

Cold snaring for small polyps or serrated polyps: Is this the answer?

Ingo Steinbrück

UEG Week Berlin 2025

Presentation

October 6, 2025

The speakers present evidence supporting cold snare polypectomy as the preferred technique for small colorectal polyps (below 10 mm) based on ESG guidelines, with particular emphasis on safety advantages for delayed bleeding and technical considerations for sessile serrated lesions.

KEY POINTS

- ESG guidelines strongly recommend cold snare resection for both diminutive polyps (under 6 mm) and polyps 6-9 mm, supported by high-quality evidence from multiple randomised controlled trials.
- A 2025 meta-analysis of 14 RCTs including over 15,000 polyps found that cold snare polypectomy achieves equivalent complete resection rates to hot snare but with significantly lower delayed bleeding risk; a retrospective study reported post-polypectomy bleeding rates of 0.1% for cold snare versus 0.56% for hot snare.
- For polyps 3-5 mm, an RCT reported that cold snare achieved en bloc resection in 99.3% versus 80% with biopsy forceps and complete resection with free margins in 80.4% versus 47.4%.
- For sessile serrated lesions, the speaker recommends cold snare piecemeal resection for non-dysplastic lesions, emphasizing the importance of lifting with dilute blue dye to delineate the characteristically indistinct borders and using a dedicated cold snare no larger than 10 mm.
- Sessile serrated lesions with dysplasia require radical resection of the dysplastic component because the speaker stated that epidemiologic data estimate progression from dysplastic SSL to carcinoma in as little as six months, with high risk of post-colonoscopy colorectal cancer if incompletely resected.
- The speaker noted that even in highly experienced hands, recurrence rates for large sessile serrated lesions after cold snare resection were around 10%, underscoring the need for meticulous technique and careful post-resection inspection of margins.

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