

CASO CLINICO

LA POLIPOSIS ADENOMATOSA FAMILIARE (FAP):

Un modello per lo studio della familiarità
neoplastica

Modena 10 dicembre 2008

Endoscopia Digestiva ASMN Reggio Emilia

Anamnesi

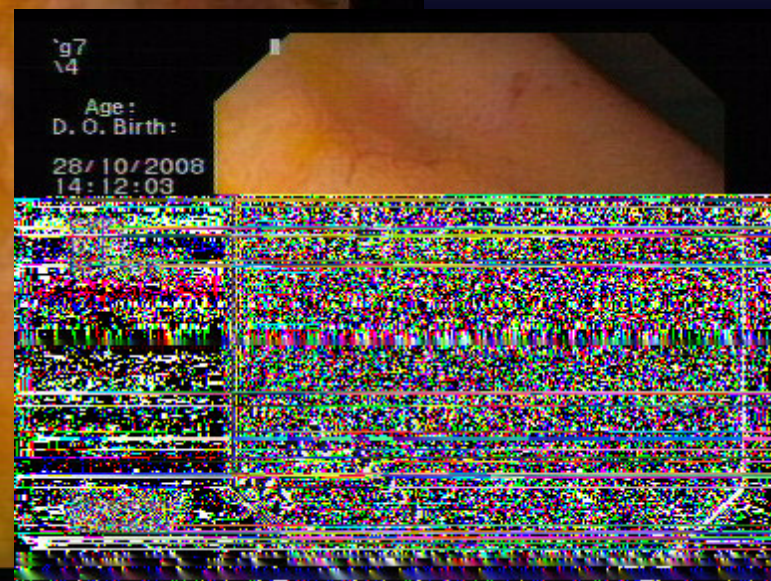
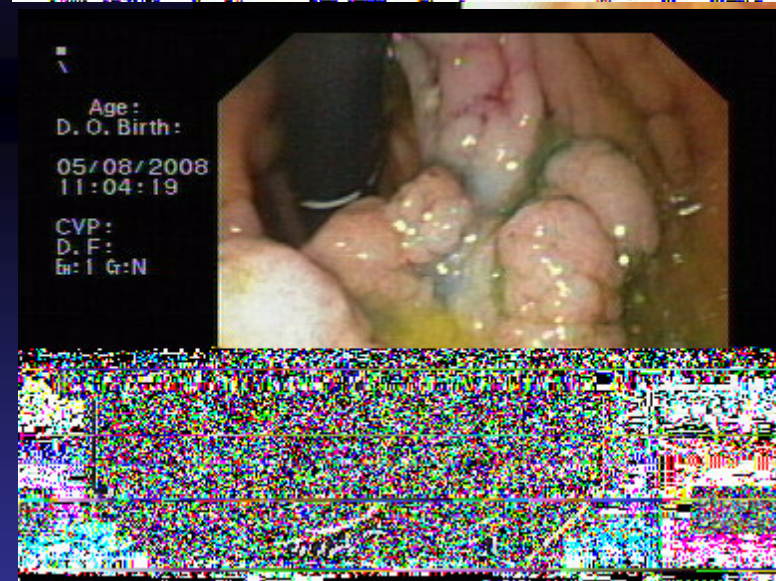
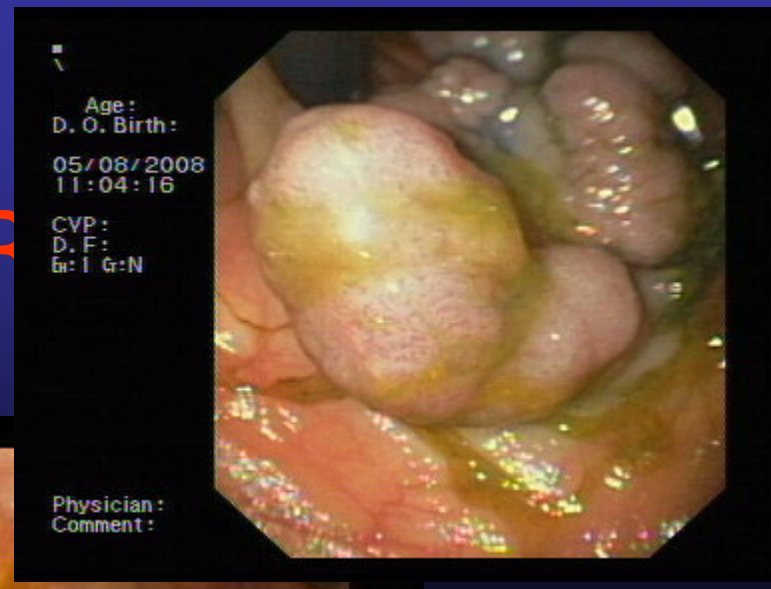
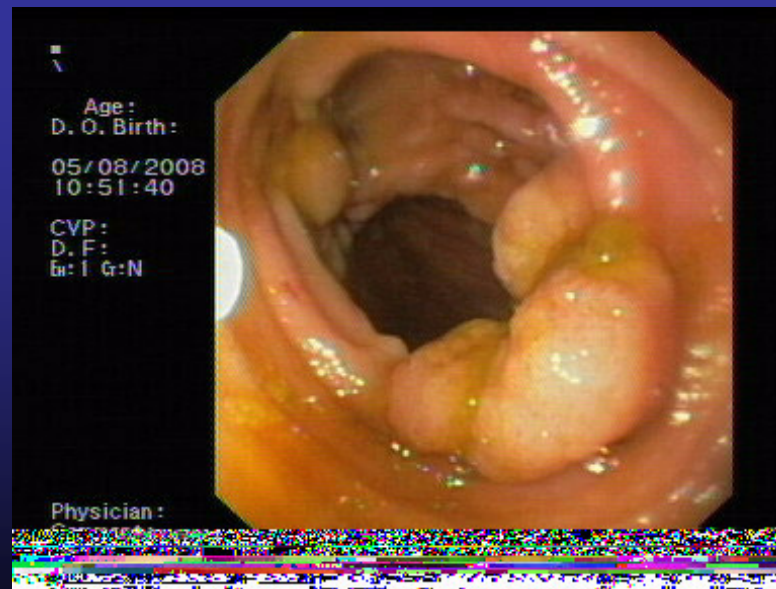
- A. C., F di 49 anni, n 1963
- 1988 Colonscopia per sospetto di FAP (nonna e madre)
- 1988 Colectomia totale con ileo-ano anastomosi confezionamento di pouch ileale
- Dal 1988 esegue controlli endoscopici c/o SC Endoscopica di Reggio Emilia
- 1998 ampullectomia endoscopica
- 2000 ampullectomia chirurgica per residuo non eradicabile endoscopicamente
- 2006 resezione duodeno-digiunale per polipo sessile piatto inasportabile
- 2007 Tiroidectomia totale per Ca papillifero

Anamnesi

- 2005: polipo sessile ovalare della pouch asportato con polipectomia
- 2005: grossa recidiva di polipo sessile di 3 cm della pouch (polipectomia)
- Gennaio 2007: recidiva in sede di pregressa polipectomia (trattamento con APC previa infiltrazione con salina)
- Giugno 2007: ulteriore recidiva del polipo della pouch (nuovo trattamento con APC)

Anamnesi

- Agosto 2008: recidiva di LST granulare misto di oltre 3 cm della pouch (piecemeal polipectomy senza ottenere aspetto endoscopico di radicalità)
- Ottobre 2008: riscontro di residuo polipoide di 3 cm su tessuto mal sollevabile per i numerosi trattamenti precedenti.
- All'esame istologico: displasia lieve moderata.

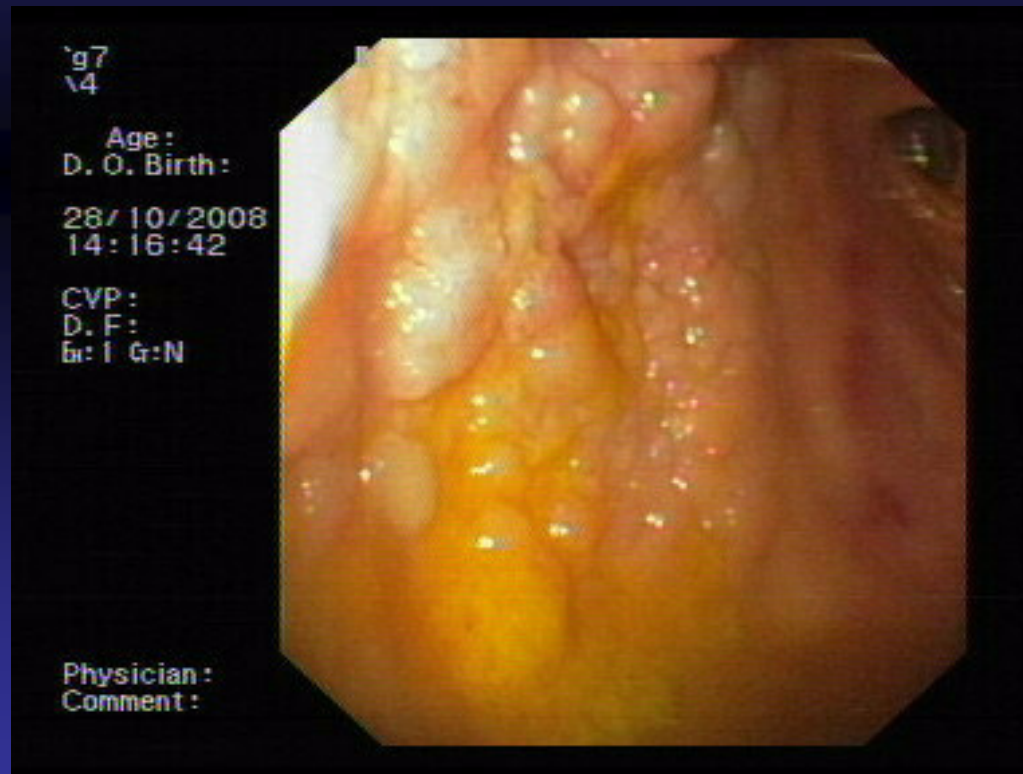


pooling of dye precludes adequate mucosal imaging. It is important that retroflexion views of the IPAA be performed in addition to en face imaging, to limit the possibility of missed pathology at the distal margin of the ileoanal anastomosis, which cannot be viewed adequately using conventional forward-viewing endos-

COSA FARE?

Chirurgia?

Approccio Endoscopico?



Endoscopic surveillance of the ileoanal pouch following restorative proctocolectomy for familial adenomatous polyposis

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The “true” incidence and natural history of IPAA neoplasia in FAP are not clearly defined. However, Parc et al. [5] and Wu et al. [6] have shown a 35% and 42% incidence, respectively, of recurrent ATZ and cuff adenoma in FAP patients at a median follow-up of 66 months; Parc and colleagues reported an incidence of pouch adenomas of 7% at 5 years, 35% at 10 years, and 75% at 15 years after IPAA formation [5]. It is in this last group that endoscopic local control of pouch intraepithelial neoplasia can potentially fail, the only alternative therapeutic option then being pouch excision. However, pouch excision carries

a risk of significant co-morbidity, a requirement for permanent ileostomy, and an overall mortality rate of 2–5%. Hence, surveillance pouchoscopy in this group of patients has now been adopted by many centers, where endoscopic local control of intraepithelial neoplasia is the preferred management.

ATZ: anal transition zone

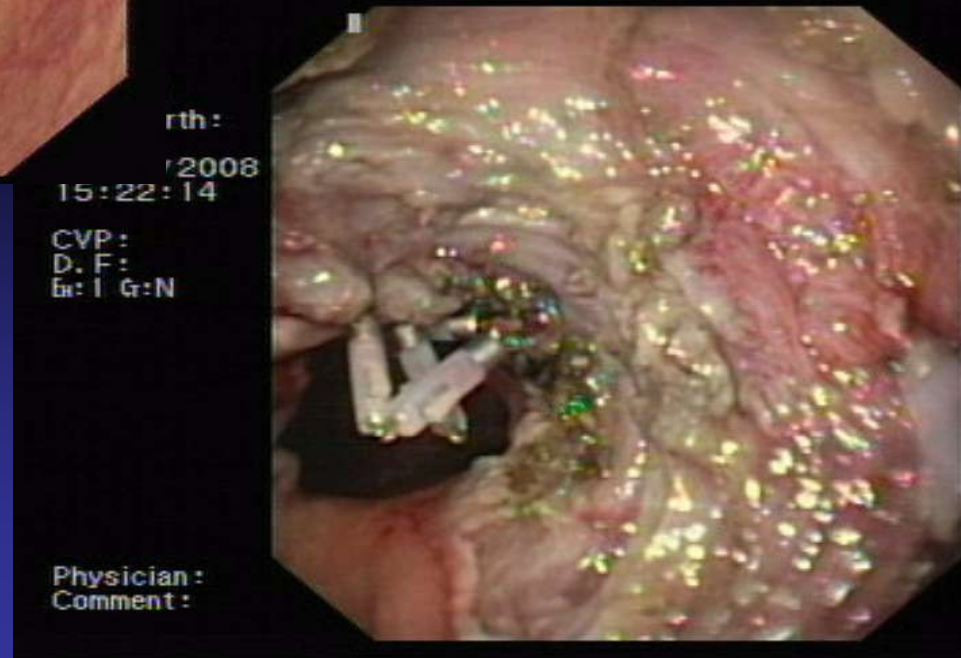
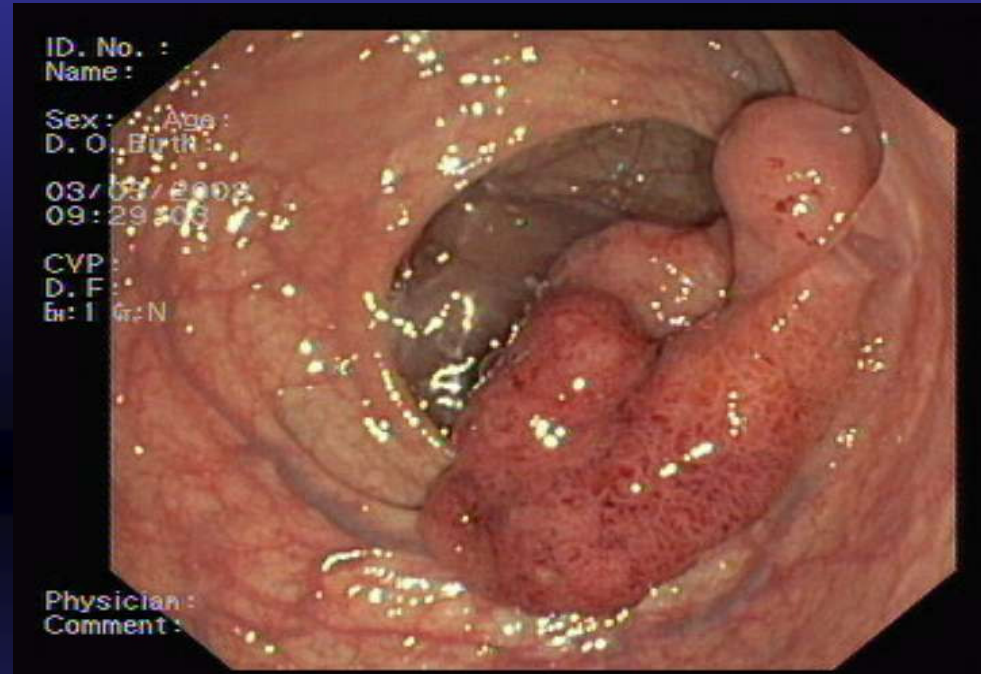
“Endoscopic Submucosal Dissection” (ESD)

Un nuovo trattamento endoscopico che
rimuove i tumori in tre fasi:

- 1) iniettando un fluido ad elevata persistenza
nella sottomucosa per sollevarla dalla
muscolare;
- 2) incidendo la mucosa circostante la
lesione
- 3) effettuando una dissezione del tessuto
connettivo della sottomucosa al di sotto
della lesione.

Fujishiro M. et al, Gastrointest Endosc 2006

ESD?



Endoscopic submucosal dissection for residual rectal polyps embedded in tissue scar: a “rescue therapy” to prevent surgical intervention?

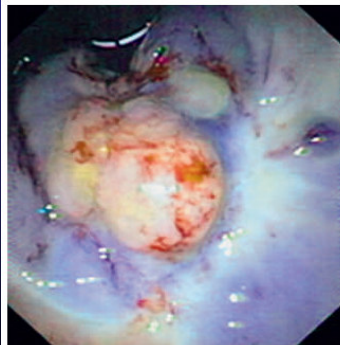


Fig. 1 Creation of a submucosal cushion. About 40 ml of a mixed solution of hyaluronic acid preparation (0.5%), saline, and diluted epinephrine (1:40000) was injected into the submucosal layer. “No lifting sign” was present.

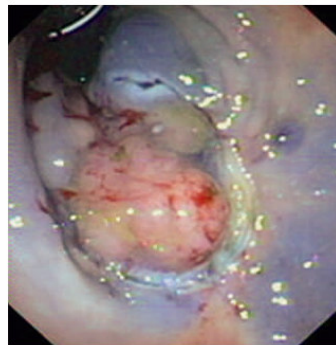


Fig. 2 Incision of the circumferential margins with standard needle knife in 120 W endocut mode (Erbe ICC 200, Tubingen, Germany).

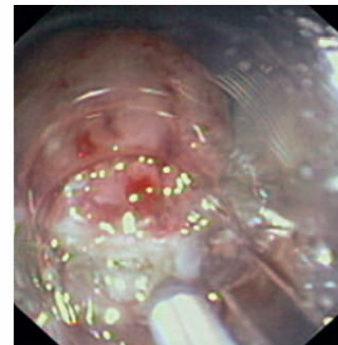


Fig. 3 Dissection of the submucosal layer with standard needle knife in 25 W forced mode. When the submucosal tissue was particularly hard due to scarring, the dissection was performed in 120 W endocut mode.

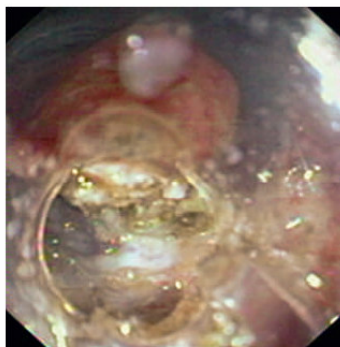


Fig. 4 Using a lateral movement and stressing the submucosal fibers using the transparent cap. Hemorrhage or visible vessels were treated by soft 60 W electrocoagulation using a coagulation forceps (Pentax SDB2422, Maeno-cho, Itabashi-ku, Tokyo, Japan) or by positioning metallic clips (Quick clip 2, HX-201UR-135, Tokyo, Japan).

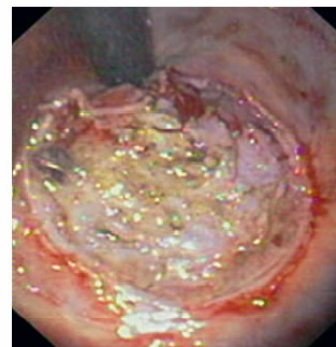


Fig. 5 Operatory field at the end of the procedure. The polyp was extracted and subsequently orientated on a rigid support.

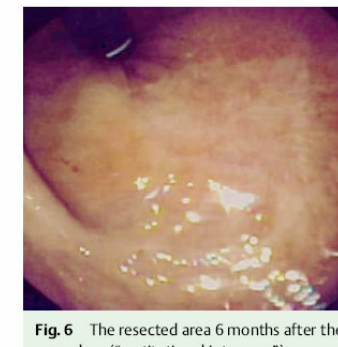
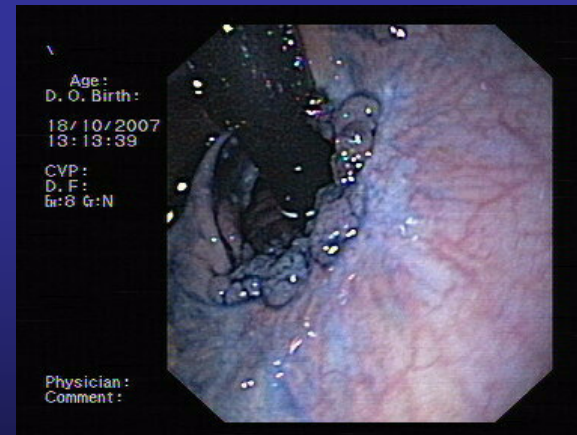
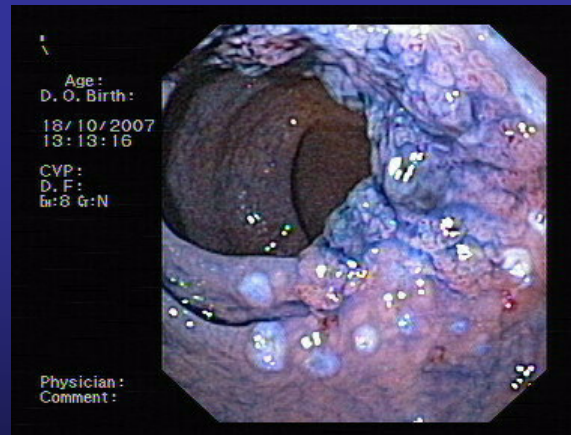
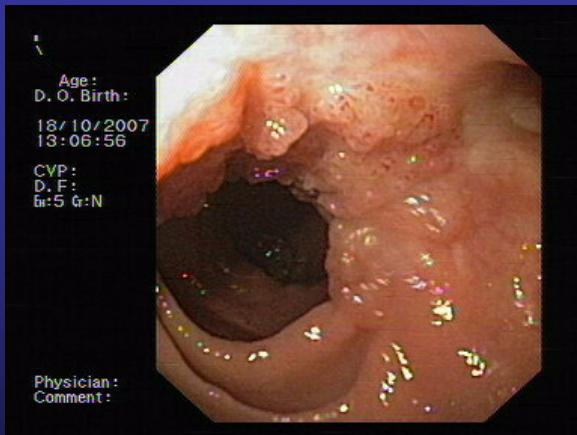
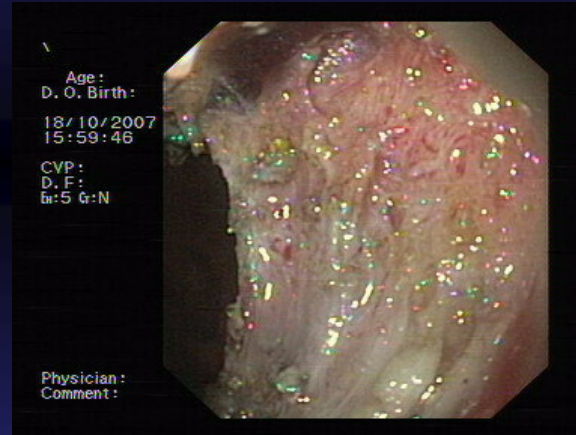
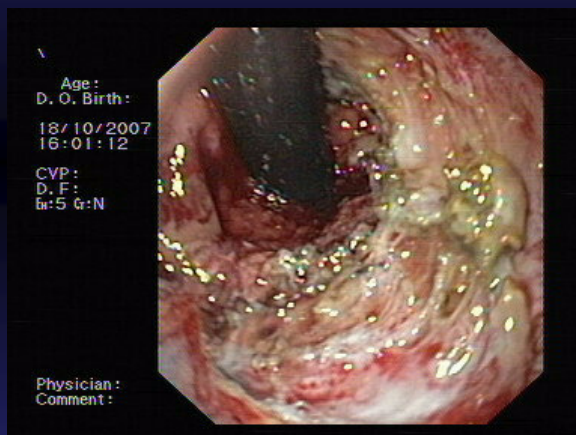


Fig. 6 The resected area 6 months after the procedure (“restitutio ad integrum”).

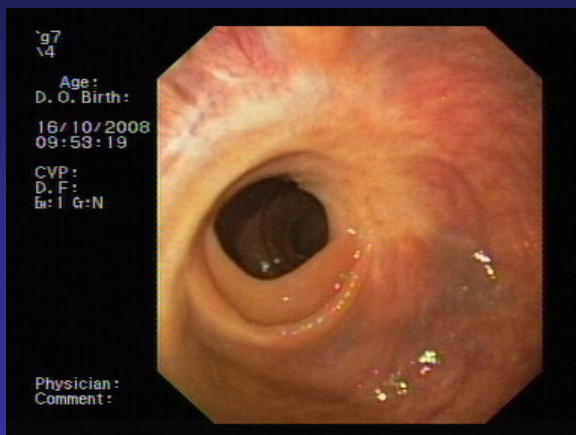
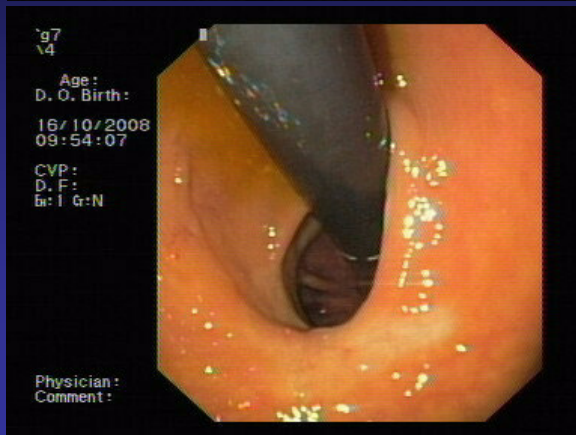
Azzolini F et al; Endoscopy 2008; E222-E223



M 69 aa, risultato dopo 9 tentativi di polipectomia



ESD: durata 3 ore,
decorso
postoperatorio
regolare.



Controllo a 1 anno