CASE 1

A screen-detected colonic conundrum

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A 68-year-old man received a kit through the post for the bowel cancer screening program. He decided to enrol and performed the test, sending it off the same day. His results came back and he was invited for colonoscopy (see Section A, page 9). He was completely asymptomatic with no change in bowel habit or rectal bleeding. He had no family history of bowel cancer and apart from treated hypertension was otherwise well.

At colonoscopy, two small hyperplastic polyps were found in the rectum and a 3 cm pedunculated polyp in the distal sigmoid. The pedunculated polyp was removed by the endoscopist using a snare and diathermy. The polypectomy site was tattooed. No other lesion was found up to the cecum.

The polyp was examined by a histopathologist and found to contain an adenocarcinoma within a tubulovillous adenoma (Figure 1.1). The pathology report was as follows.

• Macroscopic description: a 28 mm pedunculated polyp.
• Microscopic description: this is a 13 mm mucinous adenocarcinoma arising within a tubulovillous adenoma with background low- and high-grade dysplasia.
• Haggitt level 3 (invasion into stalk of polyp). The maximum thickness of invasive tumor from the muscularis mucosae is 6 mm.
• Lymphovascular invasion is not seen.
• The stalk resection margin is tumor free and is 1 mm from the tumor.
• Complete resection: yes.
• TNM: pT1, L0, V0, R0

In the first instance, a staging CT scan of the chest, abdomen, and pelvis was organized. This showed no residual abnormality in the colon and no evidence of abnormal lymph nodes or distant metastasis.
Figure 1.1 Polypectomy specimen with invasive mucinous adenocarcinoma extending into stalk (Haggitt level 3).

**DECISION POINT**

**Does he need any further treatment? What would you do?**

This is a borderline decision. The patient has an early invasive tumor arising within a polyp. Although completely excised, there is a risk of tumor in lymph nodes, which may result in tumor recurrence. This must be balanced against the risks of surgical resection. T1 tumors are subclassified using the Haggitt or Kikuchi systems depending on whether the lesion is pedunculated or sessile (see pages 11–12).

Usually a Haggitt level 3 polyp which has been completely excised would not need any additional treatment. However, the MDT was influenced by the mucinous appearance and extension of 6 mm beyond the muscularis mucosae. Our estimate of lymph node positivity risk was 20–25%. The recommendation was that the patient should undergo a laparoscopic high anterior resection.

Following the MDT meeting, the situation was discussed in detail with the patient. The patient was against major surgical resection, despite understanding the risk of residual malignant nodes. He was concerned about the risks of surgery, in particular anastomotic leakage and the small risk of needing a temporary stoma which we quoted as about a 10% risk. He opted for close colonoscopic and radiological follow-up.

Colonoscopy and CT scanning 12 months post polypectomy were normal. He remains well 18 months after the polypectomy.
LEARNING POINTS

- The NHS Bowel Cancer Screening Program (www.cancerscreening.nhs.uk) has now been rolled out across the United Kingdom although the strategy is slightly different across the different countries. In England, the fecal occult blood (FOB) test is offered every 2 years to everyone aged 60–74. The participant is sent a kit with three flaps that each contains two windows onto which the stool specimen is placed. The kit is then sent back. The result is normal (0 positive spots), unclear (1–4 positive) or abnormal (5 or 6 positive spots). Unclear tests require retesting whilst participants with an abnormal result are offered colonoscopy.
- Following local excision of rectal or colonic tumors, further surgery is required if the lesion is T2 or at the margin of resection (R1). There is some debate as to whether 1 mm or 2 mm is required to be a clear margin.
- For T1 lesions, further surgery to remove lymph nodes should be considered if:
  - Kikuchi sm3 (23% risk nodal involvement)
  - Haggitt 4
  - depth over 2000 microns (2 mm)
  - poorly differentiated
  - lymphovascular invasion
  - tumor budding.

Could we have done better?

It remains unclear if the correct decision was made, as the patient has been followed up for just 18 months. The decision made by MDTs tends to be oncologically “correct” without addressing patient wishes, except when more extreme patient views are brought to the MDT discussion. A better MDT recommendation might have been “borderline favoring surgical resection, pending discussion with patient and assessment of fitness.”

LETTER FROM AMERICA

The National Cooperative Cancer Network (NCCN; www.nccn.org) supports the use of polypectomy alone for malignant pedunculated polyps with a negative resection margin, moderate or well-differentiated neoplastic cells, and the absence of lymphovascular invasion. While studies have shown the value of submucosal invasion depth measurement, this variable is not part of the decision-making process advocated by the NCCN.

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