Should we refer diminutive polyps to post-CTC polypectomy?
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LETTERS

Should we refer diminutive polyps to post-CTC polypectomy?

We read with interest paper by Grazer et al1 comparing CT colonography (CTC) with optical colonoscopy (OC) and other screening tests in an average-risk population. In a series of 311 subjects, the authors described 13 cases of advanced neoplasia (high-grade dysplasia or a villous component) in <10 mm polyps. In detail, seven of these cases occurred in <5 mm adenomas, so that diminutive adenomas accounted for 16% of all the advanced neoplasia detected in the study, also being more frequent than 6–9 mm advanced adenomas. Such a relatively high rate of advanced neoplasia in <5 mm polyps would suggest some concern in not referring subjects with diminutive adenomas to OC, because of the fear of “an increase in colorectal cancer incidence and mortality”, as emphasised by the authors.

However, it should be noted that such data are remarkably different from the results of other larger studies. In two of these studies, together comprising >4000 asymptomatic subjects, the rate of total advanced neoplasia explained by diminutive polyps was consistently <3%, also being 4–5 times less frequent than 6–9 mm advanced adenomas, as largely expected.2,3 Such a higher frequency of 6–9 mm advanced adenomas as compared with <5 mm advanced neoplasia was also confirmed in a very large European screening study.4 Based on the consistent results of these studies, we feel that it is extremely unlikely that the referral of diminutive polyps to OC would substantially increase the efficacy of CTC in reducing the burden of colorectal cancer mortality. On the other hand, the very high proportion of diminutive polyps in the general population and the very low rate of advanced neoplasia in such lesions would needlessly increase the post-CTC referral rate, affecting the favourable cost-effective-ness profile of a CTC screening.

The discrepancy between the data of Grazer et al1 and those of previous studies may possibly be related to different reasons. The study under discussion here is based on only 311 patients, so that a small sample bias cannot be excluded. Measurement of polyp size was done by comparison with an optical colonoscopy, sofaecal occult blood tests for the detection of advanced adenoma in an average risk population. Gut 2009;58:241–8.2


Comment on: Prospective randomised multicentre trial comparing the clinical efficacy, safety and patient acceptability of circular stapled anopexy with closed diathermy haemorrhoidectomy

We read with interest the details of the prospective randomised trial comparing circular stapled anopexy with closed diathermy haemorrhoidectomy by Thaha and co-workers.1 The authors state that stapled anopexy offers a significantly less painful alternative to excisional haemorrhoidectomy and achieves a higher patient acceptability. Although the overall symptom control and safety are similar in the majority of the patients, the re-treatment rate for recurrent prolapse at 1 year is higher following the stapled procedure when compared with conventional haemorrhoidectomy.1

The authors emphasised the reduction of postoperative pain in the stapled haemorrhoidectomy patients. We believe, however, that pain is not an ideal measure with which to compare stapling techniques with classic haemorrhoidectomy because of intertechnique differences in the pathophysiology of pain. It is functional outcome that is important, both in the short term, regarding postoperative complications, and in the long term, regarding anal sphincter function, and recurrence of haemorrhoidal disease. In this respect we feel that several studies are not well documented. In several reports the stapling technique amounted to a circumferential full-thickness biopsy of the lower rectum in >20% of patients, and no data on postoperative anorectal physiology, and no comparison with preoperative data were provided.2

We believe that the stapling procedure increases operative costs; advanced surgical skills are necessary and a learning curve can be defined.3 However, stapled haemorrhoidectomy could produce injuries to the internal anal sphincter; anal sphincters are also stretched by the bivalve retractor or by the stapler head. Finally, the staple procedure does not allow the treatment of concomitant anal disease.2,3

Several operative techniques to treat haemorrhoids have been described. Milligan–Morgan’s open haemorrhoidectomy is most commonly used; other procedures, such as Ferguson’s closed haemorrhoidectomy and Parks’ submucosal haemorrhoidectomy, are technically more complex. We feel that the surgeon’s choice of technique should be primarily based on personal experience and technical training, and only a competently performed technique produces satisfactory results; haemorrhoidectomy needs skilled operators.2,3 If technical guidelines are rigorously followed, the feared complications associated with surgical procedures, such as anal stricture and sphincteric injuries, are greatly reduced.4 Furthermore, prophylactic metronidazole suppresses postoperative pain, increases patients’ satisfaction and allows them to return to work earlier. Laser haemorrhoidectomy has no advantages over standard techniques; it is also quite expensive and no less painful.

The authors report no data regarding Whitehead’s haemorrhoidectomy. We habitually carry out the Milligan–Morgan operation and we are always very precise with regard to the integrity of the mucocuta-neous bridges, to avoid postoperative anal stenosis. In 12 years, we have treated 3000 patients with haemorrhoids; of these, 30 patients (four of these with relapsed haemorrhoids after the stapling technique), in whom prolapsed haemorrhoids were completely irreducible and it was not possible to distinguish and separate the three piles, underwent Whitehead’s radical haemorrhoidectomy. No episodes of incontinence were observed in either the short term or the long term (5-year follow-up). In only one case did we verify an anal substenosis months after