- Pseudopolyps = inflammatory polyp
- Causes: UC, crohn, any colitis
- Benign (not premalignant)
- Morphology: pedunculated, sessile
- < 2 cm
- multiple, may extensive and mimic FAP

TTT: **treat the cause of colitis**

- Medical: infliximab in crohn
  OR
  Budesonide enema

Endoscopy: Polypectomy, ablation, electrocautary in case of Bleeding

surgery: 1 When Endoscopy fail
2- when there is obstruction
from resection of segment to hemicolectomy

Hamartomatous Polyps

Juvenile

- sporadic or familial
- pedunculated
- Rectosigmoid
- not pre-malignant
- highly vascular → can cause hematochezia
- intussuception
- Tt: polypectomy

- FJP
  - AD
  - premalignant to adenoma
  - screening annually at 10-12y
  - Tt: surgery according to degree of involvement

Peutz-jegur

- AD
- pedunculated, sessile, lobulated
- 1-20 poly on each segment
- jujenum
- 0.1 cm to >5cm
- Macular dark melanin deposits in Mucosal membrane

↑risk for Colorectal CA

- Risk of BC, ovary CA
  - screening: by endoscopy, colonoscopy at 20y and annually flexible sigmoidoscopy

Tt: surgery for obstruction and bleeding

Gastric Polyps

Hyperplastic polyps

- ass H.pylori / atrophic gastritis

Fundic gland polyps

- ass long use of PPI
- more in female

adenoma

- may be part of FAP if young age
- more in male

- all mostly asymptomatic

The most common complaints associated with the finding of gastric polyps are dyspepsia, acid reflux, heartburn, abdominal pain, early satiety, gastric outlet obstruction, gastrointestinal bleed, iron deficiency anemia and fatigue.

- Gold standard for Dx : Upper endoscopy

- Removed by EMR (endoscopic Mucosal Resection) then Biopsyed :

if GHP → Repeat endoscopy after one year and if there is H.pylori after 3month to confirm eradication

if FGP → if >5-10 mm → endoscopy after 1 year.

if adenoma at young age → family history and colonoscopy to exclude FAP

small intestines Polyp

1) Adenoma M.C tend to be villous than in colon
- distal duodenum, apulla, periampulla

2) Brunner gland hyperplasia or Hamartoma.

Peptic Duodenitis

nodular dudenitis → in Endoscopy

3- Periampullary mycopethelial hamartoma (Adenomyom)
- asymptomatic
- intermitten Biliary, pancreatic obstruction
- sessile, pedunculated
- affect male and female equally

4- Cronkhite–Canada syndrome : Polypoid diffuse mucosal thickening
↳ Hamartoma polyp
- alopecia, hyperpigmentation, atrophy of nails
- M:F 2:1
- Age 50–70

There are certain anatomic characteristics of the duodenum that make endoscopic resection of duodenal lesions challenging. These factors include:
1- a narrow lumen
2- a “C-loop” that makes maintaining endoscope position difficult
3- Brunner’s glands in the submucosal layer that stiffen the wall and make mucosal lifting difficult
4- a thin deep muscle layer that results in a higher rate of perforation
5- the duodenum has an extensive vascular network supplied by the gastroduodenal artery that increases the risk of bleeding, which can be severe and potentially life-threatening.

Symptoms that have been attributed to small bowel polyps include

- Dyspepsia.
- Abdominal pain.
- Overt gastrointestinal bleeding.
- Intussusception.
- Obstruction.

Methods of Resection

1- Double baloon enteroscopy : complication - Bleeding
- Perforation
- Pancreatitis

2- Endoscopic Mucosal Resection : submucosal injection of HPMC (Hydroxypropyl Methyl cellulase) to be separated from Muscularis Propria

Two ways.

1- with suction

2- without section