MINDAR
SOCIÉTÉ ALGÉRIENNE D'ENDOSCOPIE DIGESTIVE

Congrès national d'endsocopie digestive
Alger 8-9 Novembre 2024

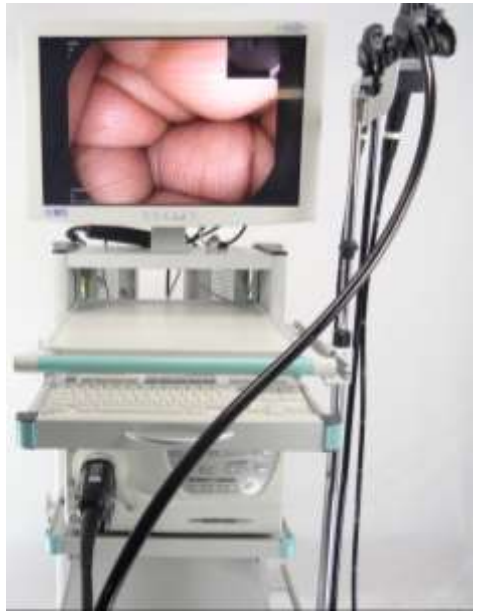
Gestion des complications en coloscopie
Hémorragie / Perforation

Dr Karim LAYAIDA
Clinique Chifa Alger
karim@layaida.com

Matériel

Endoscopes haute résolution

Bistouri electrique



Pompe de lavage

CO_2

Accessoires

Capuchons

Aiguilles d’injection

Sérum + Adrénaline

Pince coagulante

Poudre hémostatique

Clips TTC

Clips OTSC

Endoscopic HeliX Tacking System

Sonde Argon

Endoloop

Saignement

Hémorragie per-procédure

Colorectal polypectomy and endoscopic mucosal resection: European Society of Gastrointestinal Endoscopy (ESGE) Guideline – Update 2024

- Saignement pendant l'endoscopie :
  - Persistant > 60 s
  - Nécessitant un geste d'hémostase
- Fréquence :
  - 2.8% polypectomies standards
  - 11.3% lésions sessiles > 20 mm
- Facteurs favorisants :
  - Pédicule large et/ou taille tête > 20 mm
  - Localisation colon droit > colon gauche
  - Courant de section pure > endocoupe
  - Anse froide = Anse chaude
  - Antiagrégants/Anticoagulants
  - Age > 65 ans, insuffisance rénale, cardiopathie

Ferlitsch Monika et al. Endoscopy 2024
Burgess NG et al. Gastrointestinal Endsoc 2015; 81 : 813-835
Klein A, Bourke Mj. Gastrointest Endosc Clin N Am 2015; 25: 303-333

Hémostase endoscopique

Colorectal polypectomy and endoscopic mucosal resection: European Society of Gastrointestinal Endoscopy (ESGE) Guideline – Update 2024

RECOMMENDATION

ESGE suggests the use of endoscopic coagulation (STSC or coagulating forceps) or mechanical therapy, with or without the combined use of dilute adrenaline injection, for the treatment of IPB.

Weak recommendation, low quality of evidence.

-Coagulation par la ponte de l'anse
-Pince coagulante
-Hémostase mécanique : clips, endoloop
-Combinaison eventuelle avec sérum adrénaliné

Ferlitsch Monika et al. Endoscopy 2024

Hémorragie post-procédure

Colorectal polypectomy and endoscopic mucosal resection: European Society of Gastrointestinal Endoscopy (ESGE) Guideline – Update 2024

RECOMMENDATION

ESGE recommends that patients admitted to hospital with PPB who are hemodynamically stable, without ongoing bleeding, may be initially managed conservatively. If intervention is required, colonoscopy should be the first-line investigation.

Strong recommendation, moderate quality of evidence.

RECOMMENDATION

ESGE recommends that, when the polypectomy site is identified during colonoscopy for PPB and active bleeding or other high risk stigmata are identified, forceps coagulation or mechanical therapy, with or without the combined use of dilute adrenaline injection, should be performed.

Strong recommendation, moderate quality of evidence.

Saignement après la procédure jusqu'à 30 jours

Hospitalisation :

-Etat hémodynamique stabe : surveillance

-Persistance du saignement : coloscopie (préparation 4-6 litres) : hémostase

-Echec : traitement radiologique

-Echec ou non disponibilité du traitement radiologique : chirurgie

Ferlitsch Monika et al. Endoscopy 2024

ESGE guideline. Endosocpy 2021 ; 53: 850-868

ACG guideline. Am J Gastroenterol 2023; 118: 208-231

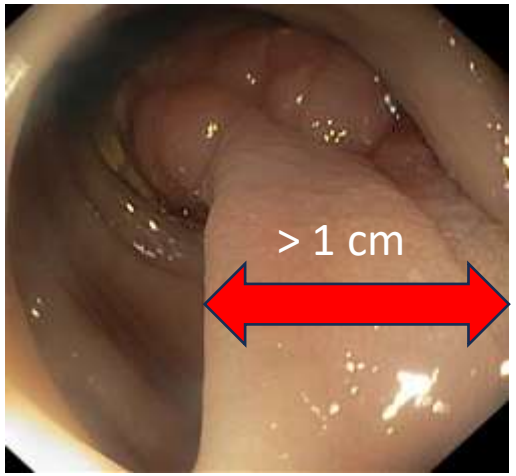
Prévention
Lésions pédiculées

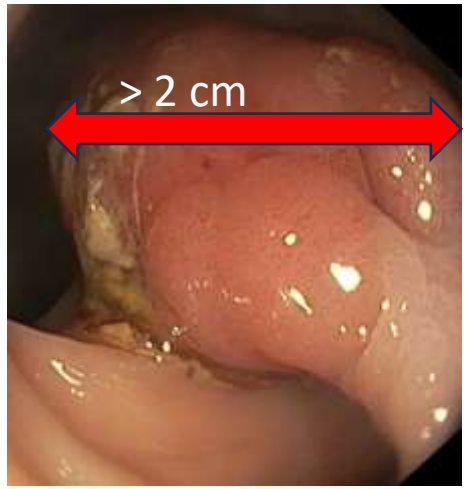
Colorectal polypectomy and endoscopic mucosal resection: European Society of Gastrointestinal Endoscopy (ESGE) Guideline – Update 2024

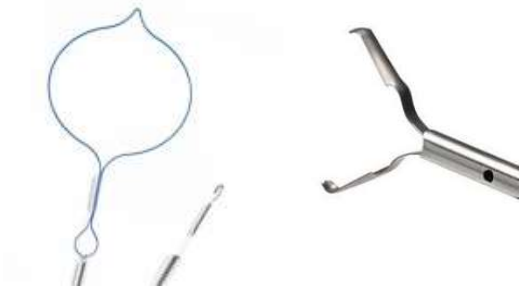
RECOMMENDATION

ESGE recommends hot snare polypectomy for pedunculated polyps.
Strong recommendation, high quality of evidence.

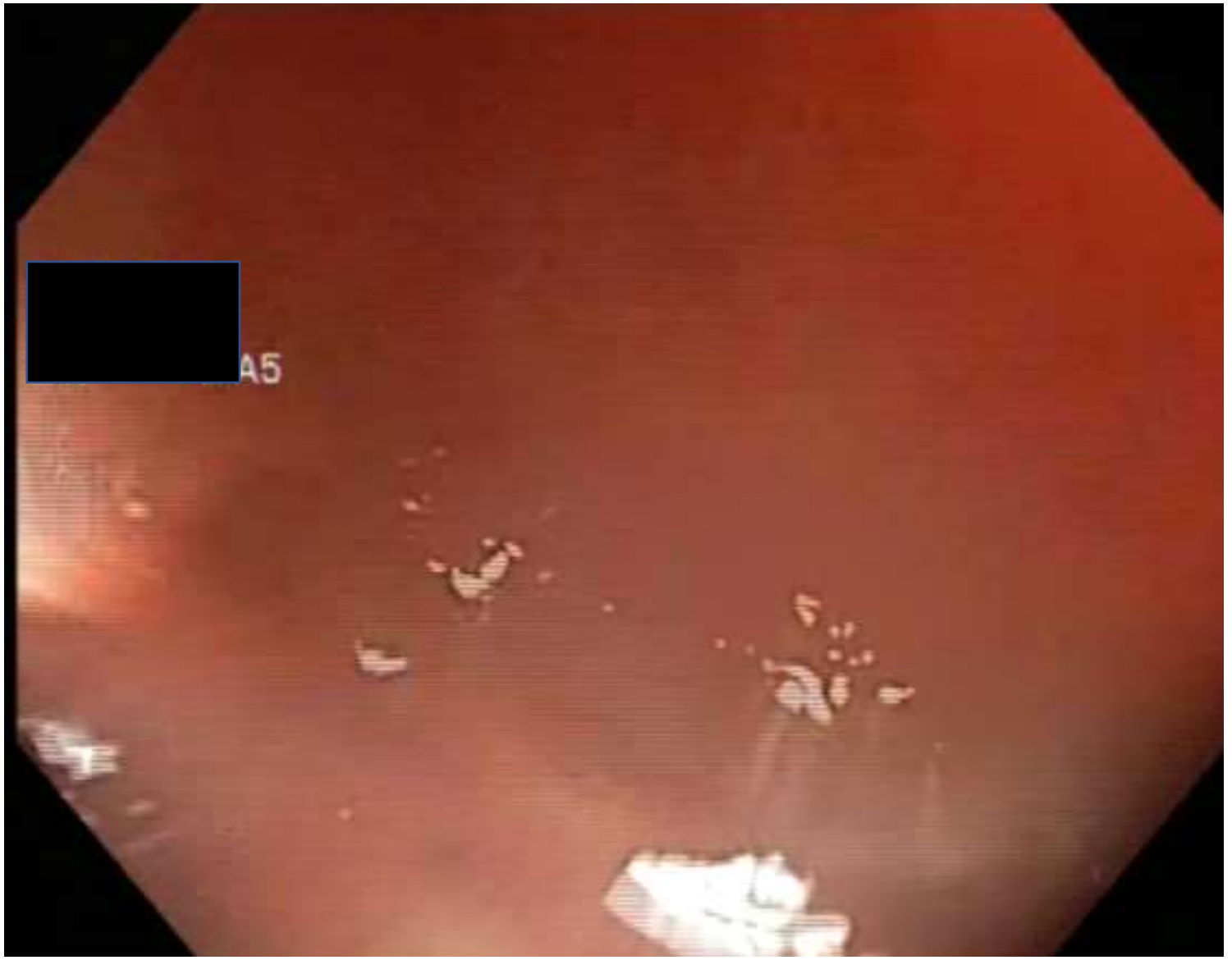
ESGE suggests the use of dilute adrenaline injection and/or mechanical hemostasis in pedunculated colorectal polyps with a head size of ≥ 2 cm or a stalk width of ≥ 1 cm to prevent immediate post-polypectomy bleeding.
Weak recommendation, low quality of evidence.







Ferlitsch Monika et al. Endoscopy 2024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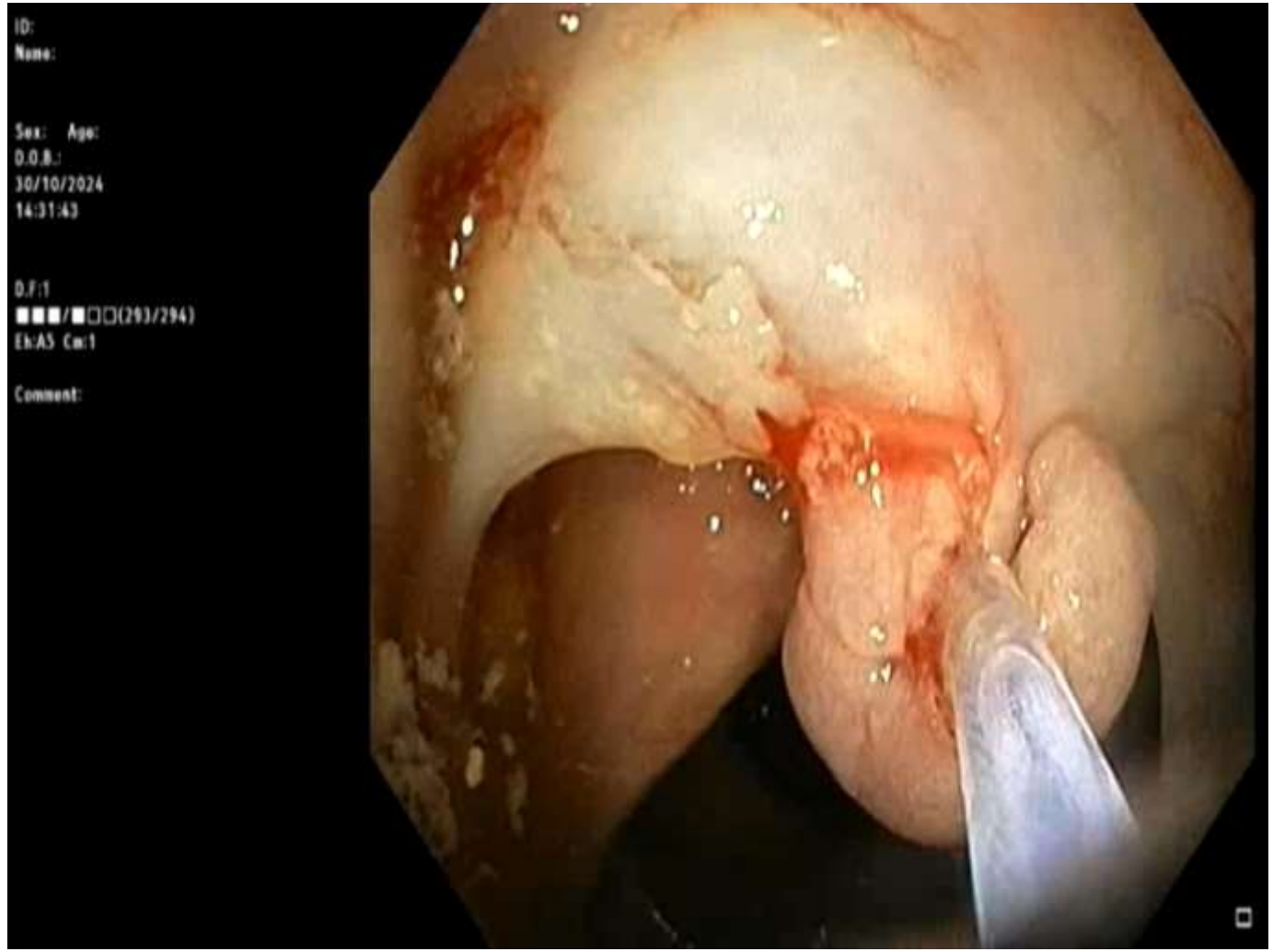
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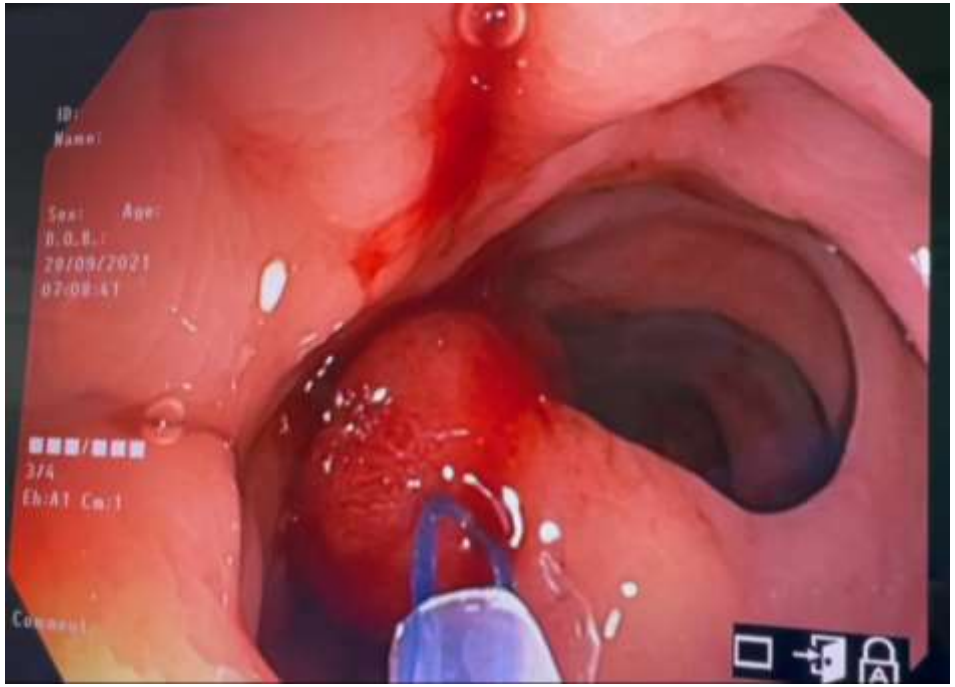
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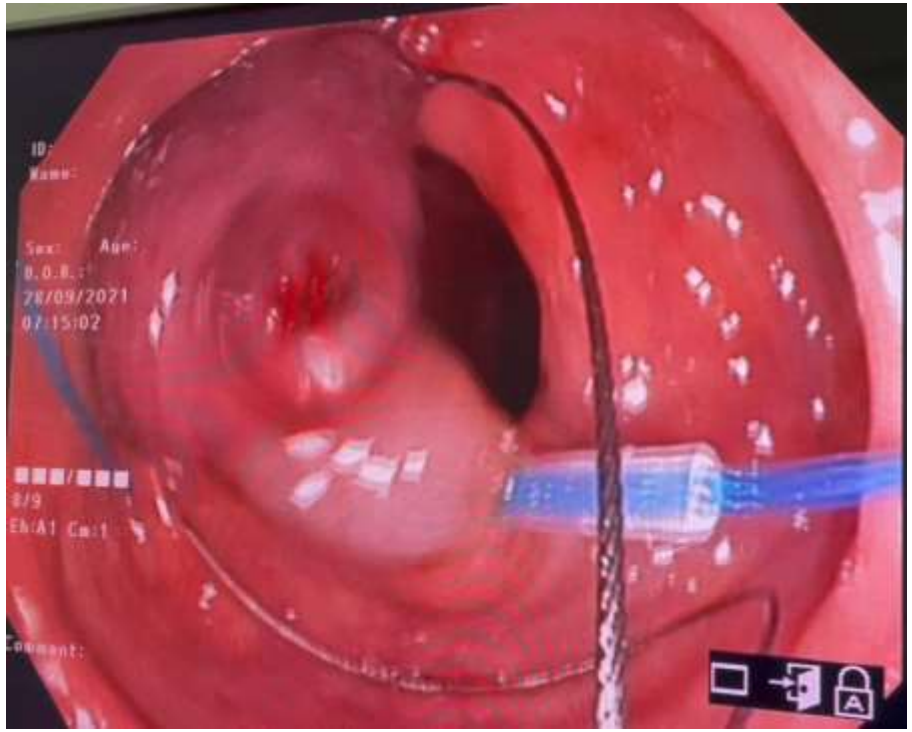
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Prévention
Lésions sessiles

Colorectal polypectomy and endoscopic mucosal resection: European Society of Gastrointestinal Endoscopy (ESGE) Guideline – Update 2024

RECOMMENDATION

ESGE recommends prophylactic clip closure of the mucosal defect after conventional EMR of LNPCPs in the right colon.

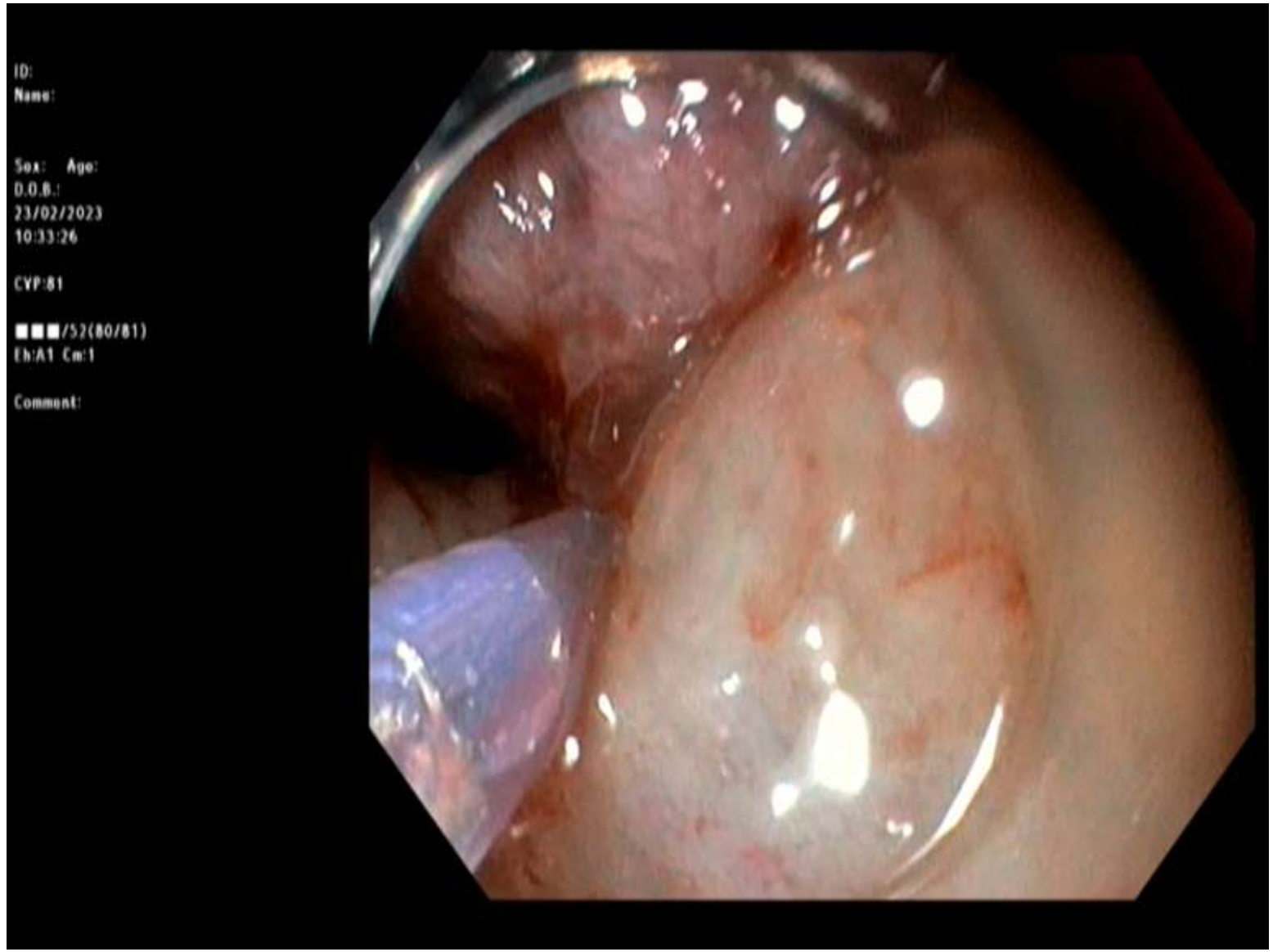
Strong recommendation, high quality of evidence.

RECOMMENDATION

ESGE suggests against routine prophylactic clipping after conventional polypectomy for lesions <20 mm and for lesions ≥20 mm in the left colon because of a lack of evidence.

Weak recommendation, low quality of evidence.

Ferlitsch Monika et al. Endoscopy 2024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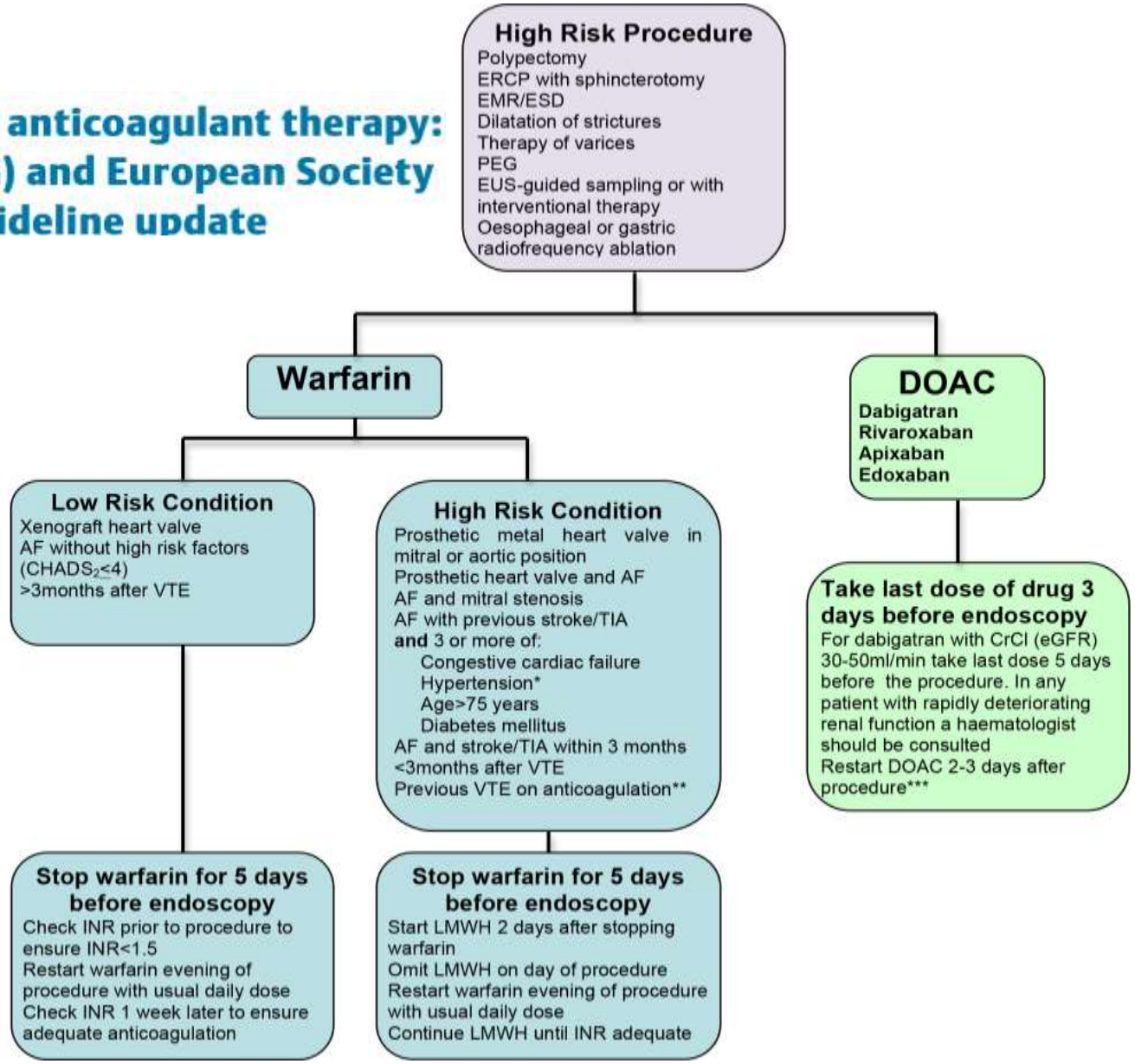
Réglages bistouri

RECOMMENDATION

ESGE recommends against using pure cutting current for pedunculated polypectomy because of an increased risk of intraprocedural bleeding. (Low quality evidence; strong recommendation.)

Comment gérer les anticoagulants?
Procédure à haut risque

Endoscopy in patients on antiplatelet or anticoagulant therapy: British Society of Gastroenterology (BSG) and European Society of Gastrointestinal Endoscopy (ESGE) guideline update



Veitch Andrew M et al. Endoscopy in patients ... Endoscopy 2021; 53

Comment gérer les antiagrégants plaquettaires ?

Endoscopy in patients on antiplatelet or anticoagulant therapy: British Society of Gastroenterology (BSG) and European Society of Gastrointestinal Endoscopy (ESGE) guideline update

High risk procedure
- Polypectomy (consider cold snare colonic polypectomy < 1 cm on continued clopidogrel monotherapy)
- ERCP with sphincterotomy
- EMR/ESD
- Dilatation of strictures
- Therapy of varices
- PEG
- EUS-guided sampling or with interventional therapy
- Oesophageal or gastric radiofrequency ablation

- Clopidogrel
- Prasugrel
- Ticagrelor

Low risk condition
- Ischaemic heart disease without coronary stent
- Cerebrovascular disease
- Peripheral vascular disease

Stop clopidogrel, prasugrel or ticagrelor 7 days before endoscopy
- Continue aspirin if already prescribed
- Restart clopidogrel, prasugrel or ticagrelor 1 – 2 days after procedure

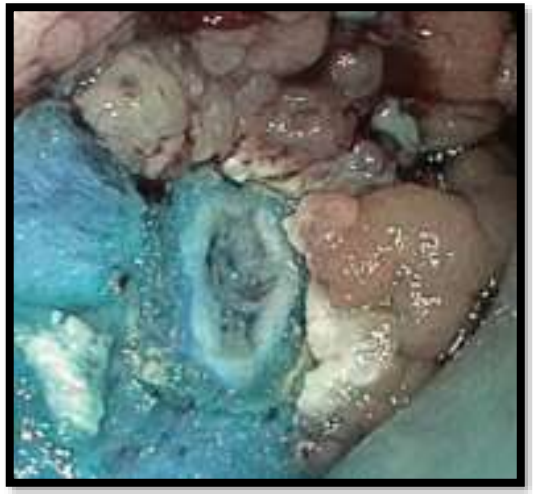
High risk condition
- Coronary artery stents

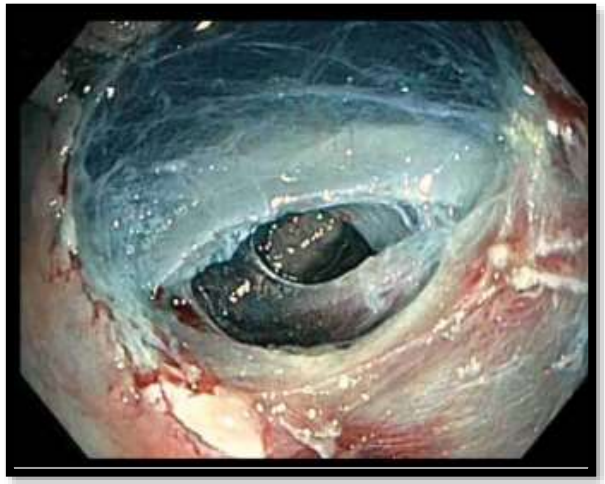
Discuss strategy with consultant interventional cardiologist
- Consider temporary cessation of P2Y12 receptor antagonist if: 6 – 12 months after insertion of drug-eluting coronary stent
  > 1 month after insertion of bare metal coronary stent
- Continue aspirin

Veitch Andrew M et al. Endoscopy in patients ... Endoscopy 2021; 53

Perforation

- Effraction de la musculeuse avec ou sans effusion de liquide ou d'air en dehors du tractus gastro-intestinal ou signe endoscopique d'un defect de la paroi colorectale





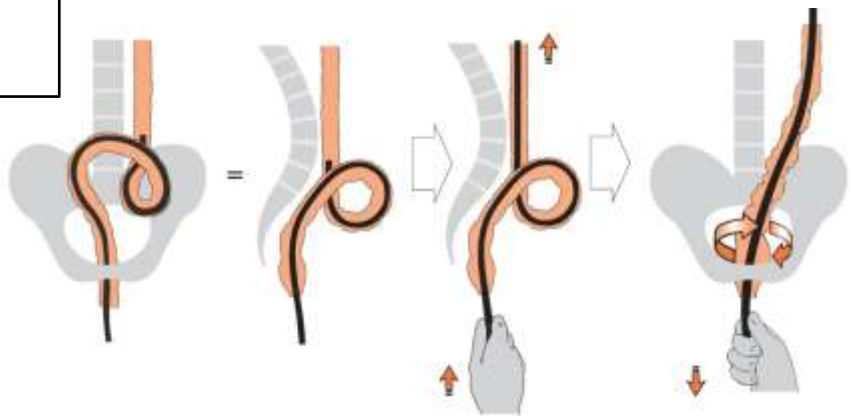
Perforation
Mécanisme

Coloscopie diagnostique
- Traumatisme direct du mur colique par l'endoscope / force de cisallement
- Barotraumatisme par insufflation : caecum

Coloscopie de dépistage 0.07-0.082%

Grave : pronostic fonction de la précocité du diagnostic ++

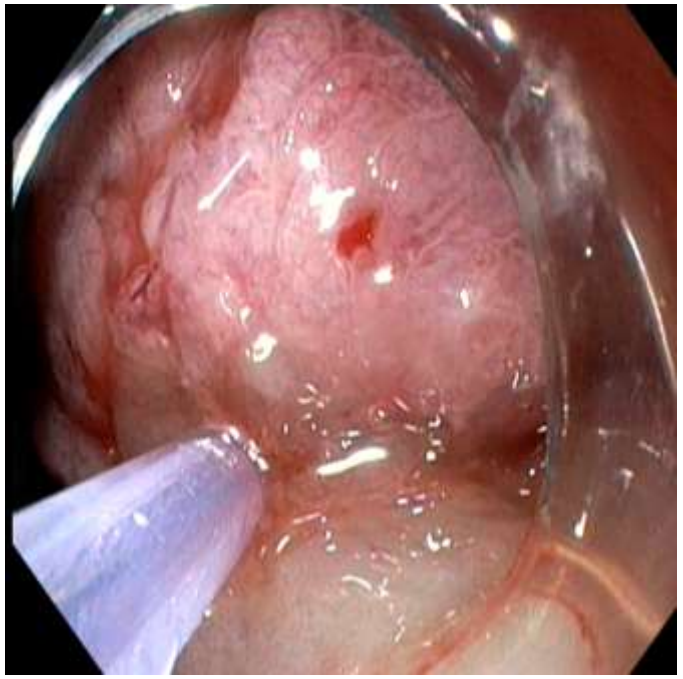
Charnière fixée, diverticulose, sténose
Cicatrice abdominale, radiothérapie, dénutrition
Expérience de l'opérateur



Arora G et al. Gastrointest Endosc 2009;69(3 Pt 2): 654–664

Perforation
Mécanisme

Traumatisme par instrument lors d'un geste thérapeutique



- Mucosectomie : 1-2%
- ESD : 3-10%
- Facteurs favorisants :
  - Taille > 25 mm
  - Localisation colon droit/transverse

Mann R, Gajendran M, Umapathy C, et al. Front Med (Lausanne) 2022;8:728704
Hassan C, Repici A, Sharma P, et al. Gut 2016;65(05):806–820
Tanaka S, Terasaki M, Kanao H, Oka S, Chayama K. Endosc 2012;24(suppl 1):73–79

Perforation retardée

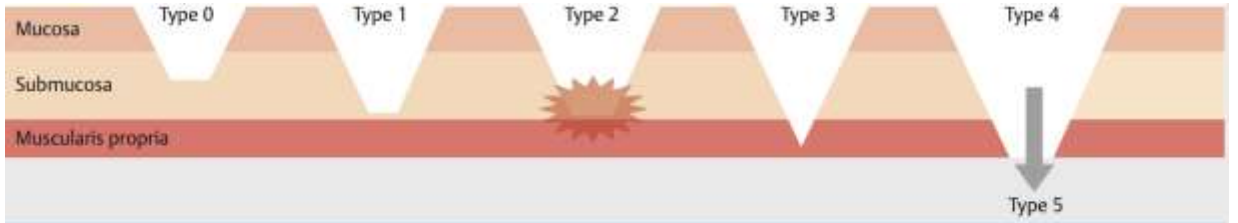
- Perforation retardée survenant dans les 24-72 h suivant le geste, par nécrose transmurale lors de l'utilisation d'un outil thermique
- Taux de recours à la chirurgie plus élevé

Colorectal polypectomy and endoscopic mucosal resection: European Society of Gastrointestinal Endoscopy (ESGE) Guideline – Update 2024

RECOMMENDATION

ESGE recommends careful inspection of the post-resection mucosal defect, using the Sydney DMI classification, to identify features of, or risk factors for, immediate or delayed perforation. Where these risk factors are identified, clip closure should be performed.

Strong recommendation, moderate quality of evidence.



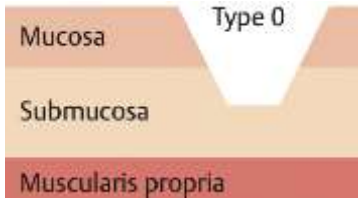
Cold snare polypectomy

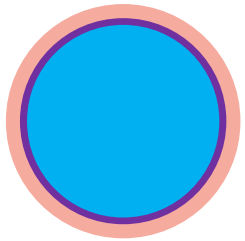
Type 0	Normal defect. Blue mat appearance of obliquely oriented intersecting submucosal connective tissue fibres
Type 1	Muscularis propria visible, but no mechanical injury
Type 2	Focal loss of the submucosal plane raising concern for muscularis propria injury or rendering the muscularis propria defect uninterpretable
Type 3	Muscularis propria injured, specimen target or defect target identified
Type 4	Actual defect within a white cautery ring, no observed contamination
Type 5	Defect within a white cautery ring, observed contamination

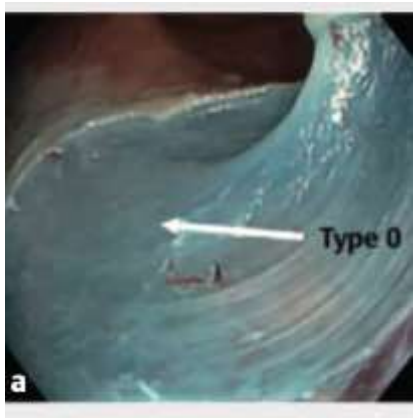
Analyser le defect en utilisant la classification de Sydney
Décision d'un traitement préventif / curatif

Ferlitsch Monika et al. Endoscopy 2024
Burgess, Gut 2017, 66(10), 1779–1789.

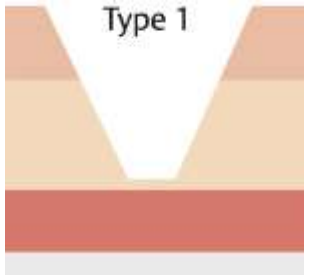
Classification Sydney après résection

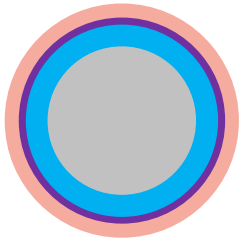


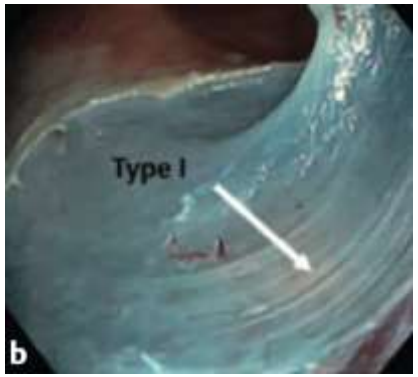




Type 0: Defect sous muqueux, musculeuse non visible



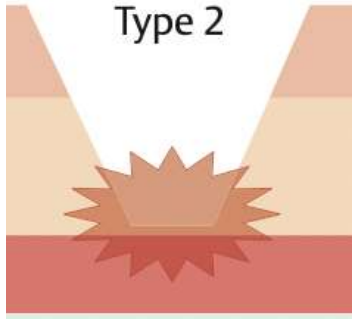


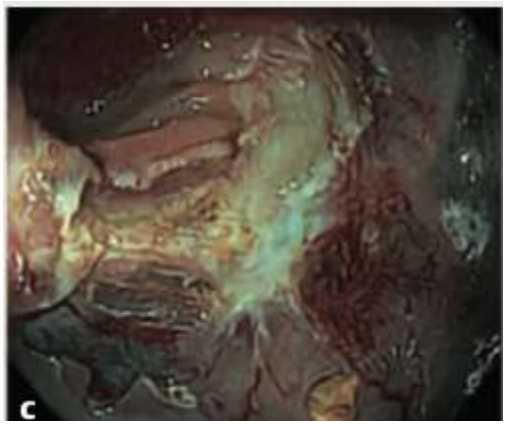


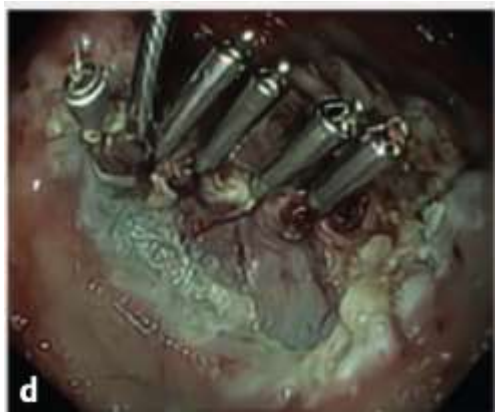
Type 1 : musculeuse visible mais intacte

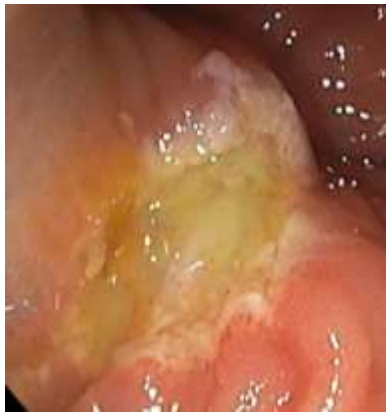
Burgess, Gut 2017, 66(10), 1779–1789.

Classification Sydney

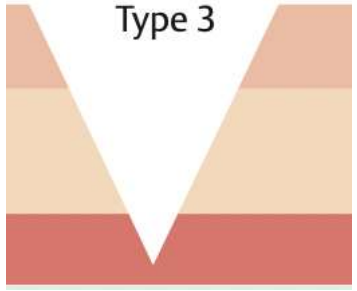


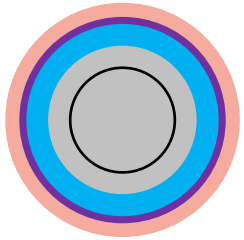


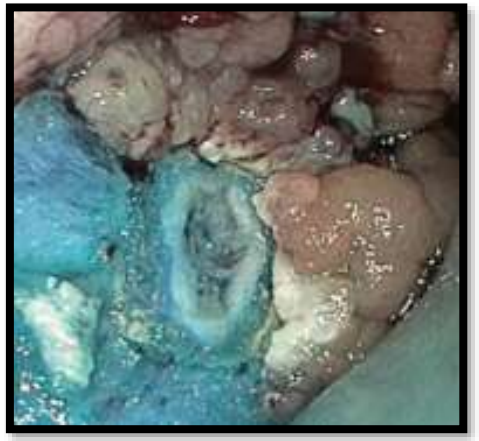


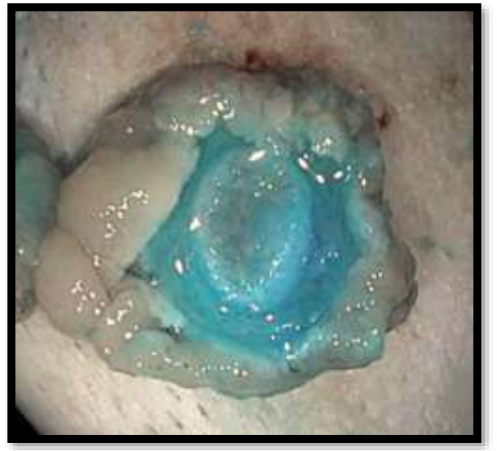


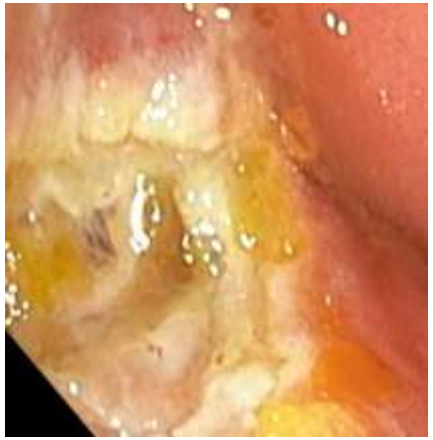
Perte focale du plan sous muqueux avec possible atteinte superficielle de la musculeuse ou fibrose rendant l'interprétation difficile





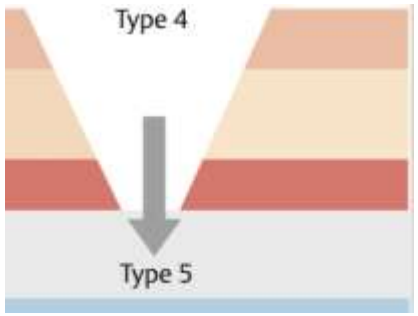


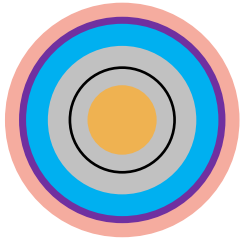




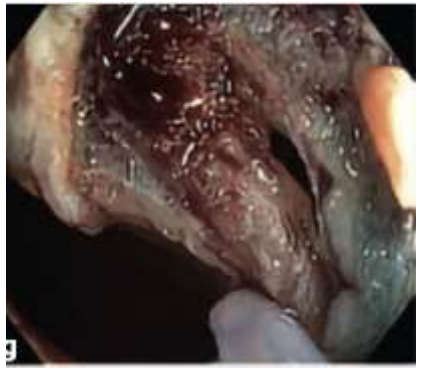
Atteinte de la musculeuse (signe de la cible)

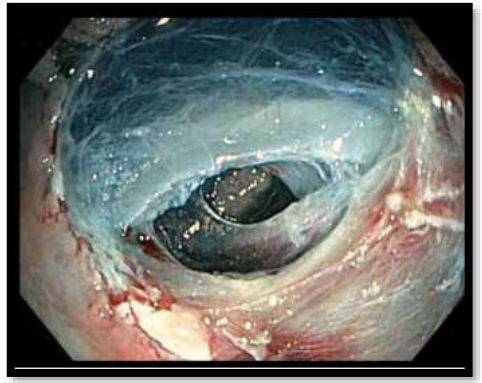
Classification Sydney

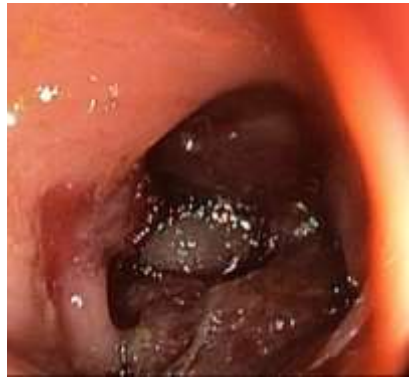




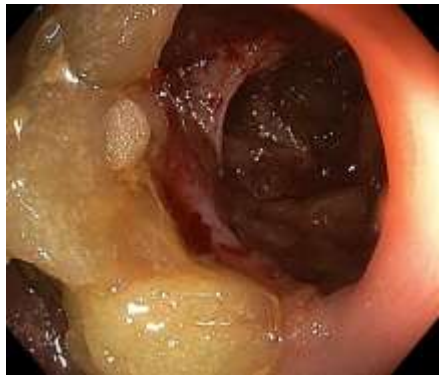
Type 4 : Perforation sans contamination fécale

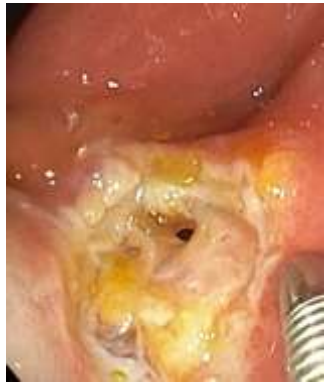


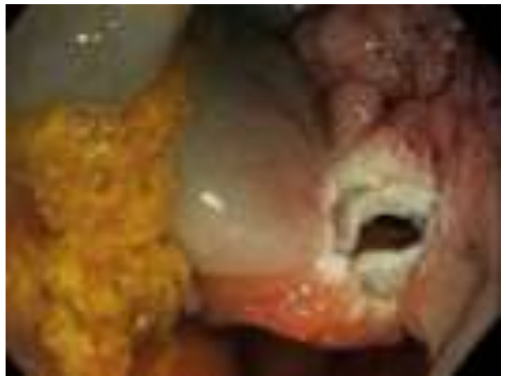




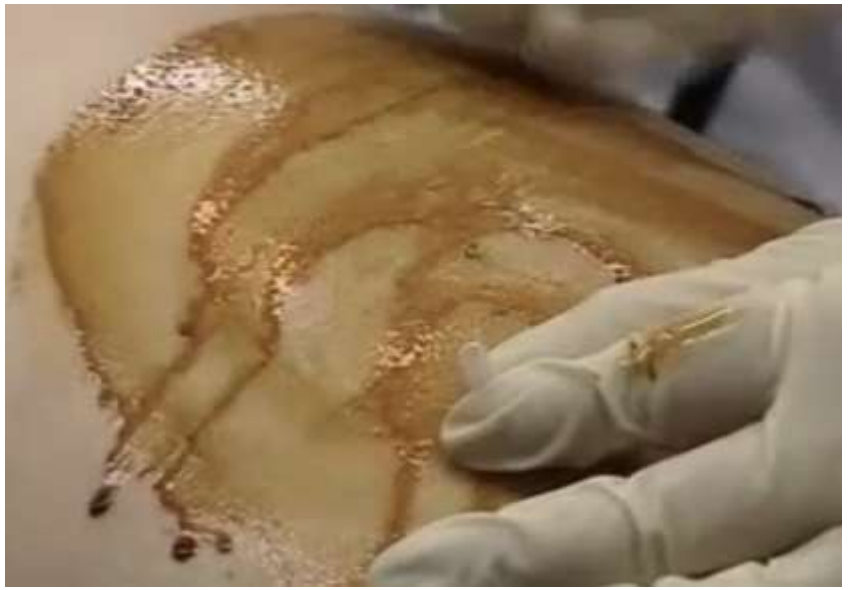
Type 5 : Perforation avec contamination fécale



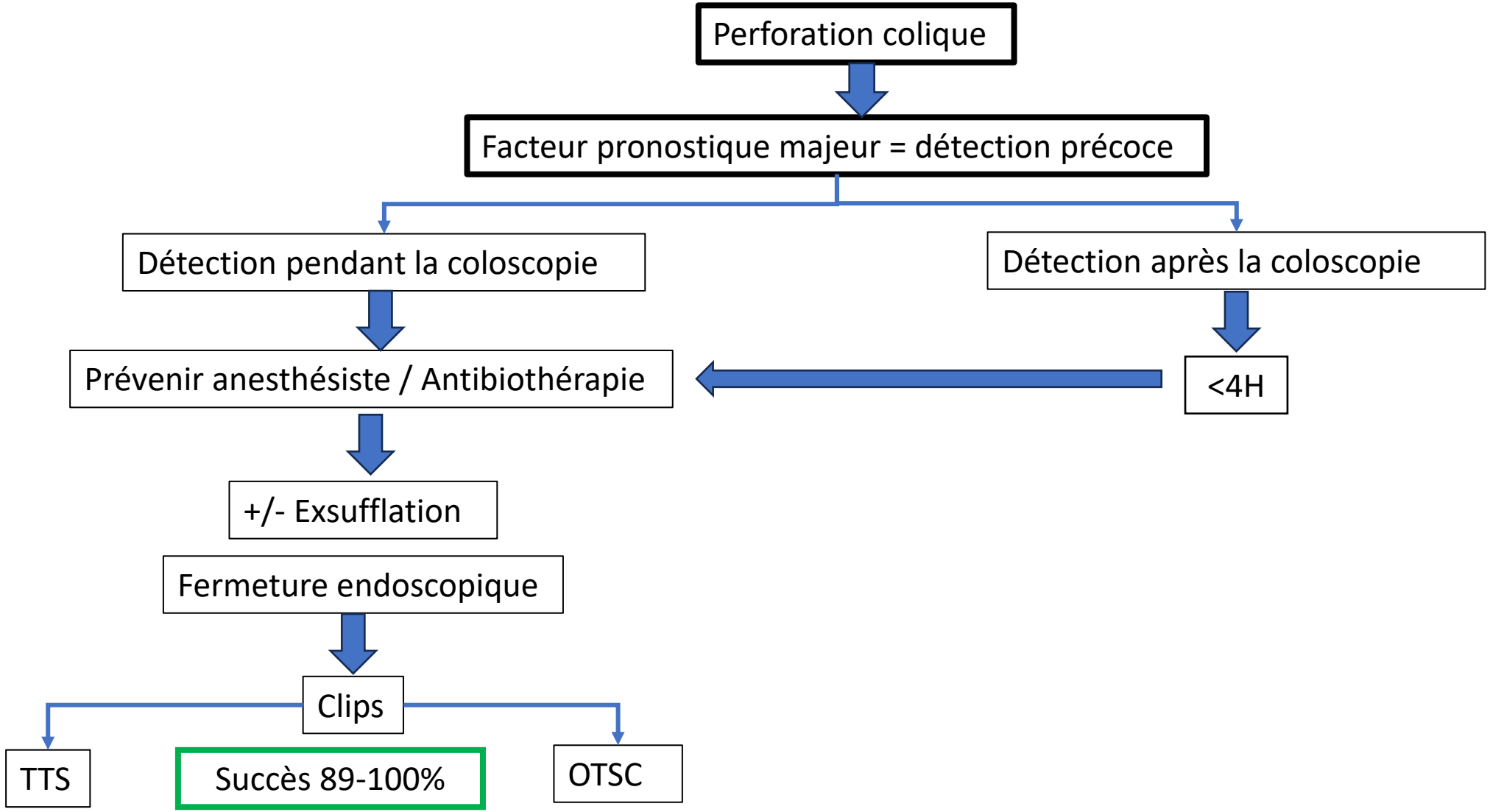




Traitement
Exsufflation + CO_2



Garder son calme



An Surg Endosc. 2016 Jul;30(7):2914-21.
Paspatis, Endoscopy 2014, 46(8), 693–711
Hawkins, American Journal of Surgery 2018, 215(4), 712–718.

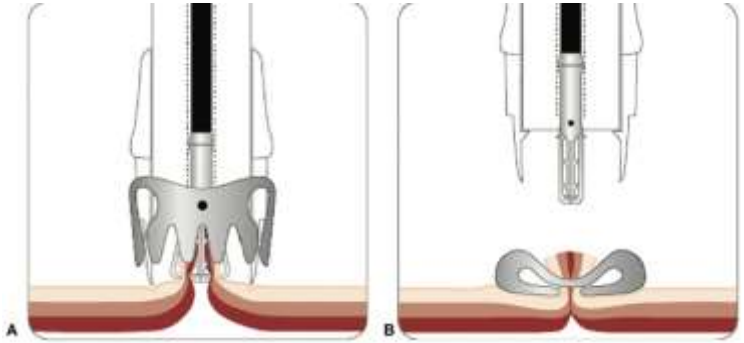
Quel clip pour quelle perforation ?

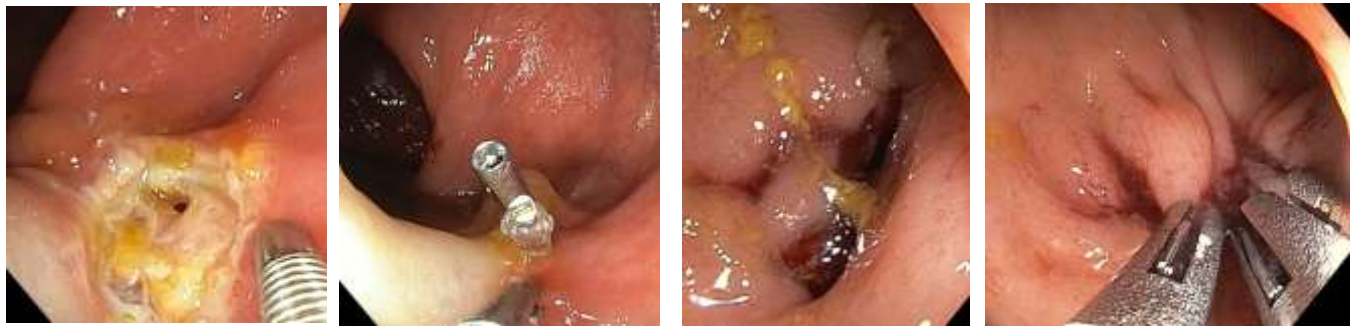
Clips TTS

< 1 cm (1.5 cm)

Clips OTSC

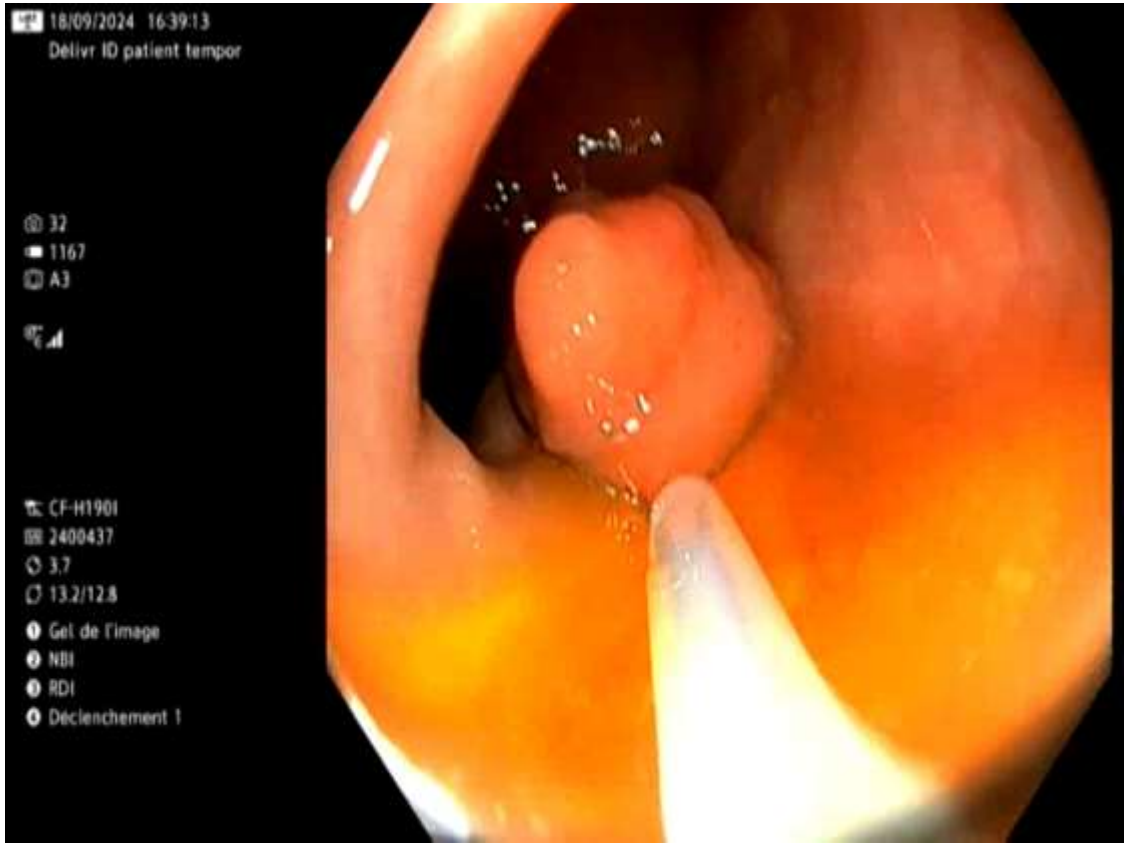
1-3 cm

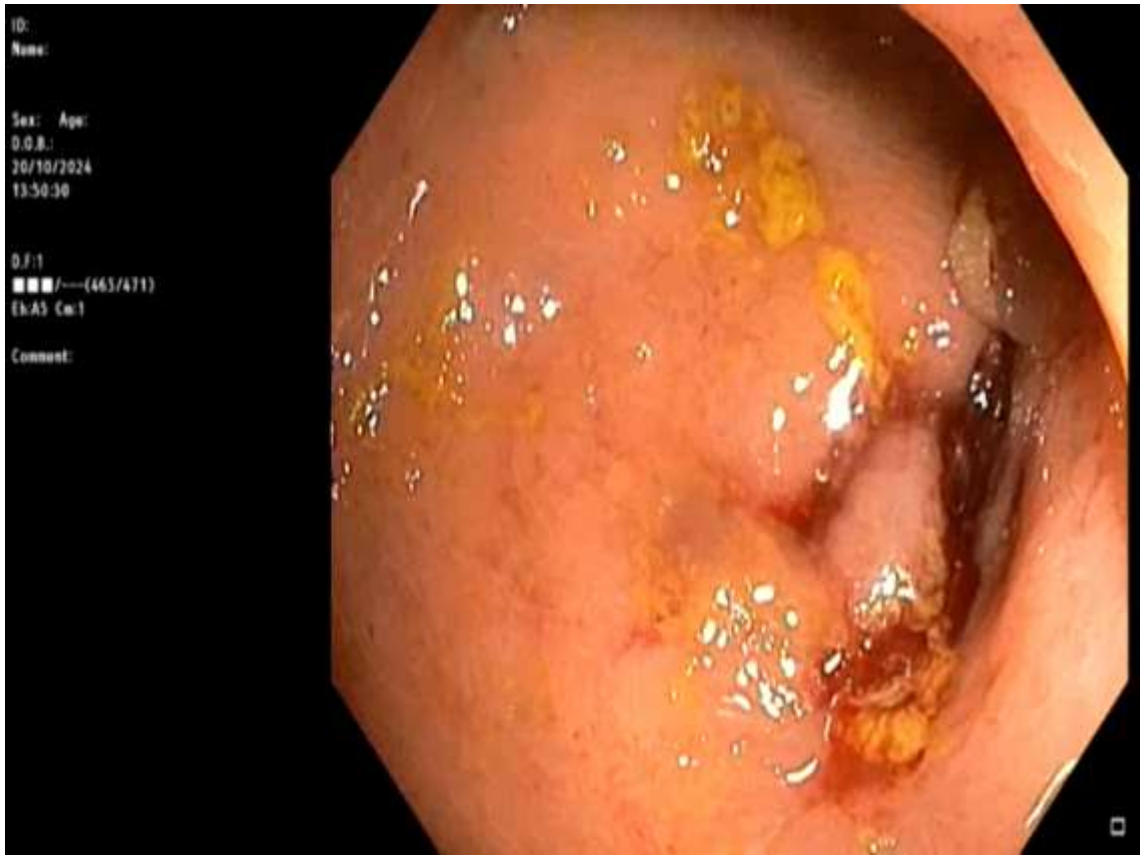




Quelle place pour les systèmes de suture ?

Garder son calme





Garder son calme

CAT après traitement endoscopique

Pas de risque de contamination péritonéale

Surveillance 24 H

ATB orale
Reprise de l'alimentation orale
Sortie

Risque de contamination péritonéale
Efficacité incertaine du traitement endoscopique
Exsufflation du pneumopéritoine

Repos digestif
ATB parentérale
Surveillance

Chirurgie

> 4H
Péritonite
Dégradation clinique : douleur persistante, Sd infectieux, Sd péritonéal
Mauvaise préparation colique
Echec du traitement conservateur
Lésion sous jacente nécessitant une chirurgie

Conclusion

- Amélioration de nos plateaux techniques pour optimiser le gestion non chirurgicale de nos complication
- Formation des gastroentérologues à la gestion des complications de l’endoscopie digestive