Hybrid argon plasma coagulation-assisted endoscopic mucosal resection for large sessile colon polyps to reduce local recurrence: a prospective pilot study

INTRODUCTION

Endoscopic mucosal resection (EMR) is currently the standard therapy for the removal of large colon polyps. EMR is an endoscopic alternative to surgery and involves expansion of the submucosal space to create a plane for safe resection without injuring the underlying muscle tissue [1]. EMR has been shown to be cost effective, have a rapid recovery time, carry a low risk for adverse events, and achieve successful resection rates upwards of 85% [2–4]. The drawbacks of EMR include a 10%–30% recurrence rate at first surveillance, a 1%–2% perforation rate, and a 5%–10% delayed bleeding rate [3–5].

Although EMR continues to be the standard of care for removal of large laterally spreading lesions, investigations into adjunctive methods aimed at reducing the rates of recurrence and adverse events are crucial. As a result, many thermal ablation techniques have been used to eliminate macroscopic and microscopic disease at the edges of the post-EMR defect; however, their effects on recurrence and safety outcomes remain inconclusive.

A novel technique, hybrid argon plasma coagulation-assisted EMR (hAPC-EMR), utilizes a two-step process to ensure complete eradication of large colon polyps. The technique is derived from hAPC therapy for Barrett’s esophagus [6],
which the bed of previously treated areas is reinjected and re-
treated. Needleless injection with the hAPC catheter allows for
a reliable lift or fluid cushion between the mucosa and muscu-
laris propria in the submucosa, and avoids any extramural injec-
tion that can hinder resection [7, 8]. Following complete resec-
tion of the colon polyp, the submucosa undergoes repeat nee-
dless injection, followed by APC of both the edges and base of
the defect.

No prospective studies published to date have evaluated the
efficacy and safety of hAPC-EMR as the initial resection tech-
nique for removal of large colon polyps. We hypothesize that
the microscopic remnant disease that leads to high rates of re-
currence after EMR may actually lie at the base of the lesion as
well as at its edges, and that treating both the base and edges
of the defect with hAPC will reduce recurrence. In the present
report, we describe a prospective, single-center pilot study
aimed at assessing the recurrence rate and safety of this novel
hAPC-EMR technique.

Methods

Study design

This was a prospective, single-center, pilot study assessing the
recurrence rate and safety of hAPC-EMR for the removal of
large sessile colonic polyps. The study was approved by the
Penn State College of Medicine/Penn State Health Institutional
Review Board. All authors had access to the raw study data, and
reviewed and approved the final manuscript.

Patients and lesions

Patients were considered eligible for inclusion in the study if
they met the following criteria: age > 18 to <89 years, with at
least one large (≥20 mm) nonpedunculated polyp, and ability
to provide informed consent. Patients were excluded from the
study if they had any of the following: biopsy-proven invasive
carcinoma, pedunculated polyps (Paris classification type Ip or
Isp), ulcerated depressed lesions (Paris classification type III),
lesions meeting Narrow-band imaging (NBI) International Colo-
rectal Endoscopic (NICE) classification type 3 criteria, inflam-
matory bowel disease, poor general health (American Society
of Anesthesiologists class > 3), coagulopathy (international nor-
malized ratio >1.5 or platelets <10), poor bowel preparation,
target sign or perforation during initial EMR, need for endo-
scopic submucosal dissection or complete resection prior to
APC, or patients who were pregnant and/or breastfeeding.

Consent and basic demographic details were obtained by
the principal investigator or research coordinator in the prepro-
cedure area prior to bringing the patient to the endoscopy
room. Patients were informed that the colonoscopy procedure
would take place even if they chose not to participate in the vo-
luntary research study.

Procedure

All study colonoscopies were performed by two experienced
therapeutic endoscopists using Olympus 190 high definition
colonoscopes with digital chromoendoscopy capability (Olym-
pus, Tokyo, Japan). Before the endoscopy procedure, patients
underwent a standard split-dose bowel preparation. During
the procedure, each polyp was identified using conventional
colonoscopic views, and polyp characteristics were recorded in
the electronic endoscopy recording system. White-light ima-
ging and NBI with near focus were used to evaluate the mor-
phology of each polyp according to the Paris classification [9]
and to assess for submucosal invasion based on NICE classifica-
tion criteria [10].

After identification and evaluation of the polyp for inclusion
in the study (Fig. 1a), each eligible polyp underwent needle-
less injection in order to lift the polyp away from the muscularis
propria (Fig. 1b). The injectate was either a colloid mixture
(half sodium chloride 0.9% + half hetastarch) or sodium chlori-
de 0.9% alone, according to endoscopist preference. Polyps
were resected using an electrocautery snare until complete re-
section was achieved (Fig. 1c). Following complete resection,
the submucosal defect was visualized with white light and NBI
before being reinjected with the same injectate solution to al-
low the base to be lifted. The polypectomy base and peripheral
edges were then thermally ablated using hAPC with a flow of
0.8 L/min and 40 watts (Fig. 1d).

All polyp tissue was retrieved for histopathological evaluati-
on. The resection base was closed using endoscopic clips ac-
cording to the endoscopist’s usual practice; however, by the
end of the trial, only polyps in the cecum and ascending colon

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were closed based on evidence from the CLIP randomized controlled trial (RCT) [11]. Patients were monitored continuously throughout the procedure, as is standard of care during any routine colonoscopy, and monitored for any adverse events in the recovery room prior to discharge.

**Standardized surveillance protocol**

At 30 days following the initial resection, the research coordinator telephoned each patient to assess for any signs of post-procedural adverse events such as post-polypectomy bleeding (PPB) and post-polypectomy syndrome (PPS). Approximately 6 months after the initial resection, patients underwent a surveillance colonoscopy. The site of the previous resection was identified using the polypectomy scar or previous tattoo, and targeted biopsy was performed. All biopsy specimens were sent for histopathological evaluation to confirm the absence of microscopic recurrent disease at follow-up.

**Study end points**

The primary end point of the study was the local recurrence rate at the 6-month surveillance colonoscopy. Secondary study end points included rates of PPS and PPB. PPS was defined as colonic wall injury from electrocoagulation that induced a transmural burn and localized peritoneal inflammation without radiographic imaging evidence of perforation [12]. Patients with PPS were identified by presentation of fever, leukocytosis, and/or abdominal pain within 1 week of colonoscopy. PPB was recorded as either immediate or delayed bleeding. Delayed PPB was defined as bleeding occurring within hours to 30 days post-procedure. Patients with delayed PPB presented with signs or symptoms of hematochezia, acute blood loss anemia, hemodynamic instability, and/or end-organ damage [13].

**Statistical analysis**

Statistical analysis was performed using SAS software version 9.4 (SAS Institute Inc., Cary, North Carolina, USA). Descriptive statistics were calculated for patient demographic details and polyp characteristics. Recurrence at 6 months and adverse events were described using frequencies. Study data were collected and managed using Research Electronic Data Capture (REDCap) electronic data capture tools hosted at the Penn State Health Milton S. Hershey Medical Center and College of Medicine [14, 15]. REDCap is a secure, web-based software platform designed to support data capture for research studies.

**Results**

**Patient demographics and polyp characteristics**

A total of 40 patients with 44 eligible polyps were included in the study. Enrolled patients were mostly male (62.5%) with a mean age of 64.6 (SD 7.8) years. Included polyps had a median size of 27 mm (interquartile range 14.5 mm) and were located in the ascending colon (cecum to the hepatic flexure; 65.9%), the transverse colon (to the splenic flexure; 22.7%), and the descending colon (11.4%). The majority of patients (82.5%) had endoscopic clips placed following hAPC treatment. Pathological analysis of the 44 polyps showed tubular adenomas (68.2%) or sessile serrated polyps (22.7%). Additional patient demographic details and polyp characteristics are shown in Table 1 and Table 2, respectively.

**Primary outcome**

At the time of writing, 32 patients (80%) with 35 treated study polyps (79.5%) completed the 6-month follow-up colonoscopy. Three patients were lost to follow-up, one patient withdrew for personal reasons, and four patients were still waiting for their colonoscopies to be rescheduled due to the COVID-19 pandemic. At follow-up, all 35 prior resection sites could be identi-
fied using standard colonoscopic views, and none showed evidence of visible or biopsy-proven recurrence.

Secondary outcome

Delayed PPB following the initial resection was experienced by three patients (7.5%; 95% CI 0.00–0.15). Each case required hospital admission for at least 1 day. One patient underwent an additional endoscopy with endoscopic clipping of a transverse colon ulcer, and one patient underwent colonoscopy with hemostatic spray for a bleeding vessel. No patients required blood transfusion and no patients experienced PPS.

Discussion

EMR is the established gold standard for removal of large laterally spreading lesions > 20 mm. The associated complication rate is relatively low, and previous studies have shown that EMR results in reduced rates of mortality, morbidity, and costs compared with surgical resection [5,16,17]. However, EMR alone has a high recurrence rate of up to 30% at 6 months, which is its main limitation. Routine surveillance has been shown to be effective at treating recurrence, although it is very burdensome for patients, increases morbidity rates, and was not found to be cost effective in previous reports [3,18].

In the present study, adherence to the surveillance colonoscopy at 6 months was low due to scheduling issues surrounding the SARS-CoV-2 outbreak. Therefore, based on decreased follow-up rates alone, it is becoming increasingly important to augment EMR to improve efficacy and reduce recurrence so that routine surveillance is required less frequently.

This prospective, single-arm, data-collection study assessing recurrence 6 months following hAPC-EMR resulted in a 0% local recurrence rate. Our study serves as a proof-of-concept pilot study suggesting that hAPC-EMR appears to offer a reduction in lesion recurrence rates when compared with conventional EMR technique, which has been used over the past 10 years. Secondary end points assessing PPB and PPS following hAPC-EMR revealed incidences of 7.5% and 0%, respectively, which are similar to rates seen with standard EMR [19]. While these results are attractive and suggest a reduction in recurrence using this technique, a larger RCT comparing hAPC-EMR with other ablative strategies, such as snare tip soft coagulation, will be required before definitive conclusions can be drawn.

We believe that the promising results shown with this technique are largely due to the needleless injection and hAPC application. Needleless injection allows for lifting of both the initial lesion and the post-polypectomy site without extramural injection. The second lift may be the critical step because it allows for safe ablation of the microscopic tissues thought to be the precursor of recurrent disease by preventing thermal injury from reaching the muscularis propria. Both the needleless injection and second lift offer added protection to the muscularis propria tissues and may help to reduce rates of PPB and PPS, as was suggested by our data. In addition, we believe that application of hAPC to both the base and edges of the post-polypectomy site may contribute to the reduced rate of recurrence seen in this study. Although there are increased costs associated with hAPC therapy, we believe that preventing recurrence is key in continuing to increase the value of EMR; doing so prevents additional endoscopy and further limits the need for endoscopic submucosal dissection and surgery.

Limitations

The present study has several notable limitations. The small sample size and nonrandomized, noncontrolled design limit our ability to draw major conclusions from the results. The protocol was written with the intention of being a pilot study, hence the small sample size. However, the pandemic further decreased the sample size of our primary analysis due to participant withdrawal. In addition, this study was conducted at a single endoscopy center by only two skilled endoscopists. A more robust, multicenter, RCT is needed before more definitive conclusions can be drawn.
Conclusion

In conclusion, this pilot study provides evidence to suggest that hAPC-EMR is safe and may result in improved recurrence rates compared with EMR alone. However, further investigation of hAPC-EMR, including larger RCTs, is recommended before definitive conclusions can be drawn.

Acknowledgments

The REDCap tools used in this project are supported by The Penn State Clinical & Translational Research Institute, Pennsylvania State University CTSA, NIH/NCATS Grant Number UL1 TR002014.

Funding

ClinicalTrials.gov (http://www.clinicaltrials.gov/) | Prospective, single-center, pilot study | NCT03390907

Competing interests

The authors declare that they have no conflict of interest.

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