Analysis of 60 patients with malignant polyps in national colorectal screening program Svit

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Gastroenterolog 2017; suplement 3: 122–123

Keywords: *malignant polyp, histologic criteria, screening program*

Objectives and study: Malignant polyps are detected in 0,75–5,6% of large bowel polyps. Definitive treatment can be endoscopic or surgical removal. There are strict histological criteria which need to be fulfilled to guarantee no further recurrence or disseminated disease (resection margin ≥1mm, depth of invasion: Haggitt level 1,2 and 3; Kikuchi level 1, well- differentiated carcinoma, no tumor budding and no lymphovascular invasion). In our retrospective study, we analyzed the validity of these criteria in our patients with malignant polyps as well as how clinicians and patients fulfill the recommendations for treatment by SVIT Multidisciplinary team of experts who carefully assess all patients with malignant polyps detected at National colorectal screening program SVIT.

Methods: We analyzed 60 patients with malignant polyps, resected in Slovenian colorectal screening program SVIT. We divided patients in three separate groups regard definitive treatment and histologic stage. We analyzed resection margin ≥1mm, depth of invasion, grade of carcinoma and lymphovascular invasion in all polyps resected.

Results: Five out of sixty patients were excluded due to inadequate data or different definitive treatment (chemoradiotherapy, no follow-up data for at least one year endoscopic or two years clinically). In the first group we have 19 patients who had only endoscopic removal and were without endoscopic recurrence (endoscopic check up after one year or more) or clinic dissemination of disease (clinical check up after two years or more). Six patients in this group did not fulfill the criteria for safe endoscopic removal and refused advised additional surgery. Resection margin ≥1mm was found in 11 patients (58%), <1mm in 4 patients (21%) and =0 in 2 patients (10,5%). Two patients (10,5%) were without confirmed resection margin due to piecemeal resection. In the second group, we have 28 patients who did not fulfill criteria for safe endoscopic removal and had an additional surgery. No residual malignant tissue were found in the surgical specimen (pT0N0). Resection margin ≥1mm was found in 5 patients (18%), three of them had lymphovascular invasion, another two were resected due to depth of invasion. Resection margin <1mm was found in 9 patients (32%) and =0 in 3 patients (11%). Eleven patients (39%) were without confirmed resection margin due to piecemeal resection. Eight patients were included in the third group. They also have not fulfilled criteria for safe endoscopic removal and have had an additional surgery. Surgical specimens showed residual disease at polypectomy site in 3 patients, in lymph nodes in 2 patients or at polypectomy site and in lymph nodes in 3 patients. 22% of all operated

patients (second and third group) had residual disease.No patient had safe resection margin in the third group, one patient (12,5%) had no safe resection margin, two patients (25%) were without confirmed resection margin, five patients (62,5%) had only partial polyp resection. Frequency of resection margin ≥1mm was significantly higher in first than second or third group ($p<0.01$). Depth of invasion was confirmed in 13 patients in the first group (mean 1,53 ± 1,12 mm), 12 patients in the second group (mean 2,16 ± 1,64 mm) and in 1 patient of third group (4,0mm). No lymphovascular invasion was confirmed in 95%, 75% and 37,5% of the first, second and third group respectively. All cancers were well and moderately differentiated and were equally distributed between groups.

Conclusions: Criteria for a definitive endoscopic treatment are good prognostic markers. Inadequate resection margin (<1mm) or piecemeal resection are the most frequent cause for additional surgery. More patients and at least five years follow-up should be included in future study before final conclusions on the importance of clinical decision criteria for surgical resection could be made.