
Between snare and surgery

INVITERT KOMMENTAR

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The author has completed the ICMJE form and declares the following conflict of interest: he has participated in a course under the auspices of Olympus.

The introduction of colorectal screening at population level has led to more polyps being detected. This also increases the need for new and improved treatment techniques.

Norway has one of the highest incidences of colorectal cancer in the world, with around 4000 new cases each year [\(1\)](#). Surgical resection combined with adjuvant chemotherapy is the main curative treatment and has considerably increased survival rates. However, patients in the pre-cancerous stage of the disease receive the same treatment. This is overtreatment. Not only is it costly for the health service, but patients are also exposed to increased risks, and in some cases can experience reduced organ function.

Nilsen et al. now present an article in this issue of the Journal of the Norwegian Medical Association, based on registry information from 2008–21, showing that a considerable number of benign colorectal polyps were removed by surgical resection [\(2\)](#).

In several of the regional health trusts, almost twice the number of patients underwent colonoscopy in 2021 than in 2008, and more than twice as many polyps were detected. Despite the fact that the majority of benign polyps can be resected using endoscopic techniques, there was an increase in the number that were resected surgically. There may be various reasons for this, but insufficient competence in endoscopic assessment and treatment of large polyps, as well as uncertainty as to whether it is possible to perform a polypectomy within the

time set aside for colonoscopy, can result in the patient being referred for surgery instead of for endoscopic resection. The continuation of this practice is probably also due to a lack of procedural codes and reimbursement for endoscopic resection, as well as production pressure that does not encourage time-consuming procedures.

Why are the authors concerned with this? Because there are other treatment modalities that yield equally good or better results with fewer complications and at lower costs. The techniques can be summarised as endoscopic resection techniques, and include endoscopic mucosal resection, endoscopic submucosal dissection and endoscopic full thickness resection. These methods require specific skills in endoscopic assessment of large polyps, and not least in performing the endoscopic resection. Nor are they entirely free from complications. Post-polypectomy bleeding is a known phenomenon, particularly in combination with anticoagulants and antiplatelet agents.

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The colorectal screening programme for the age group 55–65 years has been established in the past two years (3). The programme sets new requirements for dealing with the increased number of advanced polyps that are being discovered. Overtreatment or incomplete endoscopic resection of polyps may reduce the health benefits of screening. Thus, we see a considerable need for treatment techniques that lie somewhere between 'snare and surgery'. Endoscopists have become more aware that polyps that are resected must be examined by a pathologist, and that the pathologist's assessment has an impact on the further follow-up of the patient. For example, large polyps that are resected 'piecemeal' will require far more frequent colonoscopy check-ups than if the same polyp is resected en bloc. In addition to polyps that are discovered through the screening programme, we find a large proportion of advanced polyps in patients over the age of 75 years. For this group, endoscopic resection will allow for treatment of advanced polyps with lower risk and preservation of organ function.

Bærum Hospital was a test centre during the development of the colorectal screening programme. It is no coincidence that the initiative to provide better endoscopic treatment of colorectal polyps stems from Bærum Hospital and Akershus University Hospital, both of which are pioneers in the development of endoscopic treatment of advanced colorectal polyps in Norway (3). The Medical Department at Bærum Hospital has acquired a high level of expertise and the management have created opportunities for important professional development in Norway. By focusing on endoscopic techniques and adopting Japanese endoscopic assessment methods and dissection techniques, they are now contributing to professional development in endoscopic therapy, so that this type of treatment can benefit more patients.

Establishment of multidisciplinary meetings, training in dissection techniques on models, and registration of results in a prospective register inspired by a French model, are underway. Time will tell whether we can also achieve highly specialised endoscopic therapy in Norway. To achieve this goal, we must acknowledge where we are on the learning curve, and ensure that managers recognise the potential of endoscopic therapy, which requires planned competence building that goes beyond normal colonoscopy training.

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Publisert: 4. September 2024. *Tidsskr Nor Legeforen*. DOI: 10.4045/tidsskr.24.0430
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