York and Scarborough Teaching Hospitals
NHS Foundation Trust

Understanding Your Large Bowel Polyp

Adenomas and Hyperplastic Polyps

Information for patients, relatives and carers

Endoscopy Unit

ⓘ For more information, please contact:

Your Consultant's Secretary

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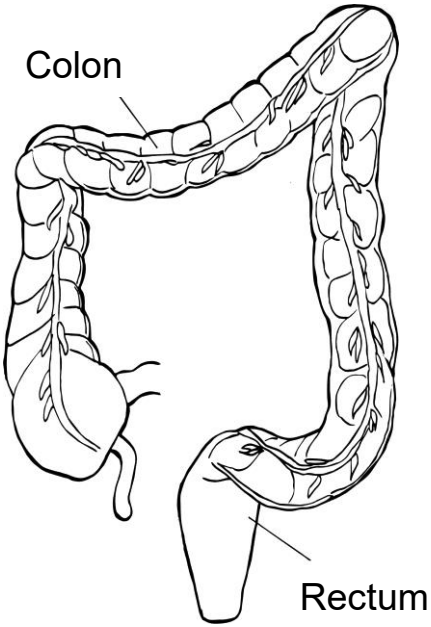
You recently had an endoscopy when we looked at your large bowel and found a polyp. We either removed the polyp or took a sample of it. A doctor called a pathologist then studied the polyp under a microscope to find out more about it. This booklet is to help you understand what a large bowel polyp is and what the pathologists found when they looked at it.

What is an ‘endoscopy’?

Endoscopy means ‘looking inside’. We look inside the bowels by using an endoscope that bends easily. The endoscope (scope) has a light and a camera. We can also take samples of tissue through the scope. If the scope is passed into the whole colon the procedure is called a colonoscopy. If the scope is passed into the left colon the procedure is called a flexible sigmoidoscopy.

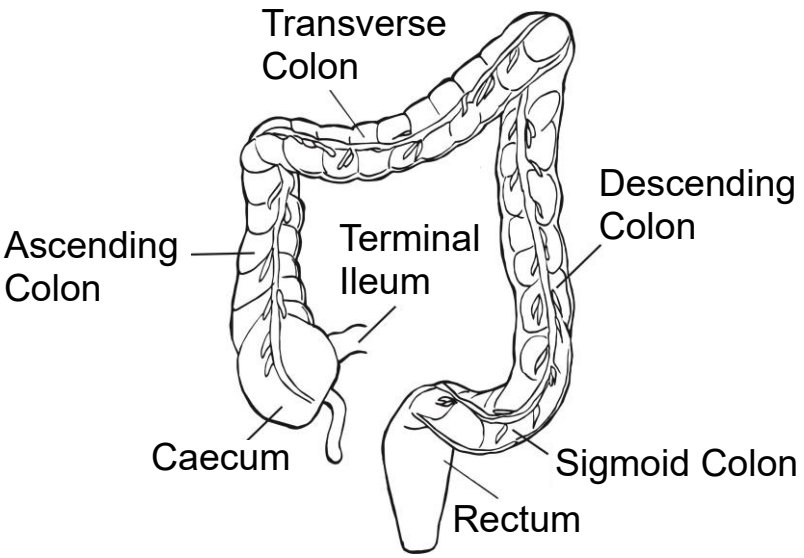
What is the ‘colon’?

Colon is the medical term for your large bowel. The colon’s main purpose is to absorb water, salt and other minerals from the contents that pass through it. Things that are of the colon are called ‘colonic’.



What is the ‘rectum’?

Rectum is the medical term for the final straight portion of the large bowel that ends in the anus. Things that are of the rectum are called ’rectal’.



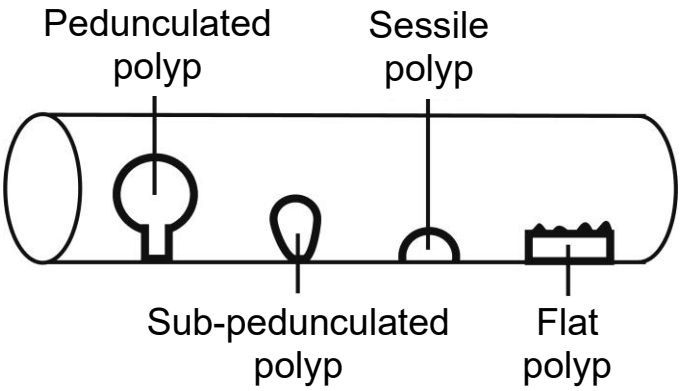
What are the parts of the colon?

Various parts of the colon have specific names (see figure). The parts of the colon are: the caecum (this is the part where the small bowel ends), ascending colon transverse colon, descending colon, and the sigmoid colon which is ‘S’ shaped. The caecum and the ascending colon form the right colon. The descending and the sigmoid colon form the left colon.

What is a polyp in the large bowel?

A polyp is a clump of cells that grows from the inner lining of the large bowel that protrudes into its hollow centre. Most polyps are harmless, but a small number can develop into cancer over time.

Polyps have different shapes:



There are two main types of polyps: hyperplastic polyps and adenomas.

What are hyperplastic polyps?

Hyperplastic polyps are usually benign (non-cancerous). If they are small we do not need to remove them. We may need to remove large hyperplastic polyps because very occasionally large polyps can become cancerous. Your doctor will advise you.

What is an adenoma?

An adenoma is also a benign polyp but usually we need to remove it as there is a small risk of this eventually becoming a bowel cancer. At first glance, an adenoma may look like the normal lining of your large bowel. However, when we view it under the microscope it looks different. There are three different kinds of adenomas - tubular, villous and tubulovillous.

What are ’tubular’, ‘villous’ and ’tubulovillous’ adenomas?

The pathologist can tell us what type of adenoma you have. The two main types of adenoma are tubular and villous. Some adenomas are a mix of both types and they are described as tubulovillous. Most small adenomas (less than half an inch in size) are tubular. Larger adenomas may be tubular, villous or tubulovillous.

What if my report mentions ’dysplasia’?

‘Dysplasia’ is a term that describes the extent of the changes in the cells of your adenoma. These changes may be in the number, shape or structure of the cells.

We describe adenomas that look mildly abnormal as having low-grade dysplasia. Adenoma cells that are more abnormal are said to have high-grade (severe) dysplasia. This is important as adenomas that have high-grade dysplasia may develop into cancer in a few years if they are not removed.

What happens now?

If possible we will have removed all your adenomas when you had your endoscopy.

If you had a flexible sigmoidoscopy we were only able to look at the left colon. This means you may need to have a colonoscopy. This will allow us to complete the examination of your large bowel and remove further adenomas.

If you had several adenomas and we were only able to remove a few, you will need to have another colonoscopy to remove them.

It is possible we took a sample of your adenoma but did not completely remove it, or only took photographs of it. If so, your doctor will advise you about the treatment that is now best for you.

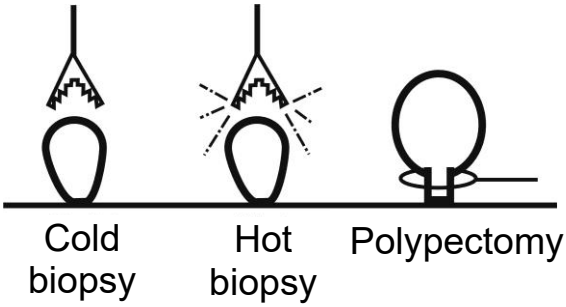
How are adenomas removed?

There are three ways of removing an adenoma all of which are painless. Your doctor will choose the right method for you.

If the adenoma has a stalk we do this by putting a snare (wire loop) through the scope and lassoing the stalk. We cut off the adenoma and retrieve it through the scope. This is called polypectomy.

If the adenoma is small we may have destroyed it by passing a safe amount of current through forceps that are passed through the scope. This is called ‘hot’ biopsy.

If the adenoma is tiny we may be able to destroy the polyp without using a current. This is called ‘cold’ biopsy (see below).

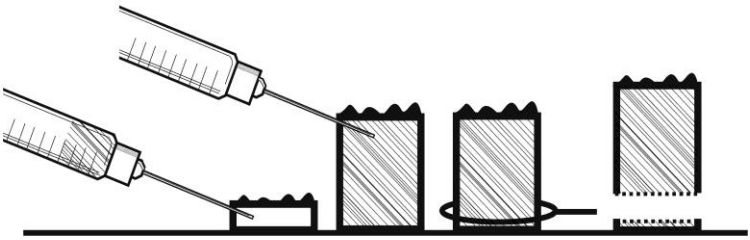


Sometimes an adenoma is big and has no stalk. This means it is too flat for us to put a snare around it and remove it using a polypectomy. If it is, you may need to have a more specialised procedure called an Endoscopic Mucosal Resection (EMR).

What is an EMR?

When we do an EMR we inject fluid underneath the adenoma. This changes its shape from a flat brick to a tall tower. This allows us to get a snare around it. The adenoma can then be removed using the snare (see figure).

If it not possible to do an EMR your doctor will discuss further treatment options with you.



Stages of Endoscopic Mucosal Resection (EMR)

Will I need another endoscopy in the future?

Once you have had a colonoscopy and all your adenomas have been removed you may need to have a colonoscopy every so often. This is to look for further polyps and deal with them.

How often we need to do a colonoscopy will depend on a number of things such as your age, general health, the number of adenomas you had, their size, and the type of dysplasia. In general, your doctor may recommend having a colonoscopy in 3 months, one year, three years, or not at all. If your polyp has been removed in pieces, rather than as a whole, we may need to do an endoscopy earlier, at three months. We will discuss this with you.

More details are provided on page 16 in the section (BSG/ACPGBI/PHE Post-polypectomy and post-colorectal cancer resection surveillance guidelines)

What are the possible complications of having an adenoma removed?

Bleeding

Sometimes people bleed heavily when we remove an adenoma. The chances of this happening vary from one in every 1,500 procedures to one in every 150 procedures. This bleeding usually settles though we may need to keep you in hospital for observation. Very occasionally people may need a blood transfusion. If the bleeding does not settle you may need a second endoscopy so we can stop the bleeding, or, very rarely, an operation.

Perforation

There is a small possibility that the endoscopy causes a perforation (hole) in your bowel. The chances of this happening are about one in 1,500. Having a polypectomy can increase this risk to one in 150 depending on the size of the polyp. If you get a bowel perforation you may need an operation to repair it.

Breathing and heart problems

We may give you a sedative before we do the endoscopy. This sedative may give you some temporary breathing or heart problems. Serious problems are rare. We carefully monitor you during the endoscopy and we can give you drugs to reverse these side effects.

Does colonoscopy detect all large bowel polyps?

Having a colonoscopy means we have looked at the large bowel carefully with the best available test. However, there is still a very small chance that we may have missed significant polyps or tumours. If you develop new symptoms it is important that you discuss this with your GP.

Ways to reduce your personal risk of bowel cancer

- Dietary changes – you should aim to eat a diet that is high in dietary fibre. This includes fruit and vegetables, wholegrains, and pulses (lentils and beans). Porridge and wheat based cereals are good breakfast options. It is recommended that you do not eat too much red meat and new evidence suggests that you should avoid processed meat (eg ham, bacon, salami). You should drink plenty of water every day. These changes help food waste move through your digestive system quicker.
- Stop smoking – your GP will have a stop smoking service that is free to access and research suggests that you are more likely to be successful in quitting smoking if you do it with support.

- Keep your weight within a healthy range (BMI 18.5 – 24) – your GP can help you with this or the web page below can calculate your BMI for you if you know your current height and weight.
- Type the web page address below or search for “NHS BMI Calculator” in your search engine box. http://www.nhs.uk/Tools/Poages/Healthyweightcalculator.aspx
- Be more physically active – this will help you to lose weight and help your bowel function more efficiently by moving food waste through your bowel quicker.
- Reduce your alcohol intake – current guidelines recommend no more than 14 units of alcohol per week for men and women (1 unit is equal to half a pint, a single spirit measure, or half a small glass of wine).
- If you are between the ages of 60 and 75 years old, participating in the National Bowel Cancer Screening Programme when offered is another way of reducing your risk of bowel cancer.

For further information about BSG/ACPGBI/PHE Post-polypectomy and post-colorectal cancer resection surveillance guidelines, please scan the QR code below.

Why stop at around 75 years of age?

- For a patient around the age of 75, once the bowel has been cleared of polyps, they are very unlikely to benefit from further surveillance colonoscopy.

- This is because, even if a new polyp occurs, it usually takes at least ten years for it to grow from a small polyp into a high-risk polyp or cancer.

- Although colonoscopy is usually safe, the risk of a complication of the test itself (e.g., bleeding) or an associated event (e.g., stroke, heart or kidney problem) occurring after a colonoscopy increases significantly in patients over the age of 75.

- Every patient should be able to discuss their own case with their doctor to weigh-up the associated risks and potential benefits of having a further colonoscopy.

Tell us what you think of this leaflet

We hope that you found this leaflet helpful. If you would like to tell us what you think, please contact:
Mr Chintapatla, Consultant Surgeon, General Surgery and Urology, The York Hospital, Wigginton Road, York, YO31 8HE or telephone 01904 721154.

Teaching, training and research

Our Trust is committed to teaching, training and research to support the development of health and healthcare in our community. Healthcare students may observe consultations for this purpose. You can opt out if you do not want students to observe. We may also ask you if you would like to be involved in our research.

Patient Advice and Liaison Service (PALS)

PALS offers impartial advice and assistance to patients, their relatives, friends and carers. We can listen to feedback (positive or negative), answer questions and help resolve any concerns about Trust services.

PALS can be contacted on 01904 726262, or email yhs-tr.patientexperienceteam@nhs.net.

An answer phone is available out of hours

Leaflets in alternative languages or formats

If you would like this information in a different format, including braille or easy read, or translated into a different language, please speak to a member of staff in the ward or department providing your care.

Patient Information Leaflets can be accessed via the Trust's Patient Information Leaflet website: www.yorkhospitals.nhs.uk/your-visit/patient-information-leaflets/

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