

UPPER GI POLYP TREATMENT AND FOLLOW-UP (EGD-1.8)

The standard of care is based on the most recent ASGE Guideline of 2015. (1)

All polyps should be either biopsied or removed by polypectomy so that histologic analysis can be performed and malignancy or dysplasia can be adequately ruled out. All known neoplastic polyps and all those at or greater than 1 cm should undergo polypectomy, as biopsy alone cannot rule out foci of high grade dysplasia or malignancy (2). In the case of multiple polyps, the largest should be removed, and others biopsied. A sessile lesion might require endoscopic mucosal resection for adequate histologic analysis. Once the polyp is resected, the surrounding antrum and corpus should be biopsied adequately to rule out dysplasia in the setting of metaplastic atrophic gastritis and to rule out H pylori. (3). Surveillance and management would be as follows.

>Adenomatous gastric polyps

- *Endoscopy 1 year after resection followed by surveillance EGD every 3-5 years

>Hyperplastic gastric polyps, resected, without dysplasia. Polypectomy of all over 0.5 cm.

- *Repeat in 1 year

- *Low risk (OLGA stage 1 or 2) to confirm H pylori eradication and to confirm absence of recurrence, but generally do not require further sampling. Exceptions:

- *Intestinal metaplasia found on mucosal sampling

- *Follow-up as per EGD 1.6-Gastric Intestinal Metaplasia

- *Gastric atrophy found on mucosal sampling

- *Follow up per OLGA stage EGD 1.9-Atrophic Gastritis

>If the hyperplastic polyp persists, or dysplasia is present, or if from high risk population, repeat in one year

- *Surveillance at regular intervals (1-2 years if requested) in cases of dysplasia

>Fundic polyps are the most common found in the West where PPI use is high. They are usually multiple and can be managed with representative biopsy and NO sequential endoscopic surveillance is indicated, unless:

- *A polyp looks significantly different, is ulcerated, is in the antrum or is over 1 cm in size, in which case resection/polypectomy is indicated.

- *Consider stopping PPI and consider familial polyposis if more than 20 polyps, large 1 cm or greater polyps, or formation at early age, (below 40).

>Removal of suspicious appearing gastric polyps is approved if more than 0.5 cm in size if histology is unclear or not determined at initial endoscopy.

>Follow up of duodenal polyps not associated with genetic syndromes

- *Superficial non-ampullary tumors

- *EGD is indicated in 3 months to assure complete resection

- *If no recurrence, repeat in 1 year is indicated

*Ampullary duodenal tumors are usually benign adenomas, but up to 15-60 percent can harbor small foci of adenocarcinoma (4)

*EGD is indicated within 3 months of initial treatment

*Repeat EGD at 6 and 12 months after initial treatment, and yearly thereafter for 5 years

*In consideration of adenomatous polyposis syndrome, a colonoscopy is also indicated if a duodenal adenoma is detected.

>Sequential periodic EGD is NOT indicated for surveillance of malignancy in individual with:

*Fundic gland polyps (except as above)

*Previous gastric operations for benign disease

*Surveillance of healed benign disease such as esophagitis and gastric or duodenal ulcer

1. ASGE Standards of Practice Committee, Evans JA. et al. The role of endoscopy in the management of premalignant and malignant conditions of the stomach. J.GIE 2015; 82: 1-8.
2. Muchidorfer SM, Stolte M, Martus P, et al. Diagnostic accuracy of forceps; a prospective multicentre study. GUT 2002; 50:465.
3. ASGE Standards of Practice Committee, Sharaf RN, Shergill AK, et al. Endoscopic mucosal tissue sampling. Gastrointest, Endosc 2013; 78:216.
4. Yamaguchi, Enjoj M. Adenomas of the ampulla of Vater; putative precancerous lesion. GUT 1991; 32:1558.