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Literature search results

What is the follow up procedure for patients after a colorectal polyp cancer is found? The treatment is a polypectomy but what care is the patient given? Radiology tests?

Resources searched

NLH, NHS Evidence, TRIP, Cochrane Database, Medline, EMBASE, CINAHL, Google

Database search terms: exp COLONIC POLYPS/ ("colonic polyp" OR "colonic polyps" OR "colon polyp").ti,ab , exp INTESTINAL POLYPS/ (polypectomy OR "colonic polypectomy" OR "colonic polypectomies" OR "colon polypectomy").ti,ab , exp PATIENT CARE/("patient care" OR "follow up care" OR "follow-up care" OR "follow up" OR "follow-up" OR "after care" OR aftercare).ti,ab , exp AFTERCARE/ "colorectal polypectomy".ti,ab , ("offer of treatment" OR "offer of test" OR "radiology testing" OR "radiological tests").ti,ab

Google search string: (colorectal polyp or polypectomy) colon ("patient care" or aftercare or "follow up") 2000..2010

Summary

Follow up procedure for patients after a polypectomy consists of regular colonoscopic surveillance, endoscopic surveillance, double contrast enema, or screening via faecal occult blood testing.

Follow up procedure is determined by different factors: the size of the polyp, patient and physician behaviour, knowledge and actions, histology of the polyp, the number of previous adenomas, and the risk factors for the patient.

Follow up time schedules vary throughout the literature: between 6-12 months after the procedure, 24-48 months after the procedure, low risk patients after 10 years and high risk patients after 3 years, or dependent on the size and amount of polyps.

Guidelines
Post-polypectomy surveillance - The Map of Medicine 2008

A flow chart giving options for patient treatment and care after a polypectomy depending on the neoplastic status of the polyp.

Colorectal Cancer Screening: surveillance guidelines after removal of colorectal adenomatous polyps. Gut, 2002

Most colon cancers are assumed to have a premalignant adenomatous polyp phase, therefore colonoscopic detection and polypectomy provides the opportunity for cancer prevention. Some patients who have undergone colonoscopy and have had adenomas removed are at increased risk of developing colorectal cancer (CRC) in the future, and therefore might benefit from colonoscopic surveillance.

Risk related surveillance following colorectal polypectomy. Gut, 2002

Patients who have had a colorectal adenoma are likely to develop a metachronous adenoma and therefore need to be kept under surveillance. It is essential to avoid unnecessary examinations by tailoring the frequency of follow up examinations to individual risk.

Evidence-based reviews

Cochrane Database of Systematic Reviews

Dietary calcium supplementation for preventing colorectal cancer and adenomatous polyps 2010

There have been suggestions, based on observational studies and on laboratory markers, that dietary calcium may protect against colorectal cancer. This systematic review of the literature identified two well conducted randomised placebo-controlled intervention studies involving 1346 subjects followed for 3-4 years. The results suggest that there may be a moderate protective effect (OR 0.74; CI 0.58,0.95) for dietary supplementation of at least 1200mg elemental calcium per day on the development of colorectal adenomatous polyps. However, no trial has directly demonstrated an effect of calcium supplementation on the development of colorectal cancer itself.

Centre for Reviews and Dissemination

Cost-effectiveness of early one-year colonoscopy surveillance after polypectomy 2009

Some colorectal cancers have been unexpectedly diagnosed within one year after polypectomy in high-quality trials. The purpose of this study was to assess the clinical and economic impact of early surveillance colonoscopy one year after polypectomy in relation to detection of colorectal cancer. The number of early one-year colonoscopies needed to detect one cancer and to prevent one cancer-related death was 354 and 1,437, respectively. The incremental cost-effectiveness ratio of performing early one-year colonoscopy as compared with not performing it was $66,136 per life-year gained.

Published research

1. Endoscopists' estimation of size should not determine surveillance of colonic polyps.

Author(s): Moug SJ, Vernall N, Saldanha J, McGregor JR, Balsitis M, Diament RH

Current British Society of Gastroenterology guidelines use adenomatous polyp size as one of the key factors in determining polyp follow-up. This study aimed to compare polyp size assessment by colonoscopists and pathologists before and after fixation to determine the optimal method for measurement

Citation: Colorectal Disease, July 2010, vol./is. 12/7(646-50), 1462-8910;1463-1318 (2010 Jul)
7. Large refractory colonic polyps: is it time to change our practice? A prospective study of the clinical and economic impact of a tertiary referral colonic mucosal resection and polypectomy service (with videos).

Author(s): Swan MP, Bourke MJ, Alexander S, Moss A, Williams SJ

Patients who have large, difficult, colorectal lesions not readily amenable to endoscopic resection are often referred directly to surgery. The application of advanced polypectomy and endoscopic mucosal resection (EMR) techniques undertaken by a tertiary referral colonic mucosal resection and polypectomy service (TRCPS) is not often considered but may be superior to surgery

Citation: Gastrointestinal Endoscopy, December 2009, vol./is. 70/6(1128-36), 0016-5107;1097-6779 (2009 Dec)

Publication Date: December 2009

Source: MEDLINE

Full Text:
Available in print at Lincoln County Hospital Professional Library

10. Management of small polyps detected by screening CT colonography: patient and physician preferences.

Author(s): Shah JP, Hynan LS, Rockey DC

Management of small polyps found on computed tomography (CT) colonography is controversial and critical to both cancer outcomes and cost. Patient and physician behavior are influenced by personal beliefs and prior experience. Thus, we aimed to understand patient and physician preferences after finding polyps on CT colonography

Citation: American Journal of Medicine, July 2009, vol./is. 122/7(687.e1-9), 0002-9343;1555-7162 (2009 Jul)

Publication Date: July 2009

Source: MEDLINE


Author(s): Franklin ME Jr, Portillo G

Colonoscopy is widely used to remove benign polyps. However, a variety of “difficult polyps” are not accessible for colonoscopic removal because of their size, broad base, or difficult location (impossible to see the polyp's base, polyps behind mucosal folds or in tortuous colonic segments). The aim of the study was to evaluate the long-term follow-up and oncologic safety of laparoscopically monitored colonoscopic polypectomy (LMCP).

Citation: World Journal of Surgery, June 2009, vol./is. 33/6(1306-9), 0364-2313;1432-2323 (2009 Jun)

Publication Date: June 2009

Source: MEDLINE


Author(s): Arditi C, Gonvers JJ, Burnand B, Minoli G, Oertli D, Lacaine F, Dubois RW,
Vader JP, Schussele Filliettaz S, Peytremann-Bridevaux I, Pittet V, Juillerat P, Froehlich F, EPAGE II Study Group

To summarize the published literature on assessment of appropriateness of colonoscopy for surveillance after polypectomy and after curative-intent resection of colorectal cancer (CRC), and report appropriateness criteria developed by an expert panel, the 2008 European Panel on the Appropriateness of Gastrointestinal Endoscopy, EPAGE II.

Citation: Endoscopy, March 2009, vol./is. 41/3(209-17), 0013-726X;1438-8812 (2009 Mar)
Publication Date: March 2009
Source: MEDLINE


Large, colorectal polyps or those that are difficult to access may be unamenable to conventional snare polypectomy and may require surgical resection. This study was designed to evaluate the resection of such lesions by the use of combined laparoscopic-endoscopic resections (CLER).

Citation: Surgical Endoscopy, April 2009, vol./is. 23/4(688-93), 0930-2794;1432-2218 (2009 Apr)
Publication Date: April 2009
Source: MEDLINE

26. Colonoscopy surveillance after polypectomy and colorectal cancer resection.


This article describes a joint update of guidelines by the American Cancer Society and the U.S. Multi-Society Task Force on Colorectal Cancer delineating evidence-based surveillance recommendations for patients after polypectomy and colorectal cancer resection. Although there are some qualifying conditions, the following general guidelines apply: after colonoscopic polypectomy, patients with hyperplastic polyps should be considered to have normal colonoscopies, and subsequent colonoscopy is recommended at 10 years. Patients with one or two small (less than 1 cm) tubular adenomas, including those with only low-grade dysplasia, should have their next colonoscopy in five to 10 years. Patients with three to 10 adenomas, any adenoma 1 cm or larger, or any adenoma with villous features or high-grade dysplasia should have their next colonoscopy in three years. Following curative resection of colorectal cancer, patients should undergo a colonoscopy at one year, with subsequent follow-up intervals determined by the results of this examination. Adoption of these guidelines will have a dramatic impact on the quality of care provided to patients after a colorectal cancer diagnosis, will assist in shifting available resources from intensive surveillance to screening, and will ultimately decrease suffering and death related to colorectal cancer.

Citation: American Family Physician, April 2008, vol./is. 77/7(995-1002), 0002-838X;0002-838X (2008 Apr 1)
Publication Date: April 2008
Source: MEDLINE

27. A nationwide survey evaluating adherence to guidelines for follow-up after
polypectomy or treatment for colorectal cancer.

Author(s): Mulder SA, Ouwendijk RJ, van Leerdam ME, Nagengast FM, Kuipers EJ

BACKGROUND: Endoscopic follow-up (FU) in patients treated for colorectal adenomas or cancer (CRC) is intended to reduce the incidence of CRC. In the Dutch postpolypectomy guidelines, the FU interval is solely determined by the number of previous adenomas, whereas in other countries size and histology are also taken into account. Whether this difference in policy is also reflected in clinical practice is unknown. Furthermore, FU guidelines after CRC are not standardized in The Netherlands, even though national recommendations are available. GOAL: To assess the adherence to the current Dutch postpolypectomy guidelines and to evaluate the FU policy after CRC resection. STUDY: A survey was sent to all Gastrointestinal Departments in The Netherlands. The survey consisted of questions on logistic organization of FU, postpolypectomy FU intervals, and FU after CRC. RESULTS: The response rate was 85%. In contrast to the national guidelines, size and histology of the adenomas were often taken into account, leading to shortening of the FU interval. With respect to the CRC cases, 52% of the respondents advised shorter FU intervals than advised by the national recommendations. CONCLUSIONS: Despite recent Dutch postpolypectomy guidelines, clinicians incorporate histology and size into their clinical strategy. Either further education on the guidelines is needed, or the guidelines need to be reconsidered. Furthermore, evidence-based guidelines for FU after CRC should be formulated.

Citation: Journal of Clinical Gastroenterology, May 2008, vol./is. 42/5(487-92), 0192-0790;0192-0790 (2008 May-Jun)

Publication Date: May 2008

Source: MEDLINE

34. Benefit-risk analysis of different risk-related surveillance schedules following colorectal polypectomy.

Author(s): Becker F, Nusko G, Welke J, Hahn EG, Mansmann U

BACKGROUND/AIMS: For colorectal screening patients a gain of life time was previously calculated to be about 30-50 days. Different recommendations for recognizing at-risk groups and defining surveillance intervals after an initial finding of colorectal adenomas have been published. However, no benefit-risk analysis regarding specific long-term effects of follow-up patients has been reported to date. METHODOLOGY: A Markov model based on time-dependent transition possibilities was developed to compare two surveillance schedules: recommendations based on the Erlangen Registry of Colorectal Polyps (ERCRP) and the National Polyp Study (NPS). The outcome was calculated for a 50-year-old patient with 30 years of follow-up after initial polypectomy. The data used in this model were taken from different sources, namely the ERCRP, the German Study Group of Colorectal Cancer, the German Statistical Yearbook, and from meta-analyses of studies reporting data on complications and sensitivity of colonoscopy. RESULTS: Patients under surveillance have a mean lifetime gain of 98 (ERCRP) and 91 (NPS) days compared with those who do not come for surveillance. Approximately 84% and 79% of deaths from colorectal carcinoma (CRC) could be prevented if patients were followed up according to the recommendations of the ERCRP and the NPS, respectively. The risk of death due to colonoscopy for patients during followup is about 0.05% lifetime risk. Sensitivity analysis showed the stability of the results under a wide range of reasonable variations of relevant parameters. In a pessimistic one-way sensitivity analysis regarding compliance, effectiveness was reduced to one third. CONCLUSIONS: Surveillance using colonoscopy is an effective tool for preventing CRC after colorectal polypectomy and similar to the screening procedure. The effectiveness is slightly higher when following the recommendations of the ERCRP, especially if a more realistic compliance is assumed.
35. Colonoscopy screening and surveillance of colorectal cancer and polyps: physicians’ knowledge.

Author(s): Zbidi I, Hazazi R, Niv Y, Birkenfeld S

BACKGROUND: Colonoscopy is the gold standard procedure for screening for colorectal cancer and surveillance after polypectomy or colorectal cancer surgery, for diagnosis in symptomatic patients and patients with fecal occult blood, and for screening in the high risk population. The adherence of referring physicians to the accepted recommendations can prevent long waiting lists for colonoscopy and save lives, costs and resources.

OBJECTIVES: To evaluate the knowledge of primary care physicians and gastroenterologists in Israel about current guidelines for colonoscopy screening and surveillance. METHODS: A 10-item questionnaire on proper follow-up colonoscopy for surveillance after polypectomy and screening for colorectal cancer in various clinical and epidemiological situations was administered to 100 expert gastroenterologists and 100 primary care physicians at a professional meeting. Answers were evaluated for each group of physicians and compared using the chi-square test. RESULTS: The compliance rate was 45% for the gastroenterologists and 80% for the primary care physicians. The rate of correct answers to the specific items ranged from 18.7% to 93.75% for the gastroenterologists and from 6.2% to 58.5% for the primary care physicians (P< 0.001 for almost every item). CONCLUSIONS: The knowledge of physicians regarding the screening and surveillance of colorectal cancer needs to be improved.

38. Association between body size and colorectal adenoma recurrence.

Author(s): Jacobs ET, Martinez ME, Alberts DS, Jiang R, Lance P, Lowe KA, Thompson PA

BACKGROUND & AIMS: Obesity has been associated with increased risk for colorectal adenoma, although its role as a risk factor after polypectomy for recurrence is unclear. Therefore, we sought to evaluate the effect of anthropometric measures of obesity on adenoma after polypectomy. METHODS: Subjects with baseline adenomas (n = 2465) and follow-up colonoscopy data were drawn from 2 randomized trials designed to prevent adenoma recurrence. RESULTS: Over a mean follow-up period of 3.1 years presence of a body mass index (BMI) ≥ 30 kg/m² was associated with a nonsignificant 17% increase in the odds for any adenoma recurrence among all subjects (odds ratio [OR], 1.17; 95% confidence interval [CI], 0.92-1.48). This result was confined to men (OR, 1.36; 95% CI, 1.01-1.83) and not observed for women (OR, 0.90; 95% CI, 0.60-1.33). Results for waist circumference did not reach statistical significance, although trends were similar to those for BMI. Analyses of the effects of obesity on more clinically significant lesions demonstrated that high BMI was a slightly stronger risk factor for advanced adenoma recurrences in men (OR, 1.62; 95% CI, 1.04-2.53) when compared with non-advanced lesions (OR, 1.26; 95% CI, 0.91-1.75). In addition, we observed an association for obesity and odds of adenoma recurrence among participants reporting a family history of colorectal cancer (OR, 2.25; 95% CI, 1.32-3.84) but not for those without (OR, 1.00; 95% CI, 0.77 to
1.31; \( P_{\text{int}} = P = .008 \). CONCLUSIONS: Our results support obesity as a risk factor for subsequent short-interval (mean follow-up time 3.1 years) development of colorectal adenomas, particularly among men and persons with a family history of colorectal cancer. Furthermore, obesity in men appears to be strongly associated with the development of clinically advanced lesions.

Citation: Clinical Gastroenterology & Hepatology, August 2007, vol./is. 5/8(982-90), 1542-3565;1542-7714 (2007 Aug)
Publication Date: August 2007
Source: MEDLINE

69. Are physicians doing too much colonoscopy? A national survey of colorectal surveillance after polypectomy.

Author(s): Mysliwiec PA, Brown ML, Klabunde CN, Ransohoff DF

Increasing use of colonoscopy for colorectal cancer screening and surveillance of colorectal adenomas after polypectomy has given rise to concerns about the availability of endoscopic resources in the United States. Guidelines recommend surveillance after polypectomy at 3 to 5 years for a small adenoma, and follow-up is not advised for hyperplastic polyps. The intensity of physicians' surveillance is largely unstudied.

Citation: Annals of Internal Medicine, August 2004, vol./is. 141/4(264-71), 0003-4819;1539-3704 (2004 Aug 17)
Publication Date: August 2004
Source: MEDLINE

Available in fulltext at Highwire Press

Available in fulltext at Lincoln County Hospital Professional Library: Note: Username: ulhtkis/Password: library
Available in print at Lincoln County Hospital Professional Library


Author(s): Odze RD, Farraye FA, Hecht JL, Hornick JL

BACKGROUND & AIMS: A previously published study by our group suggested that adenoma-like dysplasia-associated lesions or masses (DALMs) in ulcerative colitis (UC) may be treated adequately by polypectomy and continued endoscopic surveillance. The length of follow-up evaluation in these patients averaged only 42 months. The purpose of this study was to evaluate the long-term outcome of our previously defined group of UC patients, all with adenoma-like DALMs, who were treated by polypectomy. METHODS: The clinical, endoscopic, and pathologic outcome of 34 UC patients, 24 with an adenoma-like DALM, and 10 with a coincidental sporadic adenoma, 28 of whom were treated by polypectomy and continued endoscopic surveillance, and 6 by colonic resection, were compared with the outcome of 49 non-UC patients who were treated similarly for a sporadic adenoma. The mean length of follow-up evaluation averaged 82.1 months and 71.8 months for the 2 UC subgroups, respectively, and 60.4 months for the non-UC controls. RESULTS: Overall, 20 of 34 UC patients (58.8%) developed at least one further adenoma-like DALM on follow-up evaluation. One patient had flat low-grade dysplasia present in the colon, which was resected within 6 months of the initial polypectomy, and another patient, with primary sclerosing cholangitis, developed adenocarcinoma 7.5 years after her initial polypectomy. There was no significant difference in the prevalence of polyp formation on follow-up evaluation between UC patients with an adenoma-like DALM (62.5%) and UC patients with a sporadic adenoma (50%), or between either of these 2 UC patient
subgroups and the non-UC sporadic adenoma patient group (49%; P > 0.05).

CONCLUSIONS: UC patients who develop an adenoma-like DALM may be treated adequately by polypectomy with complete excision and continued endoscopic surveillance.

Citation: Clinical Gastroenterology & Hepatology, July 2004, vol./is. 2/7(534-41), 1542-3565;1542-3565 (2004 Jul)

Publication Date: July 2004

Source: MEDLINE

93. Lifestyle-related factors and colorectal polyps: preliminary results from a Norwegian follow-up and intervention study.

Author(s): Almendingen K, Hofstad B, Vatn MH

Lifestyle-related variables are suggested to play a major role in the development of colorectal cancer (CRC). Within a 3-year follow-up and intervention study with calcium and antioxidants against growth and recurrence of colorectal polyps, supplementary studies were performed in which different aspects of lifestyle were examined. Instead of polypectomy at diagnosis, polyps <9 mm were left in situ in 116 polyp patients (50-76 years, 50% men). After 3 years, all polyps were removed and subjected to histology. Two different sets of control groups were included (all controls were age- and sex-matched and proven to be free of polyps). We applied two different methods in order to assess most exposure variables. Generally, in case-control studies, the validity of the study outcomes is high if they are similar regardless of choice of controls and methods, since bias due to these choices may affect the risk estimates. In contrast, the validity of the study outcomes is low if dependent upon these choices. Our preliminary data support the theory that different factors may be of importance in different stages of the neoplastive formation, and that lifestyle-related factors are likely to play a major role in CRC development.

Citation: European Journal of Cancer Prevention, April 2002, vol./is. 11/2(153-8), 0959-8278;0959-8278 (2002 Apr)

Publication Date: April 2002

Source: MEDLINE

Available in fulltext at Ovid

2. Follow-up study after colorectal polypectomy. The predictive value of a negative double-contrast barium enema.

Author(s): Kjaergard H, Nordkild P, Hennild V, Pedersen VM, Geerdsen J

In this study the predictive value of a negative double-contrast barium enema for colonic polyps has been calculated as the ratio of the number of true negative radiologic examinations to the total number of negative radiologic examinations. The total number of negative double-contrast barium enemas for polyps of the colon was 357 in 228 consecutive patients with previous or suspected neoplastic colonic polyps examined in the period 1977-84. The predictive value of a negative double-contrast barium enema for all colonic polyps regardless of size was 87% (95% confidence interval, 84-91%). The corresponding predictive value of a negative result for polyps larger than 10 mm in diameter was 98% (95% confidence interval, 97-100%). Polyps that had not been detected by radiography were removed by colonoscopy, and 85% of them were available for histological examination. No cancers were found. The polyps were primarily neoplastic, but metaplastic and juvenile polyps were also ascertained.

Citation: Scandinavian Journal of Gastroenterology, April 1986, vol./is. 21/3(353-6), 0036-5521;0036-5521 (1986 Apr)

Publication Date: April 1986
6. Follow-up after colorectal polypectomy. II. Repeated examinations of the colon every 6 months after removal of sessile adenomas and adenomas with the highest degrees of dysplasia.

Author(s): Kronborg O, Hage E, Adamsen S, Deichgraebner E

Fifty-five patients with colorectal sessile adenomas and adenomas with the severest dysplasia were followed up every 6 months with colonoscopy and/or double-contrast enema during 4 years, after a clean colon had been obtained, by repeated colonoscopy within 3 months after piecemeal polypectomy. The repetition at 3 months resulted in detection of two cancers. An overlooked cancer was detected at 1 year, and another cancer was diagnosed between examinations. Risk of new adenomas (19 patients) was related to original size, number, and glandular structure of the polyps. Twelve of the 19 patients had new polyps above the rectum. The 336 colonoscopies were complicated by 3 laparotomies, made necessary by perforation and bleeding. The results suggest that intervals between examinations of patients with the present type of adenomas may be prolonged, and patients are now allocated at random to colorectal follow-up examination every 6 and 12 months.

Citation: Scandinavian Journal of Gastroenterology, November 1983, vol./is. 18/8(1095-9), 0036-5521;0036-5521 (1983 Nov)
Publication Date: November 1983
Source: MEDLINE

7. Follow-up after colorectal polypectomy. I. A comparison of the effectiveness of repeated examinations of the colon every 6 and 24 months after removal of stalked polyps.

Author(s): Kronborg O, Hage E, Adamsen S, Deichgraebner E

To investigate the effect of follow-up study after colorectal polypectomy, 156 patients with symptomatic stalked adenomas with light to severe dysplasia were allocated at random to colorectal examination every 6 (A) and 24 (B) months after colonoscopic polypectomy. No high-risk group could be identified. Twenty-one of the 23 new polyps were located above the rectum, but 15 could have been removed during examination with the flexible sigmoidoscope. The risk of new adenomas was similar at all 6-month examinations, during the first 4 years of the study. A small carcinoma (Dukes A) was found at 24 months in group B. A fatal colonic perforation was seen in group A after seven previous colonoscopies without complications. The new polyps caused no symptoms other than minimal bleeding in some of the patients, and because increasing the rate of colonoscopies increases risk of complications, it was considered justified to prolong the intervals to 24 and 48 months, at random.

Citation: Scandinavian Journal of Gastroenterology, November 1983, vol./is. 18/8(1089-93), 0036-5521;0036-5521 (1983 Nov)
Publication Date: November 1983
Source: MEDLINE

3. Risk related surveillance following colorectal polypectomy.

Author(s): Nusko G, Mansmann U, Kirchner T, Hahn EG

BACKGROUND: Patients who have had a colorectal adenoma are likely to develop a metachronous adenoma and therefore need to be kept under surveillance. It is essential to avoid unnecessary examinations by tailoring the frequency of follow up examinations to individual risk. METHODS: A total of 3134 patients undergoing endoscopic removal of colorectal adenomas were prospectively recorded on the Erlangen Registry of Colorectal
Polyps between 1978 and 1996. A multivariate analysis of 1159 patients on long-term follow up was performed to identify risk factors determining surveillance intervals for patients with metachronous adenomas of advanced pathology—that is, adenomas >10 mm or with high-grade dysplasia or invasive carcinoma. RESULTS: Univariate analysis revealed that sex, parental history of colorectal carcinoma, and characteristics of the initial findings—that is, size, multiplicity, and amount of villous structure—were significant predictors of metachronous adenomas of advanced pathology. On the basis of multivariate analysis, two risk groups were identified: (1) patients with no parental history of colorectal carcinoma with only small (< or = 10 mm) tubular adenomas at the initial clearing examination have a very low risk, and we estimated that 10% will develop advanced metachronous adenomas after 10 years; (2) the high-risk group contained all other patients, 10% of whom will show metachronous adenomas of advanced pathology at follow up after only three years.

CONCLUSIONS: The risk of developing metachronous adenomas with advanced pathology can be stratified for various patient and adenoma characteristics. Surveillance intervals can be scheduled for low-risk (10 years) and high-risk (three years) patients. Risk-related follow up thus helps to avoid unnecessary examinations.

Citation: Gut, September 2002, vol./is. 51/3(424-8), 0017-5749:0017-5749 (2002 Sep)
Publication Date: September 2002
Source: MEDLINE

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Available in print at Pilgrim Hospital Staff Library

42. Should we perform polypectomy for all colorectal polyps, or follow-up?

Author(s): Ozturk Z.A., Koklu S., Basat O., Yuksel O., Basar O., Filik L.

Background: There is controversy as to whether all colorectal polyps detected on colonoscopy should be removed. This study evaluated the histopathological characteristics of colorectal polyps in Turkish patients, and further determined their relationship to age, gender, size, and location. We aimed to determine the risk of neoplasms in patients with small polyps (<=5 mm), and emphasize the importance of polyp removal. Materials and Methods: Of 4,145 colonoscopies reviewed between July 2004 and June 2006, 791 polypectomies and 211 polyp biopsies were performed in 576 patients. Results: Of the 1,002 polyps histologically analyzed, 586 (58.5%) were non-neoplastic, and 396 (39.5%) were neoplastic. Among the neoplastic polyps, 311 (78.5%) were tubular, 41 (10.4%) were tubulovillous, 31 (7.8%) were villous, and 13 (3.3%) showed a malignant transformation. 63% of the non-neoplastic polyps were hyperplastic, and the remaining 37% were inflammatory polyps. Both neoplastic and non-neoplastic polyps were located predominantly in the left colon (rectum, sigmoid, descending colon). Though only 31.7% of the polyps measuring <5 mm were neoplastic, 82.4% of the polyps >20 mm in size were neoplastic. There was no significant gender difference in distribution of either neoplastic or non-neoplastic polyps. The peak prevalence of both neoplastic and non-neoplastic polyps occurred in the 50-70-year age group. Conclusion: About half of the colorectal polyps are neoplastic in patients more than 50 years old. Even small polyps seen during colonoscopy should be removed and subjected to histological analysis. Western guidelines regarding colorectal polyps may also be applicable for the Turkish population.
43. Post-polypectomy surveillance guidelines

Author(s): Schneider H.R.

Citation: South African Gastroenterology Review, March 2007, vol./is. 5/1(20), 1812-1659 (Mar 2007)
Publication Date: March 2007
Source: EMBASE

BACKGROUND: Recommendations by primary care physicians for colorectal screening after polypectomy will influence rates of colonoscopy in open-access systems that do not require consultation by a gastroenterologist before colonoscopy. OBJECTIVE: To determine the surveillance recommendations of primary care physicians after polypectomy and compare them with recommendations from the U.S. Multisociety Task Force on Colorectal Cancer. DESIGN: Cross-sectional study of physicians. SETTING: United States. PARTICIPANTS: A random sample of 500 physicians from the American College of Physicians and 500 physicians from the American Academy of Family Physicians, obtained by using a mail survey. MEASUREMENTS: Physicians were asked when they would recommend repeated colonoscopy for a hypothetical 55-year-old man with no family history of colorectal cancer after the following 6 results on colonoscopy: hyperplastic polyp, one 6-mm tubular adenoma, two 6-mm tubular adenomas, one 12-mm tubulovillous adenoma, one 12-mm tubular adenoma with focal high-grade dysplasia, and no polyp but a previous tubular adenoma. RESULTS: The overall response rate was 57% (568 physicians). Of the respondents, 48% were internists and 52% were family practitioners. Sixty-one percent of respondents would survey a hyperplastic polyp in 5 years or less, 71% would survey a single tubular adenoma in 3 years or less, and 80% would survey 2 tubular adenomas in 3 years or less. LIMITATIONS: The results are based on physicians’ self-reported practices from clinical vignettes and may not match actual practice. CONCLUSION: Primary care physicians recommend postpolypectomy colonoscopic surveillance more frequently than is recommended by practice guidelines, especially if the colonoscopy showed a hyperplastic polyp or a single small adenoma.

Citation: Annals of internal medicine, November 2006, vol./is. 145/9(654-659), 1539-3704 (7 Nov 2006)
Publication Date: November 2006
Source: EMBASE

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Available in print at Lincoln County Hospital Professional Library

44. Colorectal screening after polypectomy: a national survey study of primary care physicians

Author(s): Boolchand V., Olds G., Singh J., Singh P., Chak A., Cooper G.S.

BACKGROUND: Recommendations by primary care physicians for colorectal screening after polypectomy will influence rates of colonoscopy in open-access systems that do not require consultation by a gastroenterologist before colonoscopy. OBJECTIVE: To determine the surveillance recommendations of primary care physicians after polypectomy and compare them with recommendations from the U.S. Multisociety Task Force on Colorectal Cancer. DESIGN: Cross-sectional study of physicians. SETTING: United States. PARTICIPANTS: A random sample of 500 physicians from the American College of Physicians and 500 physicians from the American Academy of Family Physicians, obtained by using a mail survey. MEASUREMENTS: Physicians were asked when they would recommend repeated colonoscopy for a hypothetical 55-year-old man with no family history of colorectal cancer after the following 6 results on colonoscopy: hyperplastic polyp, one 6-mm tubular adenoma, two 6-mm tubular adenomas, one 12-mm tubulovillous adenoma, one 12-mm tubular adenoma with focal high-grade dysplasia, and no polyp but a previous tubular adenoma. RESULTS: The overall response rate was 57% (568 physicians). Of the respondents, 48% were internists and 52% were family practitioners. Sixty-one percent of respondents would survey a hyperplastic polyp in 5 years or less, 71% would survey a single tubular adenoma in 3 years or less, and 80% would survey 2 tubular adenomas in 3 years or less. LIMITATIONS: The results are based on physicians’ self-reported practices from clinical vignettes and may not match actual practice. CONCLUSION: Primary care physicians recommend postpolypectomy colonoscopic surveillance more frequently than is recommended by practice guidelines, especially if the colonoscopy showed a hyperplastic polyp or a single small adenoma.

Citation: Annals of internal medicine, November 2006, vol./is. 145/9(654-659), 1539-3704 (7 Nov 2006)
Publication Date: November 2006
Source: EMBASE

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Available in print at Lincoln County Hospital Professional Library

45. Non-compliance in surveillance for patients with previous resection of large (>= 1 cm) colorectal adenomas
Author(s): Brueckl W.M., Fritsche B., Seifert B., Boxberger F., Albrecht H., Croner R.S., Wein A., Hahn E.G.

Aim: To assess the extent and reasons of noncompliance in surveillance for patients undergoing polypectomy of large (≥ 1 cm) colorectal adenomas. Methods: Between 1995 and 2002, colorectal adenomas ≥ 1 cm were diagnosed in 210 patients and subsequently documented at the Erlangen Registry of Colorectal Polyps. One hundred and fifty-eight patients (75.2%) could be contacted by telephone and agreed to be interviewed. Additionally, records were obtained from the treating physicians. Results: Fifty-four out of 158 patients (34.2%) neglected any surveillance. Reasons for non-compliance included lack of knowledge concerning surveillance intervals (45.8%), no symptoms (29.2%), fear of examination (18.8%) or old age/severe illness (6.3%). In a multivariate analysis, the factors including female gender (P = 0.036) and age > 62 years (P = 0.016) proved to be significantly associated with non-compliance in surveillance. Conclusions: Efforts to increase compliance in surveillance are of utmost importance. This applies particularly to women’s compliance. Effective strategies for avoiding metachronous colorectal adenoma and cancer should focus on both the improvement in awareness and knowledge of patients and information about physicians for surveillance.

Citation: World Journal of Gastroenterology, December 2006, vol./is. 12/45(7313-7318), 1007-9327 (07 Dec 2006)
Publication Date: December 2006
Source: EMBASE

46. Preoperative colonoscopy decreases the need for laparoscopic management of colonic polyps

Author(s): Lipof T., Bartus C., Sardella W., Johnson K., Vignati P., Cohen J.

Patients are commonly referred to surgeons for surgical resection of polyps that cannot be excised colonoscopically. Repeating the colonoscopy may be met with resistance by both the patient and the referring endoscopist. However, there are two distinct benefits. First, if the lesion was not marked, tattooing facilitates laparoscopic resection. Second, and more importantly, many of these polyps can be removed endoscopically by an experienced colorectal surgeon, avoiding unnecessary colon resection. Over a period of five years, we have reviewed preoperative colonoscopy in patients who were referred for surgical treatment of benign polyps

Citation: Diseases of the Colon and Rectum, May 2005, vol./is. 48/5(1076-1080), 0012-3706;1530-0358 (May 2005)
Publication Date: May 2005
Source: EMBASE

Full Text:
Available in print at Grantham Hospital Staff Library

47. Avoiding Surgery in Patients with Colorectal Polyps

Author(s): Church J.M.

Citation: Diseases of the Colon and Rectum, November 2003, vol./is. 46/11(1513-1516), 0012-3706 (Nov 2003)

PURPOSE: Colonic polyps are sometimes difficult to remove endoscopically and are referred for surgical resection. This study was performed to determine how many polyps referred for surgery could actually be managed endoscopically. METHODS: An endoscopic database with data entered prospectively and consecutively was used to identify patients referred for surgery for a colonic polypl. Rectal polyps were excluded. All patients underwent colonoscopy before surgery to see if the polyp could be managed
endoscopically. Cases were reviewed to see the method and outcome of treatment. RESULTS: The study population consists of 58 patients referred for surgical resection of a colorectal polyp. Endoscopic polypectomy was initially, successful in 48. Five of the 48 needed surgery later for a final success rate of 43/58 avoiding surgery. There were no deaths, four complications of endoscopic polypectomy (three bleeds, one post-polypectomy syndrome) and two patients had complications of surgery (one splenic injury, one ventral hernia). Polyps ranged in size from 1.5 cm to 8.0 cm. Seven polyps contained invasive cancer (three needing surgical resection), eight contained intramucosal cancer (one operated) and 11 had severe dysplasia (three operated). Rate of persistent polyp was 16/37 at first follow up, 7/23 at second, 1/14 at third and 0/8 at fourth. CONCLUSION: Most polyps referred for surgical resection were successfully managed endoscopically. Patients with colonic polyps that are difficult or potentially dangerous to remove endoscopically should be sent for a second opinion before surgery is performed.

Publication Date: November 2003
Source: EMBASE

Full Text:
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17. Chemoprevention of colorectal cancer: systematic review and economic evaluation.
Author(s): Cooper K, Squires H, Carroll C, Papaioannou D, Booth A, Logan R, Maguire C, Hind D, Tappenden P
BACKGROUND: Colorectal cancer (CRC) is the third most common cancer in the UK: incidence increases with age, median age at diagnosis being over 70 years. Approximately 25% of cases occur in individuals with a family history of CRC, including 5% caused by familial adenomatous polyposis (FAP) or hereditary non-polyposis CRC (HNPPCC). Most develop from adenomatous polyps arising from the intestine lining. Individuals with these polyps undergo polypectomy and are invited for endoscopic surveillance. Screening via faecal occult blood testing has been rolled out across the UK
Citation: Health Technology Assessment, 01 January 2010, vol./is. 14/32(1-206), 13665278
Publication Date: 01 January 2010
Source: CINAHL

Author(s): Cox JA, Rogers MA, Cox SD
Laparoscopic bowel surgery is a recent application of minimally invasive videoscopic techniques. Understanding the anatomy and physiology of the bowel, the background of bowel disorders and their treatment, signs and symptoms of bowel disease, and the patient selection process can help perioperative nurses better care for patients diagnosed with colon polyps, diverticulitis, and inflammatory bowel disease
Citation: AORN Journal, 01 February 2001, vol./is. 73/2(375-), 00012092
Publication Date: 01 February 2001
Source: CINAHL

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A program of colorectal cancer follow-up similar to those described by Vernava et al.
registered list of Ontario practitioners involved in cancer patient care. After polypectomy
in 731 colonoscopies, a complication rate of 0.55% [39]. des Kolonkarzinoms
[Controversies on after-care of colon carcinoma].
www.biomedcentral.com/1471-2407/3/26/

Mount Sinai Queens - Treatments & Procedures
A colon polypectomy is the removal of polyps from the inside lining of the colon (large
testone). A polyp is a mass of tissue. You will be scheduled for a follow-up colonoscopy
in the future. American Society of Colon and Rectal Surgeons website.
Last reviewed November 2009 by Daus Mahnke, MD.
www.mshq.org/patient-care/health-library/colon-polypectomy

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patient follow-up lasted for 6 months. The results showed that CE... subjects who were
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