Case Report of Multiple Rectosigmoid Adenomatous Polyps and Its Management i.e. Transanal Endoscopic Microsurgery

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Abstract

Adenomatous polyps in the colorectal region are prevalent. On account of its rarity and effective excision using Transanal Endoscopic Microsurgery (TEM) with assistance from a Covidien Small Incision Laparoscopic System (SILS) Port, we present this case of an adenomatous polyp wherein the patient complaints of per rectal bleed. Most frequently asymptomatic, adenomatous polyps are the most prevalent. In the present case, five to six polyps were found in the rectosigmoid area during colonoscopy. Rectal bleeding, stomach pain, and changes in bowel function that have a high malignant potential are the most typical symptoms associated with polyps. Large rectal adenomas should only be treated with TEM at this time, and traditional Trans Endoscopic (EMR/ESD) should be stopped. Despite the availability of newer procedures like endoscopic mucosal resection (EMR) and endoscopic submucosal dissection (ESD), TEM is still the method of choice. TEM is not recorded in our country up till now. This is the first time it is performed in our country.

Introduction

The term ‘polyp’ is a clinical description of any protrusion of the mucosa. Adenomatous polyps are the most common, mostly asymptomatic. The most common symptoms attributable to polyps are rectal bleeding, abdominal pain and change in bowel significant malignant potential [1]. Large rectal adenomas are now treated with TEM, and
transendoscopic (EMR/ESD) procedures ought to be discontinued [2-3].

Case presentation

A 28-year-old male came to OPD of Sassoon Hospital with complaints of per rectal bleed for 4-5 years. There was no H/O of similar complaints in any of his family members. His vitals, systemic examination and blood reports were normal. Ultrasonography and CT Abdomen and pelvis were normal. The study of barium enema shows multiple sessile polypoidal protrusions, smooth in outline, projecting into the rectum. On colonoscopy there were 5-6 polyps in rectosigmoid region. The most distal polyp was 2-3 cm from anal verge. The average size of polyp was 2 cm. colonoscopic biopsy shows adenomatous polyp.

Management

With provisional diagnosis, the patient was taken for TEM. The patient was placed in lithotomy position under general anesthesia. SILS Port was inserted through an anal canal. Through the lumens, three short, detachable ports may be inserted, enabling an adaptable configuration of up to three 5 mm ports or two 5 mm ports and one 12 mm port. an independent insufflation line with a two-way valve.

Figure 1: Insertion of port

The CO₂ insufflation was done with pressure of 10 mm of Hg. After insertion of laparoscope 5-6 sessile polyps identified & excised by harmonic ultrasonic shear. The polyp and the surrounding mucosa were removed up to muscularis propria. The specimen was retrieved transanally. A warm normal saline irrigation was done. Haemostasis was confirmed. Intraoperatively there was no evidence of colon breach. At the end the colorectal region was carefully verified for any missed polyp and bleed. Histopathology shows tubulovillous adenoma without muscularis
involvement.

Discussion

Newer treatment modalities:
1. Endoscopic mucosal resection (EMR) [3]: Used for removal of < 2cm lesions.
2. Endoscopic submucosal dissection (ESD) [3,5]: Technique has been developed for En bloc removal of larger (usually > 2 cm) lesions.
3. TEM: Preferred because it produces an intact, single pathology specimen that can be used to determine the need for further therapy.

Large lesions cannot be excised in one piece with a conventional EMR; in fact, up to 50% of instances result in partial or fragmented resection. There is a considerable chance of local recurrence following piecemeal resection, and histological evaluation of full resection is difficult [2]. After ESD, low rates of complications and local recurrence have been documented [4]. ESD requires a high learning curve and is technically more difficult and time-consuming than traditional EMR. Treating big rectal adenomas with TEM is the current standard of treatment. 0–37% of TEM operations reveal residual adenomatous tissue in the surgical margins, and positive surgical margins are independent risk factors for local recurrence [6]. The recorded recurrence rates, which range from 3–16%, are much lower despite the extremely high positive residual margin rates [7,8]. This may be explained by the possibility that the margins get sterilised during the dissection due to diathermic 3 damage to the remaining adenomatous tissue. Strict clinical and endoscopic follow-up is advised in situations where adenomas bigger than 5 cm are excised, as local recurrences are somewhat prevalent following excision [9,10]. Even in cases of recurrent adenoma, where endoscopic resection is not practical, TEM has been demonstrated to be a valuable therapeutic choice. With reported recurrence rates of 0–19% and complication rates of 2–21%, the TEM approach has proven to be quite effective in a number of retrospective and prospective case studies [11].

Conclusion

TEM is now appropriate for adenomatous polyps which are restricted to the superficial submucosa (pT1 sm1), well or moderately differentiated, and free of lymph vascular invasion. The safest and most successful treatment option is TEM, which has a minimal risk of perioperative morbidity and death and a much greater rate of full resection.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient has given his/her consent for his/her images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published, and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.
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References