



UNITED GASTROENTEROLOGISTS

Patient Education Sheet

COLON POLYPS OVERVIEW

The presence of polyps in the colon or rectum often raises questions for patients and their family. What is the significance of finding a polyp? Does this mean that I have, or will develop, colon or rectal (colorectal) cancer? Will a polyp require surgery?

Some types of polyps (called adenomas) have the potential to become cancerous while others (hyperplastic or inflammatory polyps) have virtually no chance of becoming cancerous.

When discussing colon polyps, the following points should be considered:

- Polyps are common (they occur in 30 to 50 percent of adults)
- Not all polyps will become cancer
- Polyps can be completely and safely removed

The best course of action when a polyp is found depends upon the number, type, size, and location of the polyp. People who have an adenoma removed will require a follow up examination; new polyps may develop over time that need to be removed.

COLON POLYP CAUSES — Polyps are very common in men and women of all races who live in industrialized countries, suggesting that dietary and environmental factors play a role in their development.

Lifestyle — Although the exact causes are not completely understood, lifestyle risk factors include the following:

- A high fat diet
- A diet high in red meat
- A low fiber diet
- Cigarette smoking
- Obesity

Ageing — Colorectal cancer is uncommon before age 40. Ninety percent of cases occur after age 50, with men and women being similarly affected; therefore, colon cancer screening is usually recommended starting at age 50 for both sexes.

Family history and genetics — Polyps and colon cancer tend to run in families, suggesting that genetic factors are also important in their development.

Any history of colon polyps or colon cancer in the family should be discussed with a healthcare provider, particularly if cancer developed at an early age, in close relatives, or in multiple family members. As a general rule, screening for colon cancer begins at an earlier age in people with a family history of cancer or polyps.

Rare genetic diseases can cause high rates of colorectal cancer relatively early in adult life. One such disease, called familial adenomatous polyposis (FAP), causes multiple colon polyps. Another, Hereditary Non-Polyposis Colon Cancer (HNPCC), increases the risk of colon cancer, often beginning in the 20s and 30s, but does not cause a large number of polyps. Testing for these genes may be recommended for families with high rates of colorectal cancer, but is not generally recommended for other groups.

TYPES OF COLON POLYPS — The most common types of polyps are hyperplastic and adenomatous polyps. Other types of polyps can also be found in the colon, although these are far less common and are not discussed here.

Hyperplastic polyps — Hyperplastic polyps are usually small, located in the end-portion of the colon (the rectum and sigmoid colon), have **no** potential to become malignant, and are not worrisome. It is not always possible to distinguish a hyperplastic polyp from an adenomatous polyp based upon appearance during colonoscopy, which means that hyperplastic polyps are often removed or biopsied to allow microscopic examination.

Adenomatous polyps — Two-thirds of colon polyps are adenomas. Most of these polyps do not develop into cancer, although they have the potential to become cancerous. Adenomas are classified by their size, general appearance, and their specific features as seen under the microscope.

As a general rule, the larger the adenoma, the more likely it is to eventually become a cancer. As a result, large polyps are usually removed completely to allow for microscopic examination.

Malignant polyps — Polyps that contain pre-cancerous or cancerous cells are known as malignant polyps. The optimal treatment for malignant polyps depends upon the extent of the cancer (when examined with a microscope) and other individual factors.

COLON POLYP DIAGNOSIS — Polyps usually do not cause symptoms but may be detected during a colon cancer screening examination or after a positive fecal occult blood test. Polyps can also be detected on a [barium](#) enema x-ray, although small polyps are more difficult to see with x-ray.

Colonoscopy is the best way to evaluate the colon because it allows the physician to see the entire lining of the colon and remove any polyps that are found. During colonoscopy, a physician inserts a very thin flexible tube with a light source and small camera into the anus. The tube is advanced through the entire length of the large intestine (colon.)

The inside of the colon is a tube-like structure with a flat surface with curved folds. A polyp appears as a lump that protrudes into the inside of the colon. The tissue covering a polyp may look the same as normal colon tissue, or, there may be tissue changes ranging from subtle color changes to ulceration and bleeding. Some polyps are flat ("sessile") and others extend out on a stalk ("pedunculated").

Colonoscopy is also the best test for the follow-up examination of polyps.

COLON POLYP REMOVAL — **Colorectal cancer is the second leading cause of cancer deaths in the United States**, accounting for 14 percent of cancer deaths. **Colorectal cancer is preventable if precancerous polyps (ie, adenomas) are detected and removed before they become malignant (cancerous).** Over time, small polyps can change their structure and become cancerous. Polyps are usually removed when they are found on colonoscopy, which eliminates the chance for that polyp to become cancerous.

Procedure — The medical term for removing polyps is polypectomy. Most polypectomies can be performed through a colonoscope. Small polyps can be removed with an instrument that is inserted through the colonoscope and snips off small pieces of tissue. Larger polyps are usually removed by placing a noose, or snare, around the polyp base and burning through it with electric cautery. The cautery also helps to stop bleeding after the polyp is removed.

Polyp removal is not painful because the lining of the colon does not have the ability to feel pain. In addition, a sedative medication is given before the colonoscopy to prevent pain caused by stretching of the colon. Rarely, a polyp will be too large to remove during colonoscopy, which means that a surgical procedure will be needed at a later time.

Complications — Polypectomy is safe although it has a few potential risks and complications. The most common complications are bleeding and perforation (creating a hole in the colon). Fortunately, this occurs infrequently (one in 1000 patients having colonoscopy). Bleeding can usually be controlled during colonoscopy by cauterizing (applying heat) to the bleeding site; surgery is sometimes required for perforation.

After polyp removal — Medications that can increase bleeding, including aspirin, [ibuprofen](#) (Advil®, Motrin®), and [naproxen](#) (Aleve®), should be avoided for approximately two weeks after polypectomy. [Acetaminophen](#) (Tylenol®) is safe to take. People who

require anticoagulant medications such as [warfarin](#) (Coumadin®) should discuss how and when to resume this medication with their clinician.

A follow up appointment is usually scheduled after the polyp removal to discuss the results of the tissue analysis and the need for a repeat examination.

COLON POLYP PREVENTION

Follow up examination — People with adenomatous polyps have an increased risk of developing more polyps, which are likely to be adenomatous. There is a 25 to 30 percent chance that adenomas will be present on a repeat colonoscopy done three years after the initial polypectomy. Some of these polyps may have been present during the original examination, but were too small to detect. Other new polyps may also have developed.

After polyps are removed, repeat colonoscopy is recommended, usually three to five years after the initial colonoscopy. However, this time interval depends upon several factors:

- Microscopic characteristics of the polyp
- Number and size of the polyps
- The appearance of the colon during the colonoscopy. A bowel preparation is needed before colonoscopy to remove all traces of feces (stool). If the bowel prep was not completed, feces may remain in the colon, making it more difficult to see small to moderate size polyps. In this situation, follow up colonoscopy may be recommended sooner than three to five years later.

Persons who undergo screening (and re-screening) for colon cancer are much less likely to die from colon cancer. Thus, following screening guidelines is one of the most important measures.

Preventing colon cancer — Intensive research is underway to develop ways to prevent polyps and colon cancer with diet or medications. A number of nutrients and medications have been identified that may reduce the risk of colon cancer. Guidelines issued by one of the major medical societies in the United States (the American College of Gastroenterology) suggest the following to prevent polyps from recurring:

- **Eat a diet that is low in fat and high in fruits, vegetables, and fiber**
- **Maintain a normal body weight**
- **Avoid smoking and excessive alcohol use**

IMPLICATIONS FOR THE FAMILY — First-degree relatives (a parent, brother, sister, or child) of a person who has been diagnosed with an adenomatous polyp (or colorectal cancer) before the age of 60 years have an increased risk of developing adenomatous polyps and colorectal cancer compared to the general population. Thus, family should be made aware if the person is diagnosed with an adenoma or colon cancer.

While screening for polyps and cancer is recommended for everyone (typically beginning at age 50), those at increased risk should begin screening earlier, typically at age 40. The best test for screening in people with an increased risk of cancer is not known, although a sensitive test (such as colonoscopy) is usually recommended.

Relatives can be told the following:

- People who have one first-degree relative (parent, brother, sister, or child) with colorectal cancer or an adenomatous polyps at a young age (before the age of 60 years), or two first-degree relatives diagnosed at any age, should begin screening for colon cancer earlier, typically at age 40, or 10 years younger than the earliest diagnosis in their family, whichever comes first. Screening usually includes colonoscopy, which should be repeated every five years.

- People who have one first-degree relative (parent, brother, sister, or child) with colorectal cancer or an adenomatous polyp at age 60 or later should begin screening at age 40. If the examination shows no polyps, it should be repeated similar to a person with an average risk of colon cancer.)
- People with a second-degree relative (grandparent, aunt, or uncle) or third-degree relative (great-grandparent or cousin) with colorectal cancer should be screened for colon cancer similar to a person with an average risk.
- Some conditions, such as hereditary nonpolyposis colorectal cancer, familial adenomatous polyposis, and inflammatory bowel disease (eg, ulcerative colitis, Crohn's disease) significantly increase the risk of colon polyps or cancer in family members. Colon cancer screening in this group is discussed separately.

WHERE TO GET MORE INFORMATION — Your healthcare provider is the best source of information for questions and concerns related to your medical problem.

For more information visit www.uptodate.com/patients



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