Azienda Ospedaliero-Universitaria di Ferrara

DIAGNOSI E TRATTAMENTO DEI POLIPI COLO-RETTALI

Tavola rotonda: il trattamento dell'adenoma cancerizzato

30 marzo 2007

Bond et al

Polyp guideline: Diagnosis, treatment and suveillance for patients with Colo-rectal Polyps

AJG 2000:95;3953-3962

DEFINIZIONI

-…is a neoplasm that contains cancer cells that have penetrated trough the muscolaris mucosa layer into the submucosa

Usually describes an endoscopically resected polyp that initially seems benign but that, ON HISTOLOGICAL analysis, contains invasive carcinoma

QUESTIONS

Does the patient require cancer surgery or is colonoscopic polypectomy adequate treatment

Is the risk for local recurrence or lymph node metastasis greater than that of partial colectomy or is it so small that no further treatment is indicated

Is there any difference between carcinoma in situ and dysplasia?

No further treatment is required if

1. The polyp is considered to be completly excised by the endoscopist and is submitted in toto for pathlogical examination
2. In the pathological, laboratory, the polyp is fixed and sectioned so that is possible to accurately determine the depth of invasion, grade of differentiation and completeness of excision of the carcinoma
3. The cancer is not poorly differentiated
4. There is no vascular or lymphatic involvement
5. The margin of excission is not involved. Invasion of the stalk of a peduncolated polyp, by itself, is not an unfavorable prognostic finding as long as the cancer does not extend to the margin of stalk resection

……. ma il tempo passa

- Sono ancora validi questi criteri?
- È possibile la loro trasposizione nella pratica quotidiana di tutte le realtà?
- E’ attendibile la loro trasposizione nella pratica quotidiana di tutte le realtà?
- Gli istologi, gli endoscopisti, i chirurghi sono TUTTI eguali??

Efficacy and effectiveness

Traduzione nella pratica quotidiana, oggi

- M Risio
- G Lanza.
- L Roncoroni
- R sassatelli

Hassan C, Zullo A, Winn S, Eramo A Tomao S, Rossini FP, Morini S

The colorectal malignant polyp: scoping a dilemma

Digestive and Liver Disease 2007:39;92-100

1. The malignant polyp is the most frequent variety of early CRC in western countries
2. Malignant polyps are classified as low- and high risk according to: 1) resection margin 2) grade of differentation 3) lympho-vascular invasion
3. Infiltration of the resection margin and poor differentation are strongly associated with residual disease and mortality
4. The role of lympho-vascular invasion has been marginalized
5. Complete endoscopic treatment is adeguate for low risk, peduncolated lesions and low risk sessil lesions in > 60 years
6. Surgery is needed in the remaining cases, unless patients are at high risk for surgery

CONCLUSIONI??

PROPOSTA 2007 (DLD 2007) Malignant Polyp

- SESSILE
  - Se basso rischio istologico (resection margin, grade of differentation, lympho-vascular invasion)
  - < 50 anni
    - Indicazione alla chirurgia
  - > 50 anni
    - Follow up

PROPOSTA 2007 (DLD 2007) Malignant Polyp

- SESSILE
  - Se alto rischio istologico (resection margin, grade of differentation, lympho-vascular invasion)
  - Basso rischio chirurgico
    - Indicazione alla chirurgia
  - Alto rischio chirurugico
    - Follow up

PROPOSTA 2007 (DLD 2007) Malignant Polyp

- PEDUNCOLATO
  - Se alto rischio istologico (resection margin, grade of differentation, lympho-vascular invasion)
  - Basso rischio chirurgico
    - Indicazione alla chirurgia
  - Alto rischio chirurugico
    - Follow up

PROPOSTA 2007 (DLD 2007)
Malignant Polyp

- PEDUNCOLATO
  - Se basso rischio istologico (resection margin, grade of differentation,lympho-vascular invasion, lympho-vascular invasion)

Follow up