Colorectal lesions: Mitigating the risks!

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OP256 Delayed post-polypectomy bleeding for cold snare polypectomies of lesions

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Aims The use of antithrombotic therapy (ATT) may increase the risk of delayed post-polypectomy bleeding (DPPB). For patients on low-risk ATT, i.e. a single antiplatelet agent, the bleeding risk after cold snare polypectomies polyps < 10 mm (low-risk polypectomies) is very low at 0.15-0.49 % [1]. Accordingly, the BSG and ESGE guidelines suggest that low-risk polypectomies can be safely performed in patients on low-risk ATT [2]. However, for patients on high-risk ATT, i.e. an antithrombotic agent or multiple antiplatelet agents, data regarding the risk of DPPB for low-risk polypectomies is scarce. This study aimed to assess the risk of DPPB after low-risk polypectomies in patients on continued high-risk ATT.

Methods A retrospective analysis of prospectively collected data regarding all colonoscopies performed within two Dutch endoscopy centres between 2017 and 2023 was performed. These centres used different strategies regarding ATT for diagnostic colonoscopies: in one centre high-risk ATT was routinely continued for all patients, while in the other centre high-risk ATT was always discontinued or changed to low-risk ATT. Patients that discontinued high-risk ATT were either allocated to the 'no ATT' group (if high-risk ATT was discontinued) or 'low-risk ATT' group (if high-risk ATT was changed to low-risk ATT). Incidence of DPPB and thromboembolic events (TEs) after low-risk polypectomy were compared. Severity of complications was graded using the AGREE classification [3].

Results A total of 21.896 diagnostic colonoscopies were included, of which in 8.074 (37 %) only low-risk polypectomies were performed. These colonoscopies were performed in patients on no ATT (n = 6.730, 83 %), low-risk ATT (n = 1003, 12 %) and high-risk ATT (n = 341, 4.2 %). The overall incidence of DPPB for colonoscopies in which only low-risk polypectomies were performed was 10/8.074 (0.12 %). The incidence of DPPB for patients on high-risk ATT was similar compared to patients on low-risk ATT (2/339 [0.59 %, 95 % CI: 0.07-2.11] vs. 3/1003 [0.30 %, 95 % CI: 0.06-0.87], p = 0.61) and higher compared to patients on no ATT (2/339 [0.59 %, 95 % CI: 0.07-2.11] vs. 5/6730 [0.07 %, 95 %CI: 0.02-0.17], p = 0.04). Incidence of DPPB was similar for patients on no and low-risk ATT: 5/6730 (0.07 %, 95 % CI: 0.02-0.17) vs. 3/1003 (0.30 %, 95 % CI: 0.06-0.87), p = 0.07. DPPBs concerned grade I (n = 2) and IIIa (n = 3) complications for patients on no ATT and grade I (n = 1), II (n = 1) and IIIa (n = 1) complications for patients on low-risk ATT. DPPBs in patients on high-risk ATT concerned only grade I complications (n = 2). No TEs occurred.

Conclusions Patients undergoing low-risk polypectomies on continued high-risk ATT have a comparable risk of DPPB compared to patients on low-risk ATT. Although the risk for DPPB is higher compared to patients on no ATT, rates of DPPBs with continued high-risk ATT are very low and severity is comparable to patients on no or low-risk ATT. As such, continuation of high-risk ATT could be considered for colonoscopy indications carrying a low risk of detecting advanced polyps. This may ease burdens of ATT management around colonoscopies.

Conflicts of Interest PF received a consulting fee from Olympus and Cook Endoscopy. ED received a research grant from Fujifilm, honoraria for consultancy from Olympus, Fujifilm, Ambu, InterVenn, Norgine, and Exact Sciences and speakers' fees from Olympus, GI Supply, Norgine, IPSEN/Mayoly, FujiFilm and Steris. The remaining authors declare that there is no conflict of interest

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OP257 Exploring the risk and predictors of post-resectional stricture following circumferential endoscopic submucosal dissection for colorectal lesions: a multicenter study

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Aims The risk of post-resection colorectal stricture significantly increases when more than 90 % of the circumference is affected. In this study, we aimed to evaluate post-resectional stricture incidence and predictive factors in patients undergoing colorectal ESD for whole circumferential lesions.

Methods We retrospectively analysed a prospectively maintained dataset of patients undergoing ESD for colorectal lesions involving ≥ 90 % of the luminal circumference at 27 tertiary referral centres across Europe, North Africa, Asia, and North America between June 2018 and September 2024. Baseline clinical data and procedural outcomes, including effectiveness, safety and stricture development were collected. The primary endpoint was to evaluate the incidence and predictive factors of post-resectional strictures after circumferential ESD.

Results Overall, 301 patients were included in the analysis [median age: 71 (IQR: 62-79); female sex: 175 (58.1 %)] 254 (84.4 %) lesions were from the rectum, 47 (15.6 %) were colonic, showing a median long-axis of 95 (70.5-130) mm. 100 % circumferential involvement was present in 97 (63.8 %) cases. Among those, one case was aborted due to technical issues (99.7 % technical success). The median procedure time was 184 (IQR:133.5-270) minutes. R0 and oncological curative resection rates were 81.7 % and 80.3 %, respectively. Histopathological diagnosis showed the presence of adenocarcinoma in 107 (35.7 %) cases. In 29 (9.7 %) cases, patients underwent surgery either due to delayed perforation (2/29, 6.9 %) or invasive adenocarcinoma (27/29, 93.1 %). Consistently, 271 lesions were available for stricture assessment. 92/271 (33.9 %) patients developed stricture, with 84/92 (91.3 %) reporting symptoms after a median time of 31 (IQR:21-72) days. Most cases (87/92, 94.6 %) were in the rectum, while a few belonged to the colon (5/43, 5.4 %) ($p < 0.001$). Strictures needed treatment in 87/92 (94.5 %), either with endoscopic balloon dilation (65/92, 62.1 %), bougie dilation (23/92, 26.4 %) or other methods, such as home self-dilation (6/92, 6.5 %), self-expandable metals stents (SEMs) placement (1/92, 1.1 %), lumen apposing metal stents (LAMs) (2/92, 2.3 %) or incisional therapy (4/92, 4.6 %). All cases were successfully managed. Risk factors for rectal stricture development were a higher median long-axis of the specimen ($p < 0.001$), 100 % circumferential involvement ($p < 0.001$), the whole rectum ($p = 0.02$) and the oral side rectal ($p = 0.02$) location. At multivariate analysis, the 100 % circumferential involvement and higher long-axis confirmed to be risk factors, showing an odd ratio of 3.38 (CIs 1.77-6.08) and 1.01 (CIs 1.01-1.20), respectively.

Conclusions Circumferential ESD for colorectal lesions involving ≥ 90 % of the circumference is a feasible technique, showing a high rate of stricture development, which can be effectively treated through endoscopy. Leaving a small island of normal mucosa within the resection (especially when there is a long axis) could be an effective strategy to prevent stricture development.

Conflicts of Interest Authors do not have any conflict of interest to disclose.

OP258 Low rate of general anaesthesia and hospital admission for SITE ESD of colonic Lateral Spreading Tumour

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Aims Colonic ESD is recommended by western guidelines only in lesions at risk for early submucosal invasion also due to concerns over its safety profile and the need for general anaesthesia (GA) and hospital recover [1, 2]. In our centre we routinely perform saline immersion technique (SITE) ESD, with conscious sedation. The aim of this study was to demonstrate colonic ESD can be done without the need for GA or deep sedation.

Methods Consecutive patients referred to our hospital for colonic ESD have been retrieved from our prospective database. Baseline characteristics, technical data regarding ESD procedure and anaesthesia, operator-delivered conscious sedation were collected. Routine administration of a 5-day course of antibiotics, post ESD, was provided as per our unit protocol. Post ESD admission is not routinely applied in our centre, but reserved in case of complications, challenging cases, frail patients or patients living far from the hospital and therefore it was decided on a case-by-case basis.

Results A total of 116 patients were included in our analysis. Mean age was 67.0 years (SD11.3, range 39-88), 58.6 % were men (n = 68). Median ASA score was 2 (IQR 1-2;range 1-3). Lesion were resected respectively in the caecum (22 – 18.9 %), ascending colon (33 – 28.4 %), transverse colon (9 – 7.7 %), descending colon (18 – 15.5 %), sigmoid colon (34 – 29.3 %). Median maximum size diameter was 40 mm (IQR 30-50). Median resection time was 120 min (IQR 75-165). 107 procedures out of 116 (93.0 %) were performed under operator delivered conscious sedation, whereas 9 (7.0 %) were done under GA. Median dose of Fentanyl was 137.5 mcg, (IQR 100-187.5, range 25-375) while median dose of midazolam was 5 mg (IQR 3.75-7.5, range 1-10). Forty-two out of 116 (36.2 %) patients were admitted after the procedure for observation, median length of stay was 2 days (IQR 1-2, range 1-20), and 9/43 (11 %) patients were admitted for more than 48 hrs. Only one 80-y-o patient with asbestosis (0.9 %) experienced moderate respiratory failure in the recovery area after the procedure, which did not require invasive ventilation. The cause of this adverse event was not clearly established, although sedation was identified as a potential contributing factor. Multivariate analysis included age, ASA, complication, presence of fibrosis, area of the lesion, defect closure; age and resection time were the only risk factor for hospital admission at multivariate analysis (Age – OR 1.007, 95 %CI 1.0002 – 1.015, 0.7 % increased odds for every year, resection time – OR 1.017; 95 %CI 1.002 – 1.033, 1.7 % increased odds for every 10 min of procedure).

Conclusions Our results show that SITE-ESD in the colon does not requires GA, and only 7.7 % of our patients needed a prolonged (> 48 hrs) post-ESD hospital stay. Decreasing resection time with drainage tubes and traction devices may further improve our outcomes. Further prospective studies collecting patients' experience are warranted to reproduce our results.

Conflicts of Interest Authors do not have any conflict of interest to disclose.

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OP259 Endoscopic submucosal dissection (ESD) using a scissor-type diathermy knife for en-bloc resection of very large subpedunculated colorectal polyps

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Aims Endoscopic resection (ER) of large, subpedunculated colorectal polyps can be technically difficult, particularly in the relatively narrow left colon. Conventional snare resection risks immediate arteriolar bleeding and the snare can be difficult to manipulate around a large polyp head for an en-bloc excision. There is limited data on the safety and efficacy of ESD using a scissor-type diathermy knife (SB knife Sumitus Ltd) in the resection of large subpedunculated colorectal polyps.

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