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ABOUT COVER

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Is endoscopic mucosal ablation a valid option for treating colon polyps?

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Abstract

The present letter to editor is related to endoscopic mucosal ablation (EMA). EMA is safe and effective in the treatment of colonic polyps when endoscopic resection is not possible or available, but the indication of EMA should be determined for a further large number of studies. EMA should be used with caution for larger lesions.

Key Words: Endoscopy; Mucosal ablation; Colon polyp; Endoscopic mucosal ablation

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Core Tip: Endoscopic mucosal ablation (EMA) is safe and effective in the treatment of colonic polyps when endoscopic resection is not possible or available, but we think EMA should be more cautious with caution for larger lesions.

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TO THE EDITOR

We were pleased to read the excellent article published by Mendoza Ladd *et al*[1]. Their report showed a new and safe method for treating colon polyps. Patients were followed up for 1 year and showed no polyp recurrence. However, this study still has issues that we would like to discuss with the authors.

We want to know the indications for the endoscopic mucosal ablation (EMA) method, such as the size of the lesion and the type of preoperative pathology. Argon plasma coagulation is often used for benign diseases or small polyps or as a supplement when there is residual tumor or recurrence after endoscopic mucosal resection[2-5] or endoscopic submucosal dissection[6,7]. For large lesions of the colon, especially laterally spreading tumors, lesions often become high-grade intraepithelial neoplasias or even cancers[8]. Chemical staining, image enhancement endoscopy (such as narrow band imaging and blue laser imaging), magnifying endoscopy or confocal laser endomicroscopy[9] is needed to help make a diagnosis. If the lesion is high-grade internal neoplasia or cancer, the presurgery computed tomography examination needs to be improved to detect lymph node metastasis. During surgery, how to judge the integrity of the lesion and its marginal treatment needs to be further explored.

The main drawback of EMA is that it cannot produce complete specimens for pathological analysis. The pathology of the preoperative lesion biopsy may not reflect the entire lesion condition. We cannot know whether the lesion has high-grade intraepithelial neoplasia or carcinoma, nor can we determine whether the patient needs additional surgical treatment. Although the review of colonoscopy and biopsy after 1 year did not reveal lesion recurrence, lesions can take longer to recur.

In summary, the indication of EMA should be determined from a large number of studies. EMA should be used with caution for larger lesions.

FOOTNOTES

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