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Research Article

**STUDY THE CLINICAL RESULTS OF ASSISTANCE WITH  
COLON ENDOSCOPIC RESECTION OF POLYPS  $\geq 24$  MM AT  
THE SIR GANGA RAM HOSPITAL, LAHORE**<sup>1</sup>Urwah Shahid, <sup>2</sup>Muhammad Danish Zafar, <sup>3</sup>Joveria Saeed<sup>1</sup>House Officer, Jinnah Hospital Lahore, <sup>2</sup>House Officer, Rawalpindi Medical University, <sup>3</sup>House Officer, Jinnah Hospital Lahore.**Article Received:** October 2019    **Accepted:** November 2019    **Published:** December 2019**Abstract:**

**Aim:** Study the clinical results of assistance with colon endoscopic resection of polyps  $\geq 24$  mm at the Sir Ganga Ram Hospital, Lahore and evaluate changes over a 10-year period.

**Methods:** Our current research was conducted at Sir Ganga Ram Hospital, Lahore from March 2017 to August 2019. Retrospective observational examination, information was provisionally collected for all cases of sessile colon polyps  $\geq 22$  mm that were evacuated using the EMR by colonoscopy authorized by the Bowel Cancer Screening Program (BCSP) in the 2006 and 2014 range.

**Results:** 580 injuries in 570 patients were studied for the EMR; 427 wounds were actually extracted using the EMR. A recurrence/left adenoma at the EMR site was found in 56 (17%) at the primary recognition endoscopy; treated by endoscopy in 54/58 (96%) patients; 4/57 (6%) were carefully resected. Complete destruction at the second reconnaissance endoscopy; 280/296 patients (93%). Repetition in 24 patients (9%) and endoscopic resection of the repetitive lesion in 23/24 patients. The overall complexity rate was 18/428 (5%). There was no passage related to the strategy. Over a 10-year period, there was a predictable decrease in the number of patients with good-hearted polyps who were not treated with EMRs and who were referred to for careful resection ( $P = 0.004$ ). There were increases in the quantities of EMRs completed annually ( $P = 0.002$ ), the average size of resected polyps ( $P = 0.026$ ) and level 4 and 5 polypectomies ( $P < 0.002$ ).

**Conclusion:** Endoscopic resection of the mucosal mucosa of huge sessile polyps  $\geq 22$  mm by colonoscopy under license from the intestinal cancer screening program indicated a broad nature of this EMR administration after some time.

**Keywords:** Endoscopic Mucosal Resection; Endoscopic Polypectomy.

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**INTRODUCTION:**

Endoscopic mucosal resection (EMR) is an infusion rehabilitation method that evacuates huge sessile or adenomatous lesions inside the colon. Polyps that have recently been referred to for careful resection are currently normally removed by endoscopy [1]. The size, anatomical area and availability of a polyp in relation to mucosal folds and flexions determine the difficulty and danger of perforation and oozing during expulsion [2]. Five degrees of skill to expel colorectal polyps have been proposed [3]. They differ from level 0 where no injuries are expelled, all mentioned to propel endoscopists to level 5 where huge sessile wounds or other test polyps that may somehow require precise evacuation are extracted by endoscopy [4]. As an activity to improve the understanding of the results of endoscopic mucosal resection of amicable colonic polyps at Sir Ganga Ram Hospital, Lahore, it was selected that huge sessile polyps distinguished by the restorative and conservative endoscopic group be mentioned for evaluation and evacuation by authorized colonoscopes from the BCSP (Bowel Cancer Screening Program) [5].

**METHODOLOGY:**

Our current research was conducted at Sir Ganga Ram Hospital, Lahore from March 2017 to August 2019. Retrospective observational examination, information was provisionally collected for all cases of sessile colon polyps  $\geq 22$  mm that were evacuated using the EMR by colonoscopy authorized by the Bowel Cancer Screening Program (BCSP) in the 2006 and 2014 range. Patients with basic internal inflammatory disease were excluded from the survey. Consideration was given to socio-economic aspects, the resection system, the completion of the introductory resection, the rate of repetition at the beginning of the observation endoscopy, the level of polypectomy, histology, the rate of destruction of polyps at the second recognition endoscopy and the disadvantages in screening and non-diagnosis over a period of more than 10 years. The endless provision of a reference following a presentation from the lower gastrointestinal multidisciplinary group or a reference from medicinal or prudent partners, peak-age patients with numerous co-morbidities have been evaluated and clarified on the EMR system and the hazards in question, explicitly the risk of opening requiring medical intervention. A reference letter was sent to the endoscopy unit to ensure that an appropriate time measurement was designated on the endoscopy list for the EMR technique to be performed. As soon as the system arrived, endoscopists met with patients and obtained their informed consent. The wounds were expelled through the infusion helped EMR strategy.

Complete resection of the catches was the main point for each situation. Frequencies (%) were used to allocate the unattenuated factors, and 96% CIs were determined where applicable. The Understudy t-test was used to examine the spread of non-stop factors and the distinction between screening and non-selective collection. All tests were bilateral and  $P < 0.06$  was considered noteworthy. The examination of time trends was used to inspect the general example of progress in EMR administration after some time. Logarithmic changes in free factors were used in the examination of temporal models to improve information elucidation. We used the absolute mean rate error, the mean total deviation and the mean square deviation to reflect on the attacks of various smoothing techniques in time model models. A polynomial approach to relapse was used to take into account different potential matching factors in the time profile survey. A multivariate study and a two-part strategic relapse model were used to evaluate the random components related to repetitive or residual adenomas at the time of the main recognition endoscopy. The examination of the facts was carried out using the SPSS 23 software.

**RESULTS:****Patients demographics, lesion characteristics and EMR outcome:**

Over a 10-year period, 578 wounds in 569 patients were distinguished from the UHL EMR database. 427 wounds (140 in screening collection and 289 in non-screening collection) were actually extracted using the EMR. The mean age of the patients was 69.6 years (standard deviation 13 years), and 54% of the patients were male. Fragmentary EMRs were performed in 383 (91%) cases of successful EMRs and 45 (11%) cases of "En-coalition". The average and average size of the polyps was 34 mm (SD 16 mm) and 32 mm (IQR 27 - 42), separately. The EMR was not implemented in 73 patients; rather, it was referred to as a careful resection. Of these patients, 38 were undoubtedly suffering from a malignant tumour. The remaining 36 patients were referred for careful resection due to particular difficulties. In fact, these embarrassing wounds were located as pursuits: 4 inside the appendix hole, 3 inside the ileo-caecal valve, 8 inside a section related to diverticular disease, 3 unable to retain air, 2 in a hemorrhoid and 18 of each precarious situation inside the colon in escalation or hepatic flexion). There were 34 patients with deficient resection that depended on the proximity of a sign of non-lifting; therefore, these patients were referred for careful resection. Of these, 23 patients had a deep invasive malignant tumor and 18 patients had a preventative polyp. Of the 427 patients who achieved an effective EMR, 336 (78%)

had their first endoscopic observation on average 7 months (standard deviation of half a year). A total of 98 patients were not eligible for a first observational endoscopy (23 of them had co-distality that increased the danger of the methodology, 37 chose not to have a recurrent strategy, 5 moved and 33 patients died due to disease). Patients who refused a follow-up endoscopy were offered CTVC as an alternative. Patients who moved were trained to orchestrate a subsequent endoscopy with their new general practitioner. Of the 332 patients who underwent underlying recognition endoscopy, 272/328 patients (84%, 96% CI 0.79 to 0.87) did not have a repetitive

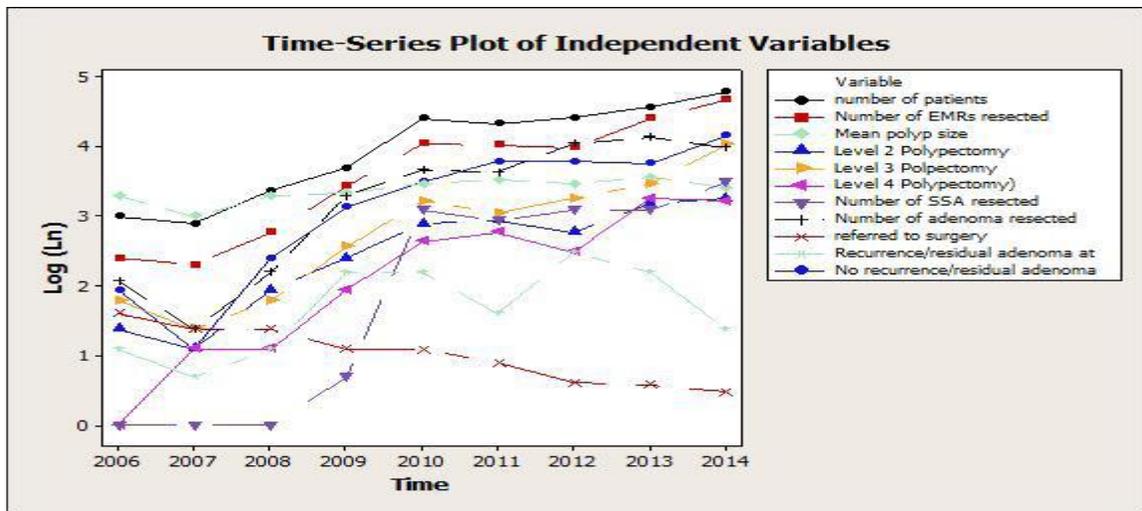
adenoma / ongoing treatment. Complete annihilation at the second observation endoscopy (mean 16 months, standard deviation 8 months) was observed in 268/294 patients (93%, 96% CI 9.68 to 9.45). Recurrence was observed in 23/292 patients (9%, 96% CI, 0.59-1.31). Of these 25 patients, 23 (97%) were treated by endoscopy. The resection was far-fetched in one patient due to basic fibrosis, and this patient continues to be under observation. A total of 38 patients were not eligible for a second recognition endoscopy (21 patients refused other methods, 14 patients died due to illness, 7 patients had a concurrent disorder that increased the danger to the system).

**Table 1 Time-trend analysis over a 2-year period by means of polynomial best-fit regression model.**

variables	Trend analysis	Mean absolute percentage error (MAPE)	Mean absolute deviation (MAD)	Mean square deviation (MSD)	Adjusted R2	S-value	P value
Number of patients identified for EMR	S-curve trend model	3.83	0.147	0.042	0.9	69.34	< 0.001
Number of EMRs completed	S-curve trend model	5.96	0.197	0.055	0.98	222.19	0.001
Number of sessile serrated adenomas resected	Quadratic trend model	29.5	0.486	0.343	0.88	31.6	0.001
Mean polyp size (mm)	S-curve trend model	2.98	0.097	0.017	0.61	7.37	0.024
Recurrence at the time of first surveillance endoscopy	Quadratic trend model	28.14	0.376	0.150	0.23	3.32	0.111
Number of Adenomas resected	S-curve trend model	12.7	0.266	0.13	0.92	45.57	< 0.001
Level 2 polypectomy	S-curve trend model	11.07	0.188	0.053	0.98	361.33	< 0.001
Level 3 polypectomy	Linear tend model	10.58	0.224	0.074	0.97	131.99	< 0.001
Level 4 polypectomy	Quadratic trend model	11.79	0.196	0.058	0.93	54.78	< 0.001
EMRs not performed; patients referred for surgical resection (benign polyps)	Quadratic trend model	6.028	0.053	0.004	0.82	18.74	0.003
Complete eradication at the time of first surveillance endoscopy	S-curve trend model	14.08	0.245	0.144	0.8	17.2	0.003

**Table 3: Multivariate analysis using best-fit multiple logistic regression model:**

Risk factors for recurrent/residual adenoma	Odd ratio (OR)	P Value
20	3.18 (2.85, 16.55)	0.03
21 – 30	0.70 (0.31, 1.63)	0.41
31 – 40	1.13 (1.50, 4.69)	0.012
Argon plasma coagulation use (APC)	0.27 (0.07, 0.98)	0.047
Prophylactic end clips post EMR	1.04 (0.42, 2.59)	0.92



### DISCUSSION:

The UHL EMR information for large sessile polyps  $\geq 24$  mm displayed in this original copy shows that over a 10-year period, the amount of EMR methodology performed was multiplied by 10 and the presence of intermittent/remaining adenomatous tissue decreased from 34% of cases in the main year to 8.6% of cases in grade 9 [6]. This result was supported by a general rate of real disadvantages of 5%. None of these patients needed to be admitted or an employable mediator [7]. With respect to our situation, more patients were referred to in the group of patients who were not screened for careful resection due to specialized disorders ( $P = < 0.06$ ), who were not eligible for follow-up endoscopy due to fundamental co-morbidities ( $P = 0.019$ ) and whose adenoma at the EMR site at the time of the first endoscopic observation ( $P = < 0.002$ ) was repeated/filled following a left tumour at the time of primary endoscope examination [8]. Throughout the 10-year period, examination of the temporal pattern revealed an increase in the number of patients recognized for EMR each year, by comparing increases in the amount of successful EMRs performed each year ( $P = 0.002$ ), the mean size of the resected polyp ( $P = 0.025$ ), the amount of resected deisolated tooth adenomas ( $P = 0.002$ ) and the amount of levels 2, 3 and 5 polypectomies performed ( $P < 0.002$ ). A decrease in the amount of unrealized EMRs for type polyps was observed in patients who had undergone careful resection ( $P = 0.004$ ) [10].

### CONCLUSION:

The intermittent adenomas/lingering at the EMR site at the time of the main recognition endoscopy did not show a notable factual distinction based on the

examination of the temporal profile over this 10-year period ( $P = 0.112$ ).

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