Having an EMR/Complex Polypectomy Procedure

You have been referred for a procedure known as a complex polypectomy / Endoscopic Mucosal Resection (EMR). This is because you have a complex polyp in your large bowel (colon) that requires a specialist resection by members of the Complex Polyp Team. This letter aims to provide you with some information including the risks and benefits of the procedure.

1. The procedure

You will be given bowel preparation instructions similar to those provided for your previous colonoscopy. During the procedure you will be offered intravenous sedation or “gas and air” (Entonox) to help you feel more comfortable. The procedure will feel like a colonoscopy, except it will take longer to perform and as a result, you may experience more discomfort or bloating this time. Please be aware that the endoscopist may have to move you into different positions to obtain an optimal position for the procedure.

EMR itself involves injecting a lifting fluid through a telescope to lift the polyp off the bowel wall. This will form a protective cushion to minimise the risk of complications, including bleeding. You should not experience significant pain during the procedure and if you do, you should bring it to the attention of the endoscopist at the time of the procedure.

2. The benefits of the procedure

EMR enables removal of the polyp endoscopically without resorting to a conventional operation (surgery). In general, benign polyps should be removed by endoscopic means rather than by surgery, but there are some complex polyps which are too difficult to remove by this method. In this situation, we have to abandon the EMR procedure in favour of surgery at a later date.

Polyps are precursors to bowel cancer development, but the evolution from polyp to cancer is unpredictable. It can take from months to years to develop depending on the size and type of polyp, but in general the bigger the polyp, the bigger risk. Removing the polyp removes the risk of cancer development and also enables us to examine the entire polyp under the microscope to look for pre-cancerous and cancerous cells.

It is unknown whether this polyp is causing any symptoms you may have, but we know from past experience that they can do this, so its removal may also help with this.

3. The Risks and complications of the procedure

The procedure itself can take anything between 30 minutes and two hours. You may experience a bit more discomfort than your last colonoscopy,

but this should subside after the procedure. Occasionally when the procedure is particularly complex, we may need to admit you overnight for observation and you will be discharged the following day if everything is stable.

During the procedure:

a. We will carefully assess whether the polyp is suitable for removal. We may decide it isn't and stop at this point.
b. We may carefully assess the polyp and decide it looks cancerous and decide to take more biopsies rather than removing it to avoid any complications.
c. The most likely scenario is that it does look suitable for removal and we will proceed.

After the procedure, you will be discharged following a period of observation in the unit. You will receive a copy of the endoscopy report. A little bit of spot bleeding on wiping yourself can occur, particularly if the polypectomy takes place lower down in your bowel (for example in the rectum), but persistent or larger quantity bleeding is not expected.

We recommend you do not fly for two weeks after the procedure.

If you notice persistent, large quantity bleeding, abdominal pain, fever, shivers, feeling faint or generally unwell, you should attend the Emergency Department with a copy of your colonoscopy report.

Serious potential complications can include:

A. Bleeding and haemorrhage. (2% risk)

Mild bleeding during the procedure is part of the procedure. You need not be alarmed by what you see on the television screen at the time of the procedure as everything is much more magnified on the screen. The endoscopist has a lot of accessories at their disposal to deal with any significant bleeding, or can sometimes use these in a preventative fashion. If bleeding (haemorrhage) cannot be stopped, you will be admitted to hospital for observation. Further treatment may include a blood transfusion, a repeat colonoscopy or very rarely, may require an operation or an x-ray test (angiography) to stop the bleeding. Rarely, this may be a life-threatening complication.

Bleeding can occur in 2% of patients up to two weeks after polyp removal which is why we do not recommend flying within this timeframe. Symptoms of significant bleeding include passing blood, including clots, and feeling unwell or faint or tired. Patients who suspect bleeding should present immediately to the Emergency Department (A&E) with their endoscopy report.

B. Perforation at the time of the procedure. (1 in 250 Risk)

This is where a hole or defect occurs in the bowel wall during or after the procedure. This is a serious complication and can be life-threatening. When it occurs at the time of the procedure and is evident, we will use various accessories to close the defect, such as with a clip device. This is

largely successful, but we will admit you to hospital for observation and for treatment with intravenous fluids and antibiotics. You will undergo further investigations, including a CT scan, to assess the severity of the perforation. If the perforation is sealed, you may not need an operation and will be discharged several days later. In the worst-case scenario, if the perforation persists, you may require surgery to repair it which may result in a temporary stoma (bag) on your abdomen - but this is rare.

This is the most serious complication of EMR.

C. Incomplete removal and polyp regrowth (polyp recurrence risk 15%)

Uncommonly we cannot remove all the polyp and we have to repeat the procedure or consider another approach.

A small island of residual polyp can remain with the potential for the polyp to regrow. This can usually be treated with follow up procedures. This is the reason why we organise repeat colonoscopy camera tests at an interval such as three or six months.

D. Post polypectomy syndrome (5%)

This is where the diathermy (heat) that we use during the procedure causes thermal (heat) injury which manifests with marked abdominal pain after the procedure. If this is severe, you may be admitted for observation and treated with pain killers (analgesia) and intravenous antibiotics to ensure that there is no other complication such as perforation.

E. Late Perforation (1 in 250 risk)

This is where the perforation (hole) in the bowel occurs anytime from days up to two weeks after the procedure. The symptoms would include unexpected abdominal pain, shivers, feeling hot and sweaty and faint with signs of infection or feeling generally unwell. The treatment for this is exactly the same as for the immediate perforation. The important thing is that you attend the Emergency Department (A&E) with a copy of your report as soon as you develop these symptoms.

4. Are there alternatives?

Yes, there are.

(a) Leave it alone: Large and complex polyps are classified as pre-malignant lesions and carry a risk of transforming into cancer over time. This is why we would usually aim to remove the polyp to prevent its development into a cancer. Examples of when the polyp would be left alone include if the patient is too unwell, too frail to undergo any therapeutic procedure, or if this is the patient's wishes.

(b) Surgery: The other alternative would be surgery, colectomy, which can be performed either as open or laparoscopic (keyhole) surgery. This is usually reserved for polyps we cannot remove endoscopically, or we think are likely to be complicated or have a high chance of reoccurrence.

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