Pasient med akutt buk etter koloskopi

Kasuistikk

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Gastronett 2014

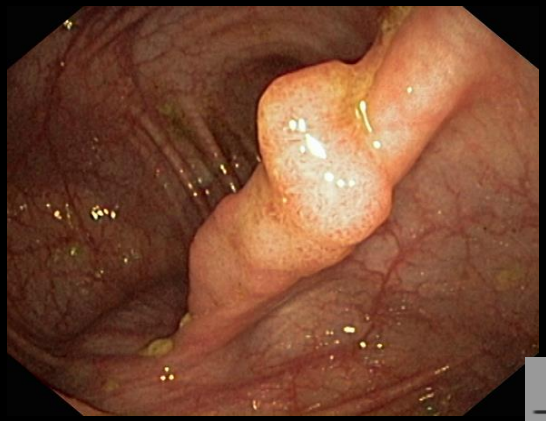
Complications after 18,442 colonoscopies

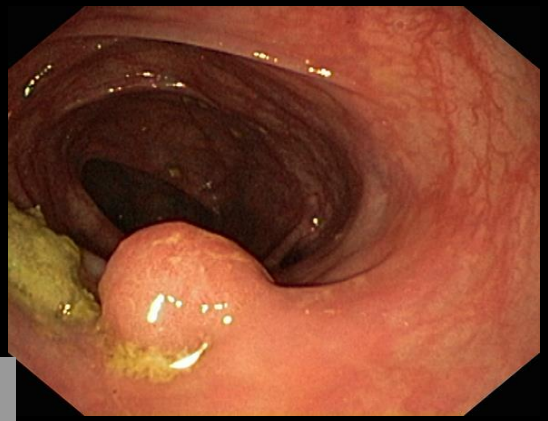
Complication	No.	Comments
Vasovagal	63	No interventions
Bleeding	36	4 hospital admission (observation only)
Perforation	4	2 closed with clips, 2 not specified
Burnt serosa	1	
Pain	2	Causing discontinuation of the examination
Syncope	4	
Hypoglycemia	1	Known diabetic
Other	1	
Unspecified	50	
Total	**162**	

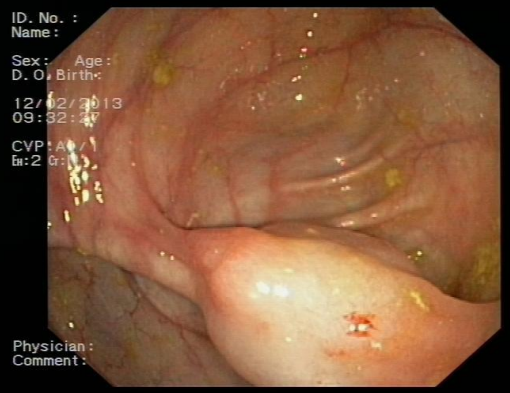
Severe complications (any perforation or bleeding requiring hospital admission):
5 perf./burnt serosa and 4 bleeds admitted =9 cases (0.5 per 1000)

Pas: k-36

- DM II
- Hypothyreose
- ANCA pos, nyrebiopsi: fokal gl.nefritt med halvmånedannelse, Predn og CellCept
- Lav HB: koloskopi sommeren 2012. Stilket polypp i ascendens (fjernet), og bredbaset polypp i cøcum.
- Elektiv innleggelse for polypectomi i cøcum februar -13



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Sex : Age :
D. O. Birth :
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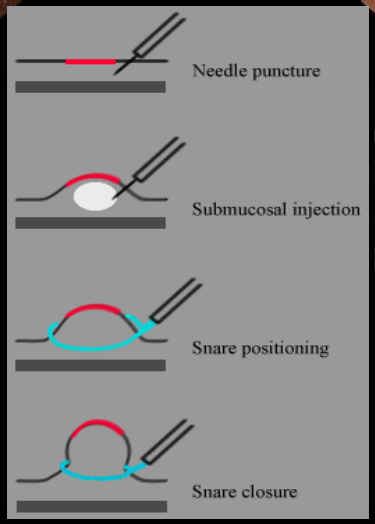
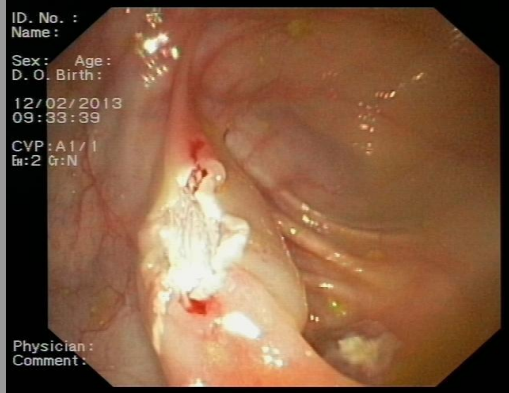
Physician :
Comment :


Needle puncture
Submucosal injection
Snare positioning
Snare closure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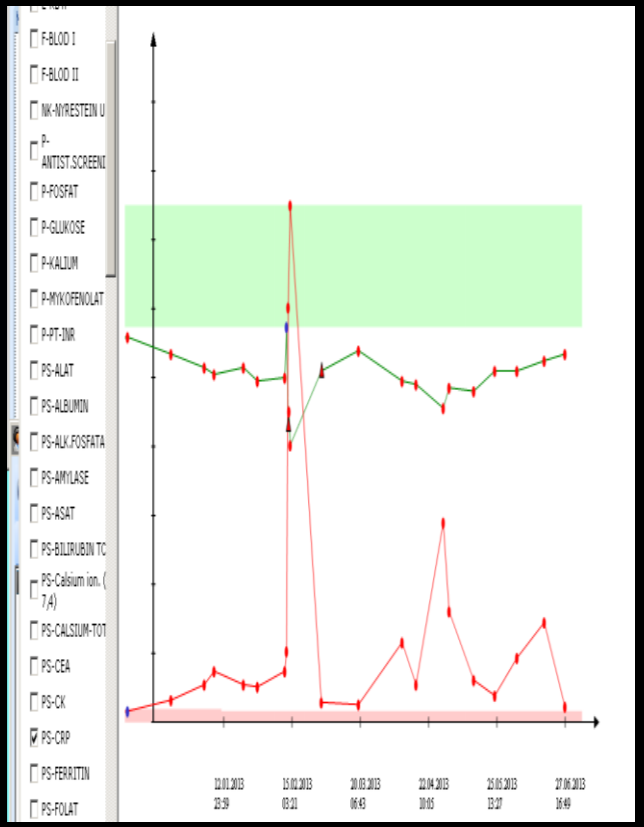
Physician :
Comment :

- Et par timer etter polypectomi: akutte smerter i høyre fossa iliaca. Febril, tachycard, lavt BT. Fall i Hb, høy CRP
- Ikke transfundert.
- Kontinuerer oppholdet for observasjon.



- Ingen fri luft. Rikelig med colondivertikler.
- Fri væske omkring lever, i høyre flanke og i bekkenet.
- Reaktive forandringer omkring høyre colon

- Histologi: tubulært adenom med lett til moderat atypi
- Endoskopisk bedømt radikalt fjernet
- Ikke gjenværende adenomer i colon
- Ikke nødvendig med koloskopikontroll

- Postpolypektomiblødning
- Postpolypektomi koagulasjonssyndrom
- Ingen perforasjon

- Komplikasjonen medførte 5 døgn i sykehus

Location in the Right Hemi-Colon Is an Independent Risk Factor for Delayed Post-Polypectomy Hemorrhage: A Multi-Center Case–Control Study

VOLUME 106 | JUNE 2011 www.amjgastro.com

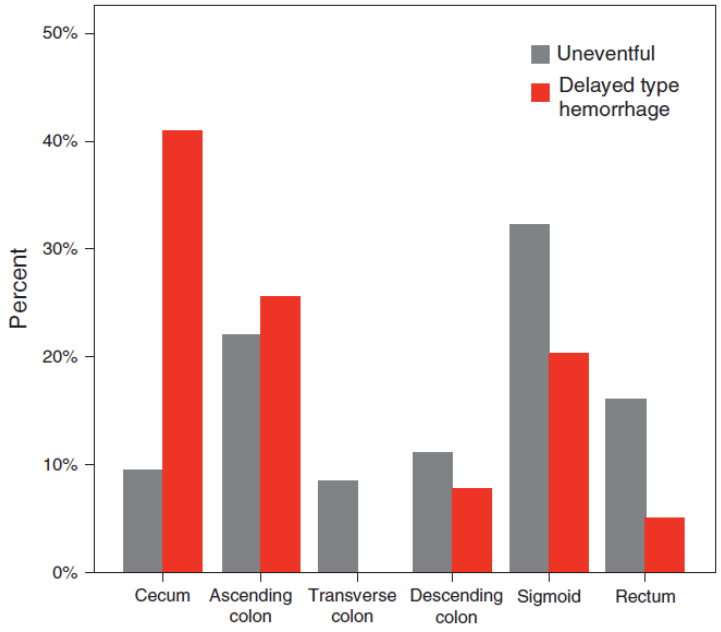


Figure 1. Distribution of bleeding and non-bleeding polyps in the colon.

Study Highlights

WHAT IS CURRENT KNOWLEDGE

- ✓ Large polyp size is an important risk factor for delayed type post-polypectomy hemorrhage.

WHAT IS NEW HERE

- ✓ Polyp location in the right hemi-colon is also an important risk factor for delayed type post-polypectomy hemorrhage.
- ✓ The cecum could be at especially high risk of delayed type post-polypectomy hemorrhage.
- ✓ Polyp type (sessile or pedunculated) is not a risk factor for delayed type post-polypectomy hemorrhage.

Polyp location in the right hemi-colon seems to be an independent and substantial risk factor for delayed post-polypectomy hemorrhage. A low threshold for preventive hemostatic measures is advised when removing polyps from this region.

Factors that predict bleeding following endoscopic mucosal resection of large colonic lesions

Endoscopy 2011; 43: 506 – 511

Background and study aims: Endoscopic mucosal resection (EMR) for large colonic laterally spreading tumors (LSTs) is a safe, efficacious, and cost-effective treatment. The most common serious complication is delayed bleeding, which reduces these advantages, but consensus guidelines for large-polyp EMR do not exist.

Patients and methods: Data from two large prospective intention-to-treat studies of EMR for colonic LSTs 20 mm or greater in size were analyzed. Data collection was comprehensive, and included patient and lesion characteristics. EMR technique and cessation of anticoagulant and antiplatelet therapy was standardized. Clinically significant delayed bleeding was defined as that requiring hospital admission.

Conclusions: Proximal lesion location is a highly significant risk for clinically significant delayed bleeding following colonic EMR, and this knowledge could form the basis of a targeted therapeutic trial. Recent aspirin use also increases bleeding risk – specific consensus guidelines in this area are required for colonic EMR.

Clinical outcomes and risk factors of post-polypectomy coagulation syndrome: a multicenter, retrospective, case–control study

Endoscopy 2013; 45: 202–207

- Retrospektiv studie
- 9 universitetssykehus i Korea
- 34 pasienter med PPCS-syndrom (post-polypektomi CT abdomen)
- 68 pas i kontrollgruppe
- 0,7/ 1000 behov for hospitalisering pga PPCS etter polypektomi

PPCS, also known as post-polypectomy syndrome or transmural burn syndrome, refers to the development of abdominal pain, fever, leukocytosis, and peritoneal inflammation in the absence of frank perforation that occurs after colonoscopic polypectomy with electrocoagulation [12–16].

Conclusions: In this study, the rates of major PPCS and mortality were only 2.9% and 0%, respectively. Hypertension, large lesion size, and non-polypoid configuration of the lesion were independently associated with PPCS. Therefore, patients may be reassured by the excellent prognosis of PPCS, while endoscopists should be especially careful when performing colonoscopic polypectomies in patients with hypertension or large and non-polypoid lesions.

Risk of electrocoagulation syndrome after endoscopic submucosal dissection in the colon and rectum

Endoscopy 2013; 45: 714–717

Background and study aims: The risk of post endoscopic submucosal dissection electrocoagulation syndrome (PEECS) is unknown. We aimed to investigate the incidence and clinicopathologic risk factors associated with PEECS after colorectal endoscopic submucosal dissection (ESD).

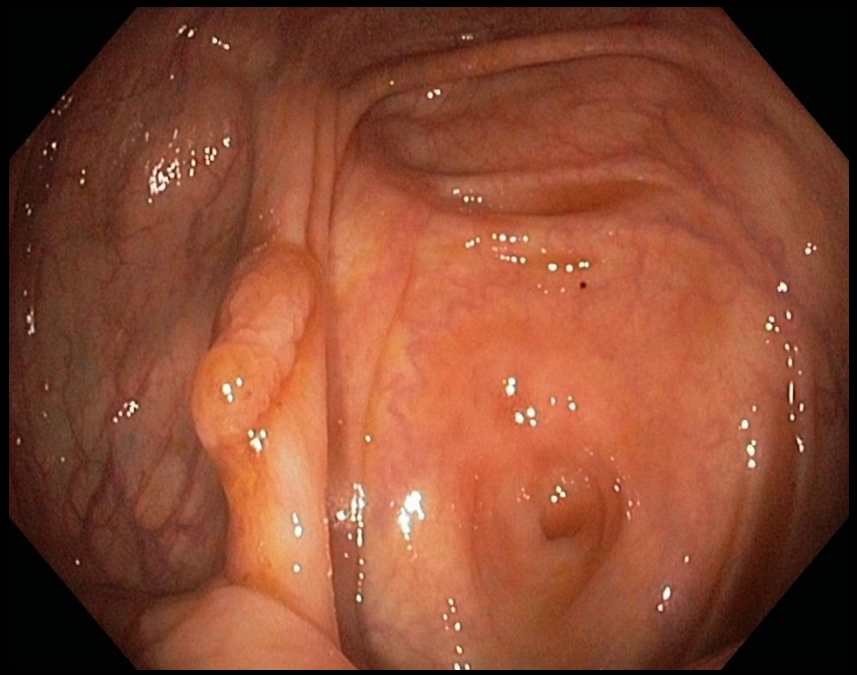
Conclusions: Large tumor size and tumor site other than rectosigmoid were independent risk factors related to PEECS. Patients with tumors larger than 3 cm, in colon areas other than the rectosigmoid, should be observed carefully after colorectal ESD.

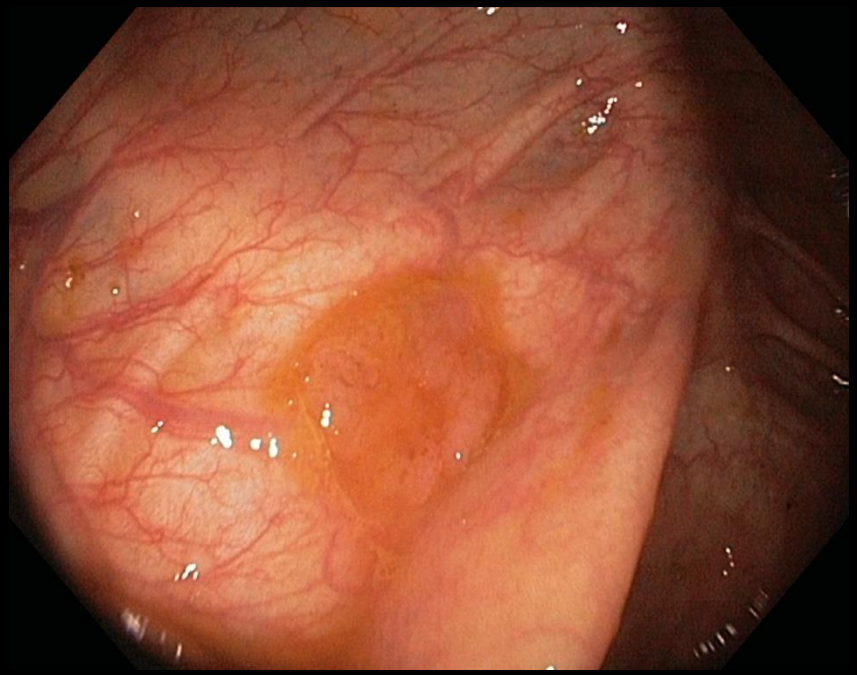
Factors	Odds ratio (95 %CI)	*P* value
Tumor location (rectosigmoid vs. other than rectosigmoid)	7.6 (2.1 – 27.9)	< 0.01
Lesion size (< 3 cm vs. ≥ 3 cm)	5.0 (1.2 – 21.7)	0.03
Histopathology (other than carcinoid vs. carcinoid)	1.0 (0.1 – 7.1)	0.98
En bloc resection vs. piecemeal resection	8.1 (0.62 – 106.1)	0.11
Procedure time (< 60 min vs. ≥ 60 min)	1.9 (0.55 – 6.4)	0.32

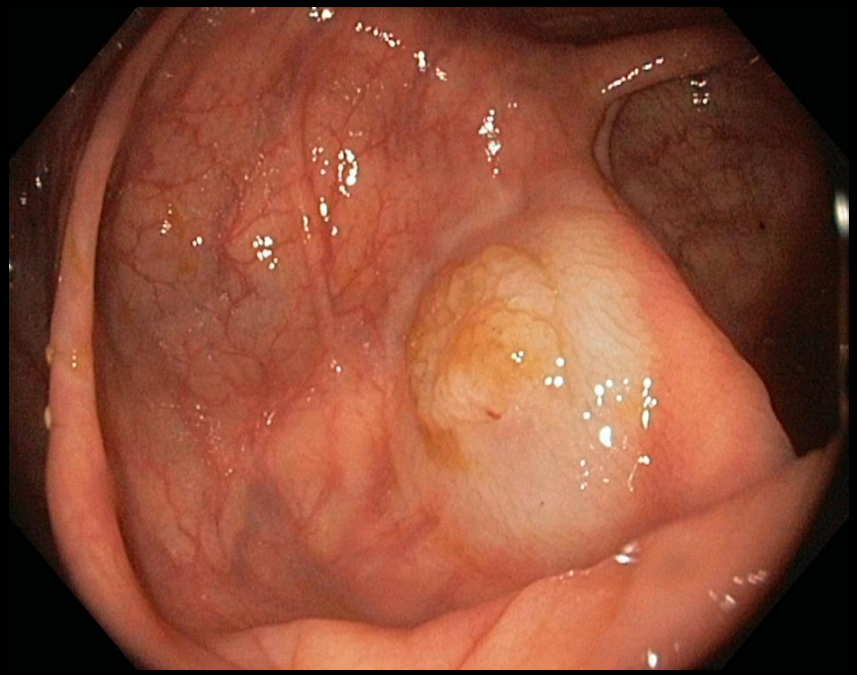
CI, confidence interval.

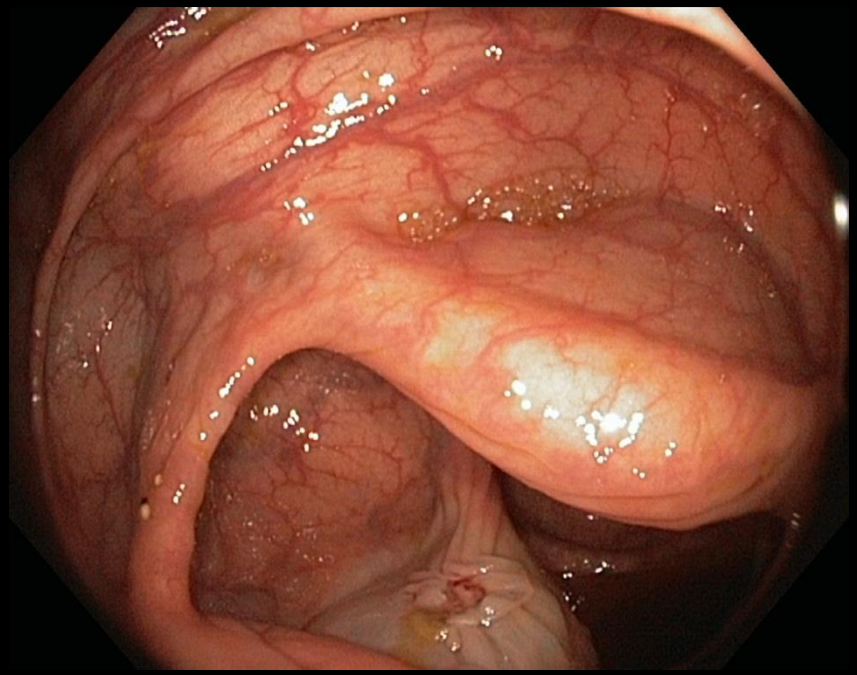
Table 3 Multivariate analysis of risk factors for post-endoscopic submucosal dissection electrocoagulation syndrome (PEECS).

Pas 2: 62 år gammel mann







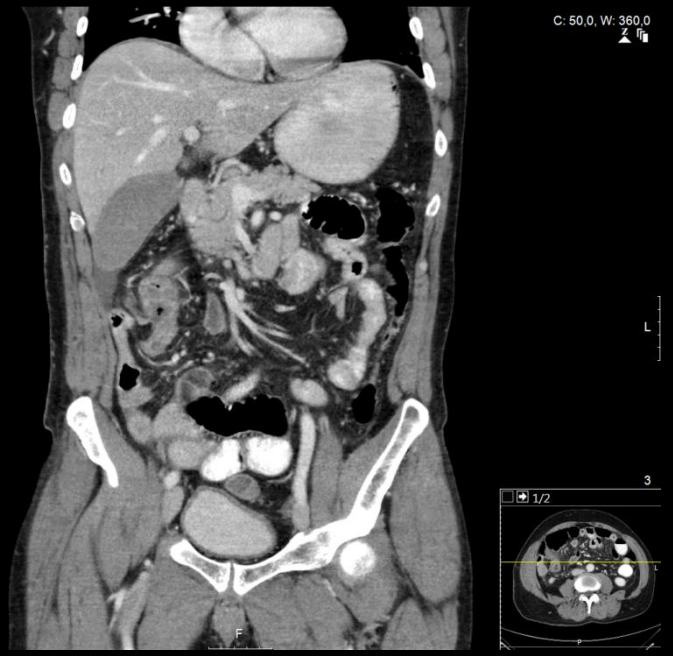


10 min etter endt prosedyre

- Akutte kraftige magesmerter i høyre fossa
- Slipp- og palpasjonsøm
- Innlegges kirugisk avdeling for observasjon/ behandling
- Mistenker PPCS eller perforasjon
- Initial CT abdomen uten patologi

CT dagen etter skopi

- Uttalt inflammasjon i tarm på høyre side.
- Fri væske
- Perforasjon og peritonitt kan ikke utelukkes
- CRP 40 - 317



Laparotomi dagen etter skopi

- Colonperforasjon med serosarift i cøcum
- Purulent væske i buken
- Meckels divertikkel
- Ileocøcal reseksjon
- Antibiotika
- 7 dagers opphold kirurgisk avdeling
- 6 ukers sykemelding

Risk factors for adverse events related to polypectomy in the English Bowel Cancer Screening Programme*

Endoscopy 2014; 46: 90–97

Background and study aims: The English National Health Service Bowel Cancer Screening Programme (NHSBCSP) is one of the world's largest organized screening programs. Minimizing adverse events is essential for any screening program. Study aims were to determine rates and to examine risk factors for adverse events.

Patients and methods: Bleeding and perforations in NHSBCSP colonoscopies between August 2006 and January 2012 were examined. Logistic regression was used to examine risk factors for adverse events, including age, gender, polyp size, morphology, and location. For accurate attribution of adverse events, procedures with resection of only one polyp ("single-polypectomy") were analyzed in detail.

Conclusion: This is the largest study focusing on polyp-specific risk factors. We have confirmed that the greatest risk factor for both post-polypectomy bleeding and perforation is polyp size. This is the first demonstration of substantial and significantly increased risk for both noteworthy bleeding (requiring transfusion) and perforation from cecal polypectomy for a given polyp size, compared with elsewhere in the colon.

Risiko for blødning

Table 3 Risk of bleeding requiring transfusion as an adverse event at polypectomy: logistic regression models, with location as a univariate factor and a multivariate model. (Data from single-polyp resections only. No other variables contribute to the multivariate model apart from polyp size. All other variables were not significant predictors of risk in analysis.)

	Logistic regression models, odds ratio (95 %CI)	
	Univariate analysis (Model 1)	**Multivariate analysis (Model 2)**
Distal colon	1.00	1.00
PCxC	1.20 (0.33 – 4.45)	2.78 (0.74 – 10.51)
Cecum	5.20 (1.53 – 17.71)[1]	10.56 (3.05 – 36.47)[2]
Log size*		5.54 (3.74 – 8.23)[2]
Pseudo R^2 (Deviance)	2.4 % (282.2)	15.1 % (245.6)

CI, confidence interval; PCxC, proximal colon excluding cecum.
[1] $P<0.01$
[2] $P<0.001$
* Risk based on change of polyp size by one unit in log size (e. g. 1 log unit change represents a size increase from 7 mm to 20 mm, or from 20 mm to 54 mm); see Figure 2.

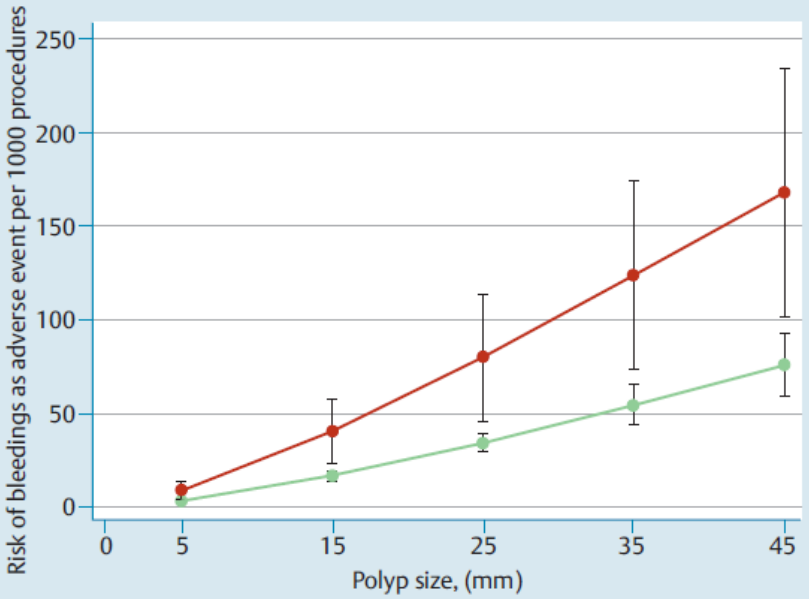


Fig. 1 Bleeding as an adverse event of polypectomy: modelled risk per 1000 procedures by polyp size for cecal (upper line) and noncecal (lower line) locations. This analysis used data from only "hot snare" procedures where only a single polyp was resected.

Risiko for perforasjon

Table 4 Factors affecting risk of perforation as an adverse event at polypectomy: logistic regression models. Data from single-polyp resections only.

	Logistic regression models, odds ratio (95%CI)		
	Univariate (Model 1)	Multivariate with size only added (Model 2)	Multivariate full model (Model 3)
Distal colon	1.00	1.00	1.00
PCxC	0.48 (0.11–2.11)	0.83 (0.18–3.78)	1.11 (0.26–4.71)
Cecum	1.87 (0.54–6.47)	3.08 (0.78–12.18)	4.49 (1.26–16.03)[1]
Log size*		2.42 (1.35–4.32)[2]	2.10 (1.00–5.49)[1]
Pedunculated			2.00 (0.73–5.49)
Pseudo R^2 (Deviance)	0.7% (331.4)	3.9% (320.6)	4.3% (319.3)

Table 5 Factors affecting risk of bleeding, bleeding requiring transfusion, and perforation as adverse events at polypectomy: multivariate logistic regression models, from single-polyp resections only and for hot snare resections only.

	Logistic regression models, odds ratio (95%CI)			
	All bleeding (Model 1)	Bleeding requiring transfusion (Model 2)	Perforation (Model 3)	Perforation (sessile polyps only) (Model 4)
Distal colon	1.00	1.00	1.00	1.00
PCxC	1.17 (0.77–1.78)	3.34 (0.90–12.42)	0.96 (0.14–6.33)	2.65 (0.16–42.71)
Cecum	2.49 (1.54–4.03)[1]	13.50 (3.93–46.42)[1]	5.60 (1.37–22.83)[2]	12.19 (1.24–119.5)[2]
Log size*	4.17 (3.41–5.09)[1]	4.92 (2.84–8.51)[1]	2.09 (0.89–4.90)	2.02 (0.60–6.84)
Pedunculated			2.01 (0.74–5.47)	N/A
Pseudo R^2 (Log likelihood)	8.0% (–1304.5)	12.3% (–119.5)	3.2% (–125.4)	8.5% (–31.52)

Lærdom..

- Tynn vegg i cøcum øker risikoen for komplikasjoner ved terapeutisk endoskopi
- EMR like etter injeksjon
- Bruke lite koagulasjonsstrøm ved diatermi
- Sikre polypptomten med clips
- Selektere pasienter til polypektomi i cøcum?