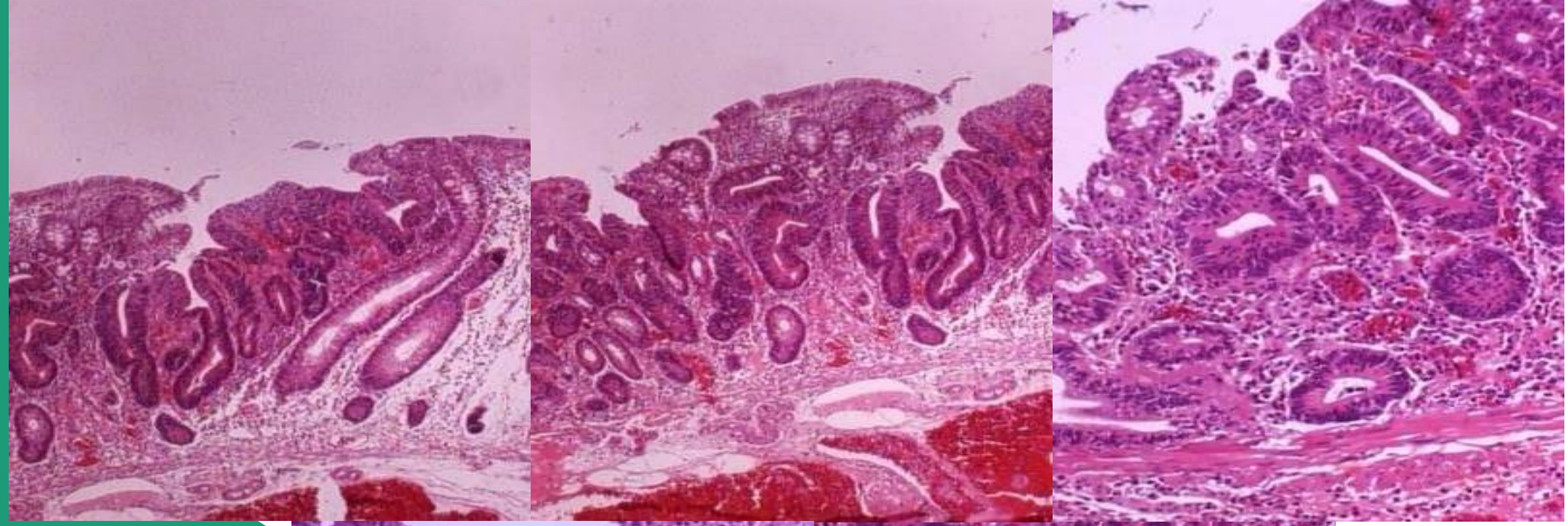

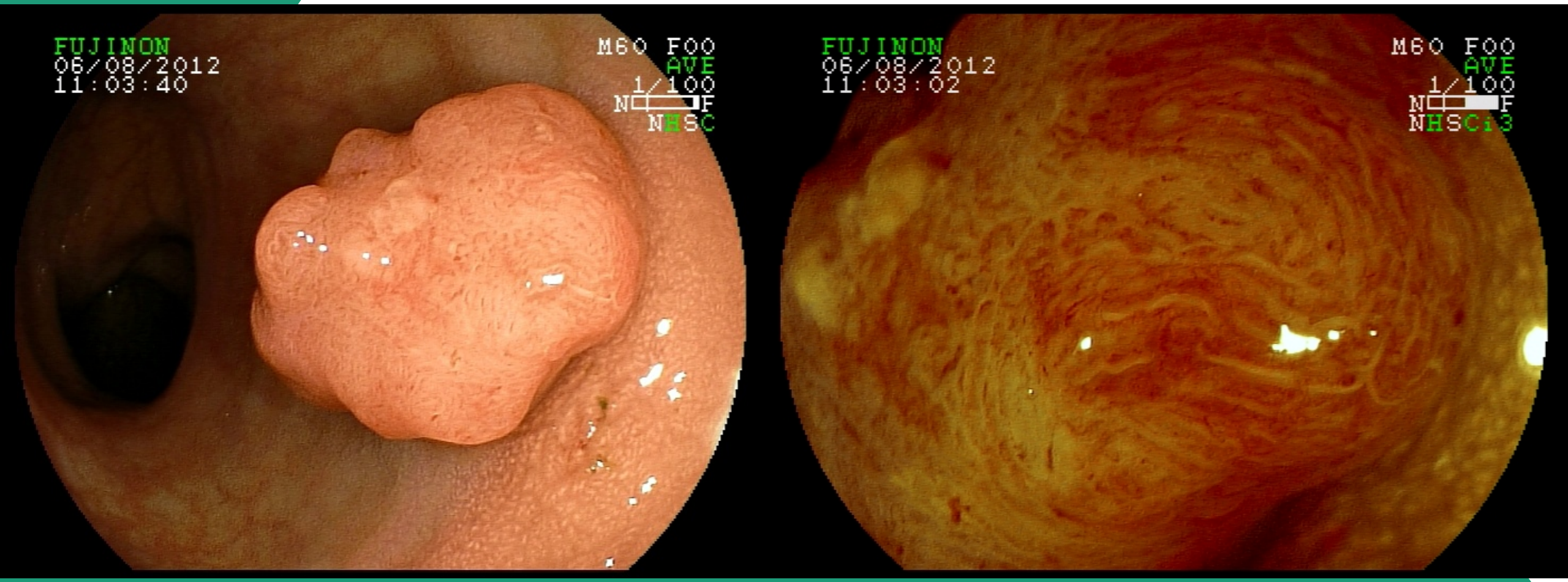
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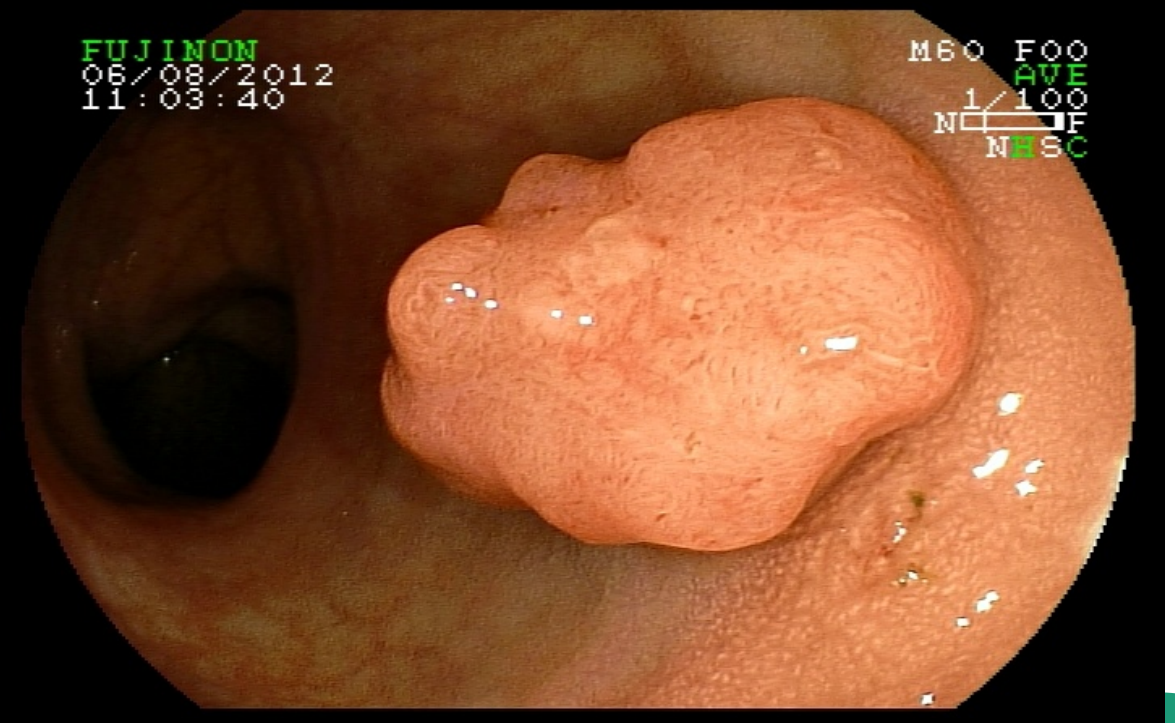
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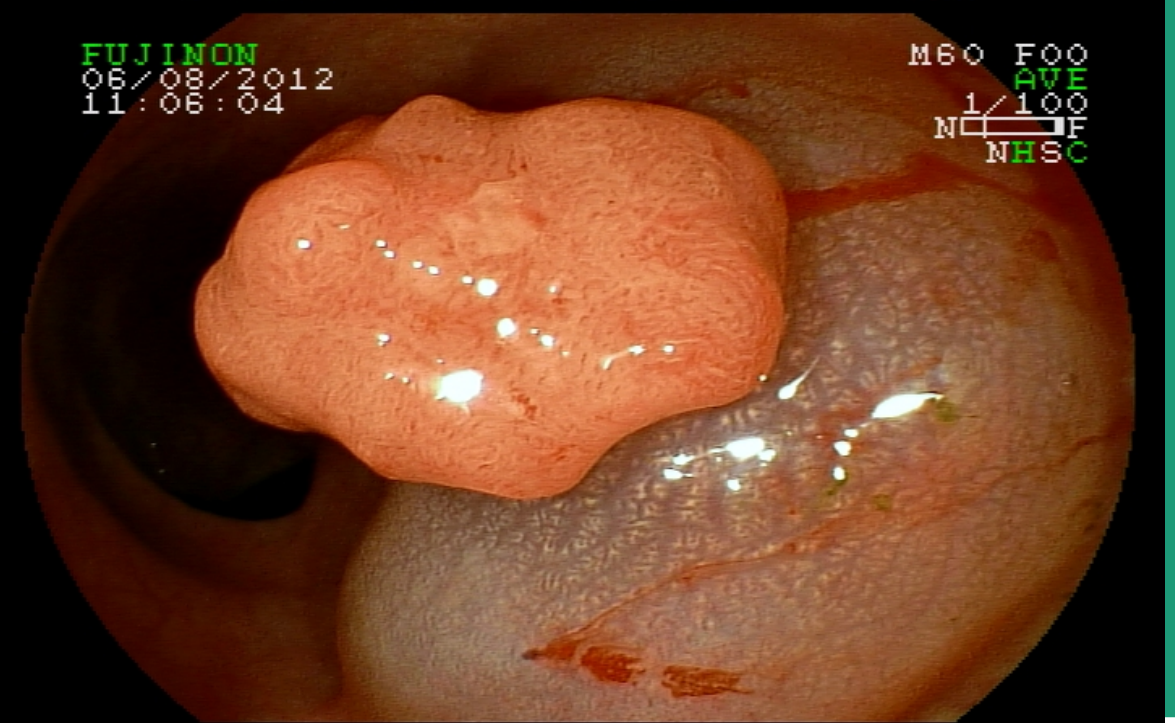
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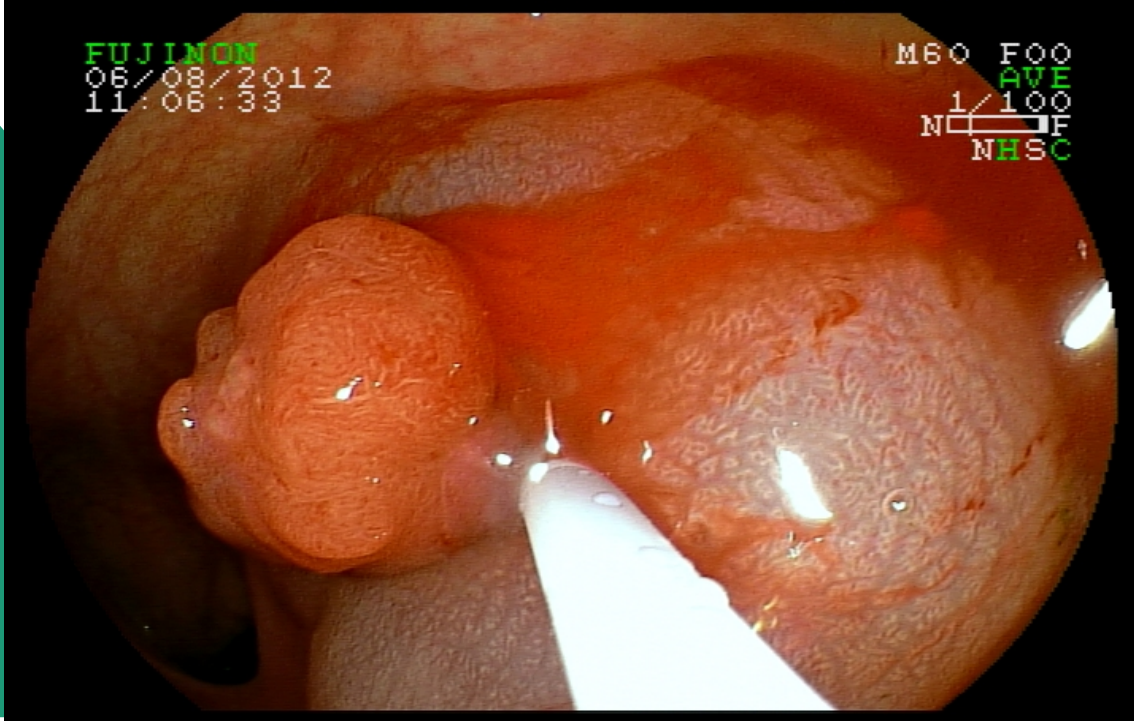
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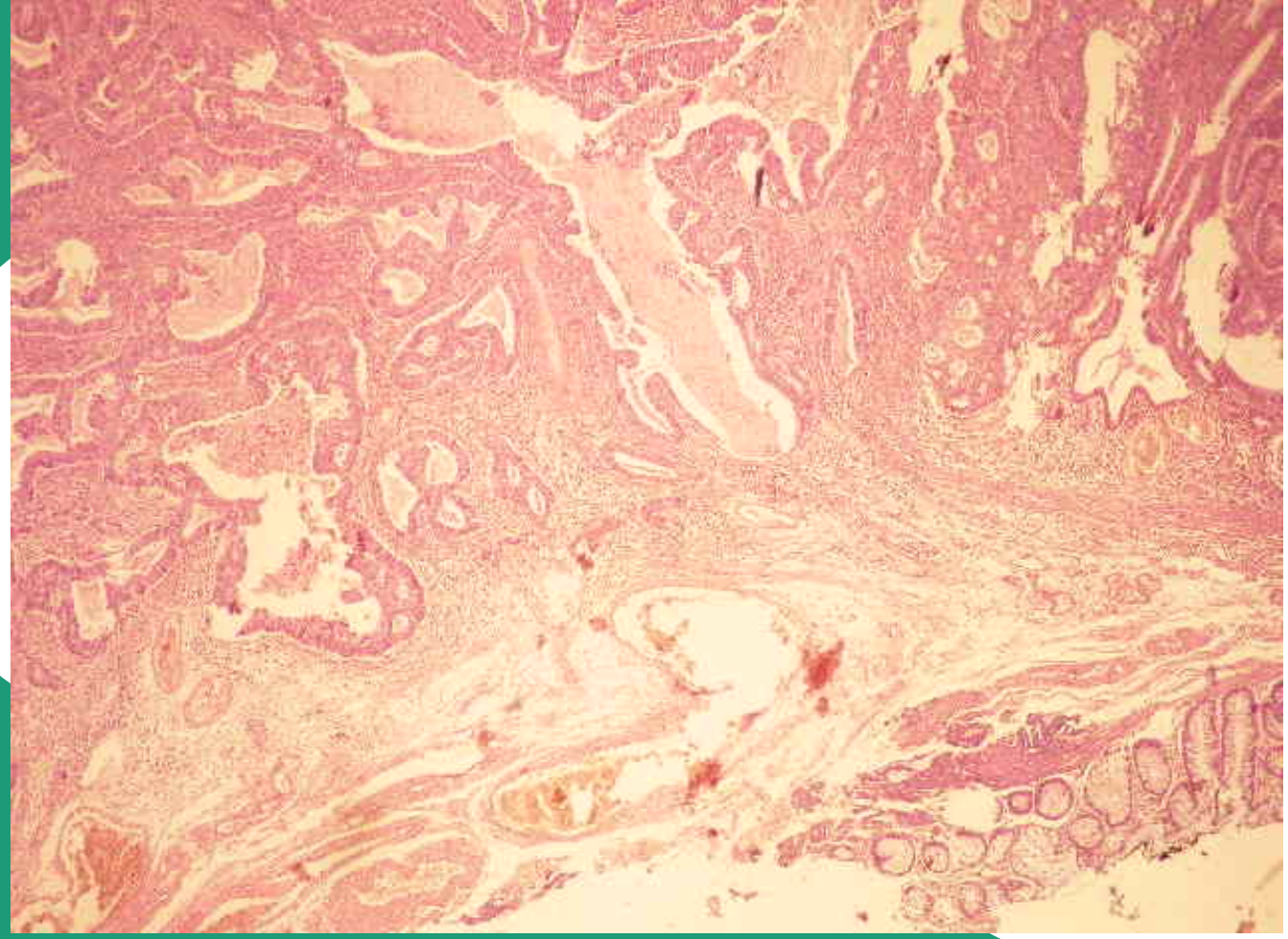


- ADENOCARCINOMA MODERADAMENTE DIFERENCIADO EM ADENOMA VILOSO DE ALTO GRAU (DISPLASIA MODERADA A ALTA), COM INVASÃO PARA SUBMUCOSA (0,655 MILÍMETROS = 655 MICRÔMETROS).
- AUSÊNCIA DE INVASÃO ANGIOLINFÁTICA.
- MARGENS CIRÚRGICAS LATERAIS E PROFUNDA LIVRES.

Guideline

Thieme

Colorectal polypectomy and endoscopic mucosal resection: European Society of Gastrointestinal Endoscopy (ESGE) Guideline – Update 2024

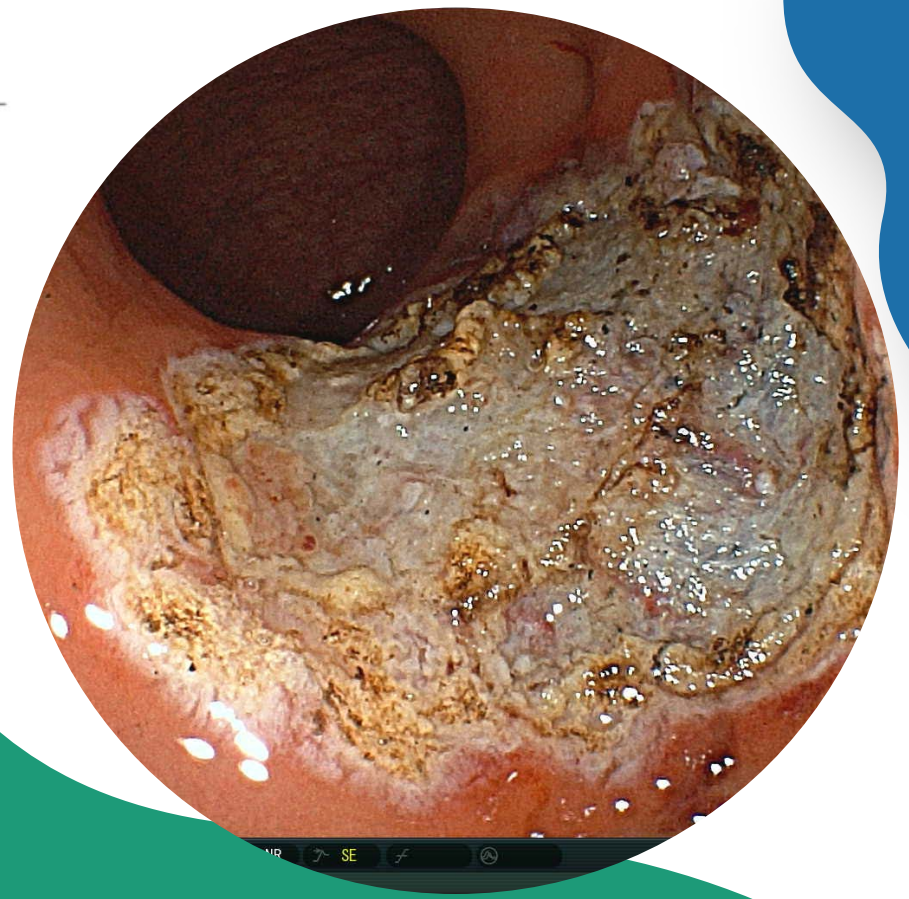
ESGE

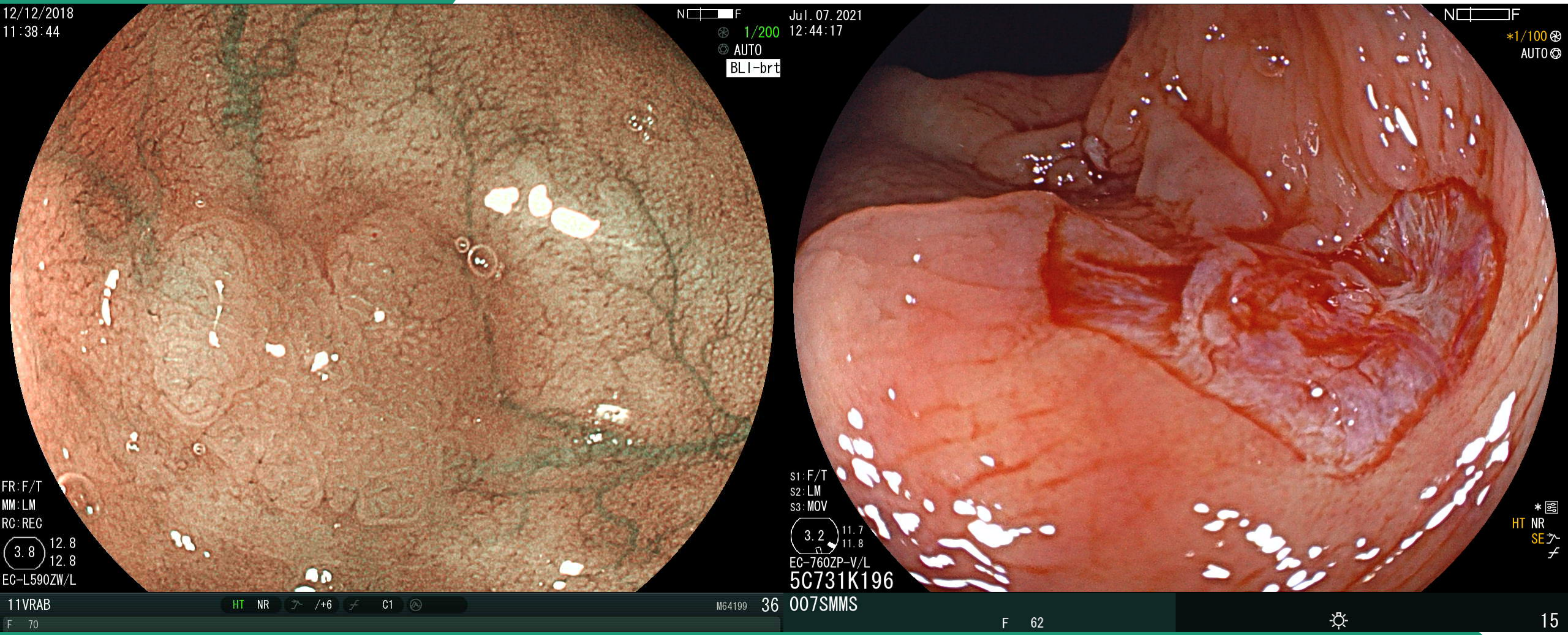
RECOMMENDATION

ESGE recommends that the majority of colonic and rectal lesions can be effectively removed in a curative way by standard polypectomy and/or by EMR.
Strong recommendation, high quality of evidence.

RECOMMENDATION

ESGE recommends that polyps without characteristics of deep submucosal invasion should not be referred for surgery, without consultation with an expert endoscopy center for evaluation for polypectomy/EMR/ESD.
Strong recommendation, moderate quality of evidence.

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