

Endoscopy Lower

Evaluation of resect and discard strategy in clinical practice at a single tertiary centre: a prospective cohort study of diminutive polyps

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Introduction: Globally, there is increasing interest in resect and discard strategies for diminutive colorectal polyps in an effort to reduce costs of colonoscopy. Current efforts are focused on using real time colonoscopy assessment to predict the nature of polyps. Previous groups in Europe have proposed a management algorithm based on clinical and colonoscopy characteristics to apply a resect and discard strategy for specific patient groups. The aim of this study was to evaluate the impact of the proposed resect and discard strategy in clinical practice at a single tertiary centre in Australia using the current National Guidelines.

Patients and methods: 303 consecutive patients attending outpatient colonoscopies in the endoscopy unit of Royal Prince Alfred Hospital in Sydney between February, 2012 and March, 2013 who consented for enrolment were included in the study. The procedures were performed by senior gastroenterologists as well as advanced trainees under their supervision. Patients were then allocated into groups according to previously proposed algorithm: 1. advanced age or frail people not suitable for future surveillance; 2. those with diminutive polyp(s) associated with cancer or polyp(s) ≥ 10 mm; 3. those with 1 polyp ≤ 5 mm associated with 1 polyp 6–9 mm; and 4. those with personal history of colorectal neoplasm. The final analysis then looked at these specific groups to determine how their surveillance intervals would be affected and the potential effect of this resect and discard protocol might have on pathology workloads.

Results: Of the 303 patients, 17 were excluded due to incomplete procedures (as a result of difficult sedation, poor bowel preparation, or severe looping). A total of 221 polyps were removed from 108 patients – 56 men and 52 women with mean age of 63.1 years (range 40–85 years). 27 polyps (12.2%) were not able to be retrieved. 40/108 cases (37%) were allocated to the specific groups. In this subset, only 2 would have their surveillance intervals adjusted – 1 case from 3 to 5 years; and 1 case from 5 to 3 years. This would correlate to discarding of 73 diminutive polyps (33%) that would not have affected the polyp surveillance interval with significant savings on pathology-associated costs.

Conclusion: The proposed resect and discard protocol as previously suggested for specific clinical scenarios could be used with little impact on surveillance intervals in these cases.

Small bowel lipomas may be a cause of significant obscure GI bleeding: report of three cases identified by capsule endoscopy

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Introduction: Video capsule endoscopy (VCE) is well established in the investigation of obscure small bowel (SB) bleeding. SB tumors are identified in up to 13% of cases and may be benign or malignant. Lipomas are benign submucosal tumors that are usually asymptomatic but can uncommonly ulcerate and bleed or cause intussusception and obstruction. Typical VCE appearance is of a pale or yellow submucosal lesion with a smooth surface but may be atypical when complicated. We report three cases of obscure SB bleeding due to small bowel lipomas identified by VCE and their subsequent management.

Case 1: 66-year-old male presented with abdominal pain, melaena and iron deficiency with a normal esophagogastroduodenoscopy (EGD) and mild diverticulosis on colonoscopy. No regular medication. VCE identified a large lesion with apical umbilication in the mid tertile with initial differential diagnosis including GIST. The lesion was resected laparoscopically and found to be a 2.8 cm lipoma in the distal jejunum. (Figure 1). Patient improved with no recurrence of symptoms.

Case 2: 76-year-old female presented with melaena. She took aspirin daily. EGD found a hiatus hernia and colonoscopy was normal. VCE identified a hemorrhagic polypoid mass with surface ulceration and active ooze that was difficult to localize due to non-passage of the capsule (Figure 2). Subsequent CT and then surgical resection showed lipoma in the mid jejunum (Figure 3). Patient recovered well after surgery with no recurrence of bleeding.

Case 3: 86-year-old female presented with hematemesis and melaena. He was taking aspirin daily. EGD showed a large submucosal lesion with typical lipoma appearance in the second part of duodenum. She suffered recurrent melaena requiring transfusion. VCE was performed to establish the source of bleeding. VCE identified the known duodenal lesion (Figure 4) and further demonstrated erosive changes, active ooze and no other significant SB pathology thus confirming the source of bleeding. Surgery was not considered due to age and comorbidities. Current management is supportive.

Conclusion: Lipomas are benign submucosal tumors that are most commonly incidental findings in SB assessment but may result in hemorrhage, abdominal pain, and intestinal obstruction. We have presented three cases in which lipoma was the source of significant obscure SB bleeding. In two cases lipoma had an atypical appearance due to ischemia. Concurrent aspirin therapy may increase the risk of bleeding presumably due to erosive changes at the lipoma surface. Lipoma should be included in the differential diagnosis of a submucosal bleeding mass seen at VCE.

Prospective single-blinded single-centre randomized controlled trial comparing moviprep with prekit c using standard split preparation protocol in patients for elective colonoscopy

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Introduction: The diagnostic accuracy of colonoscopy is heavily dependent on the quality of bowel preparation. Minimisation of adverse events and patient tolerability often affects completion of bowel preparation.

Aim: To compare the efficacy, tolerance and safety of two different bowel preparations, Moviprep and Prekit C, using standard split preparation protocol.

Methods: Patients requiring elective colonoscopy were randomized to one bowel preparation – Moviprep (MP; Polyethylene Glycol-Based Solution) or Prekit C (PKC; Combined Polyethylene Glycol and Sodium Picosulfate-Based Solution). Serum electrolytes were collected within two weeks prior to and on the day of colonoscopy. Patients completed a standardized questionnaire regarding the tolerability of the bowel preparation (score: 0–20, 20 indicating the most tolerable) on the day of colonoscopy. Two colonoscopists, blinded to the bowel preparation, independently assessed the quality of the bowel preparation using the Ottawa Score (score: 0–14, 14 indicating the poorest quality). Mann Whitney U test was used for statistical analysis.

Results: 74 patients have been recruited to the trial to date; 33/35 randomised to PKC and 32/39 to MP have completed their colonoscopy and bowel quality assessment. The median Ottawa scores were similar in both groups (6 [IQR: 3–10.5] (PKC) vs 6 [1.5–14] (MP); $p = 0.87$). There