europacolon portugal
APOIO AO DOENTE COM CANCRO DIGESTIVO

Vigilância Pós-Polipectomia

Pressupõe Colonoscopia Total com preparação adequada

Achado Endoscópicos / Histologia	Intervalo Recomendado	
Ausência de Pólipos	5-10 anos →	Baixo Risco
Hiperplásicos (cólon ascendente/transverso)	5-10 anos →	Baixo Risco
Até 2 adenomas tubulares < 10mm	5-10 anos →	Baixo Risco
3 ou mais adenomas tubulares	3 anos	
Adenomas tubulares > 10mm	3 anos	
Adenomas vilosos ou tubulo-vilosos (25% componente viloso)	3 anos	
Adenomas com Displasia de Alto Grau	3 anos	
< 10 adenomas	< 3 anos	
Ressecção de lesão em fragmentos	6 meses	
Adenocarcinoma (pós-cirurgia)	1 ano	
Adenomas Serreados		
>15 pólipos	1 ano	
Com displasia ou > 10 mm	3 anos	
Sem displasia <10 mm	5 anos	

(a) Um dos seguintes critérios: (1) pelo menos 5 pólipos proximais ao sigmoide com 2 ou mais pólipos >= 10mm; (2) quaisquer pólipos serreados com história familiar de síndrome de polipose serreada; (3) >20 pólipos serreados de qualquer tamanho em qualquer localização.

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AGA

Guidelines for Colonoscopy Surveillance After Screening and Polypectomy: A Consensus Update by the US Multi-Society Task Force on Colorectal Cancer

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Podcast interview: www.gastro.org/gastropodcast. Also available on iTunes.

Screening for colorectal cancer (CRC) in asymptomatic patients can reduce the incidence and mortality of CRC. In the United States, colonoscopy has become the most commonly used screening test. Adenomatous polyps are the most common neoplasm found during CRC screening. There is evidence that detection and removal of these cancer precursor lesions may prevent many cancers and reduce mortality.[1] However, patients who have adenomas are at increased risk for developing metachronous adenomas or cancer compared with patients without adenomas. There is new evidence that some patients may develop cancer within 3–5 years of colonoscopy and polypectomy—so-called interval cancers.

Ideally, screening and surveillance intervals should be based on evidence showing that interval examinations prevent interval cancers and cancer-related mortality. We have focused on the interval diagnosis of advanced adenomas as a surrogate marker for the more serious end point of cancer incidence or mortality. In 2006, the United States Multi-Society Task Force (MSTF) on CRC issued a guideline on postpolypectomy surveillance,[2] which updated a prior 1997 guideline. A key principle of the 2006 guideline was risk stratification of patients based on the findings at the baseline colonoscopy. The surveillance schema identified 2 major risk groups based on the likelihood of developing advanced neoplasia during surveillance: (1) low-risk adenomas (LRAs), defined as 1–2 tubular adenomas <10 mm, and (2) high-risk adenomas (HRAs), defined as adenoma with villous histology, high-grade dysplasia (HGD), ≥10 mm, or 3 or more adenomas. The task force also published recommendations for follow-up after resection of CRC.[3]

More recently, the British Society of Gastroenterology updated their 2002 surveillance guideline in 2010.[4] Their risk stratification differs from the US guideline, dividing patients into 3 groups: low risk (1–2 adenomas <10 mm), intermediate risk (3–4 small adenomas or one ≥10 mm), and high risk (>5 small adenomas or ≥3 with at least one ≥10 mm). They recommend that the high-risk group undergo surveillance at 1 year because of concerns about missed lesions at baseline. US guidelines place emphasis on performing a high-quality baseline examination. In 2008, the MSTF published screening guidelines for CRC, which included recommendations for the interval for repeat colonoscopy after negative findings on baseline examination.[5]

New issues have emerged since the 2006 guideline, including risk of interval CRC, proximal CRC, and the role of serrated polyps in colon carcinogenesis. New evidence suggests that adherence to prior guidelines is poor. The task force now issues an updated set of surveillance recommendations. During the past 6 years, new evidence has emerged that endorses and strengthens the 2006 recommendations. We believe that a stronger evidence base will improve adherence to the guidelines. The 2012 guidelines are summarized in Table 1 and are based on risk stratification principles used in the 2006 guideline. The ensuing discussion reviews the new evidence that supports these guidelines. This guideline does not address surveillance after colonoscopic or surgical resection of a malignant polyp.

Methodology

Literature Review

We performed a MEDLINE search of the postpolypectomy literature under the subject headings of colonoscopy, adenoma, polypectomy surveillance, and adenoma surveillance, limited to English language articles from 2005 to 2011. Subsequently, additional articles were gleaned from references of the reviewed articles. Relevant studies include those in which outcomes addressed the relationship between baseline examination

Abbreviations used in this paper: CI, confidence interval; CIMP, CpG island methylator phenotype; CRC, colorectal cancer; CT, computed tomography; FDR, first-degree relative; FOBT, fecal occult blood test; HGD, high-grade dysplasia; HP, hyperplastic polyp; HR, hazard ratio; HRA, high-risk adenoma; LRA, low-risk adenoma; MSTF, Multi-Society Task Force; NCI, National Cancer Institute; OR, odds ratio; PPT, Polyp Prevention Trial; RR, relative risk; TVA, tubulovillous adenoma; USPSTF, United States Preventive Services Task Force.

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