

# Spot<sup>®</sup>Ex

## Endoscopic Tattoo

### GASTROENTEROLOGY

Guidelines to ensure effective and reliable endoscopic tattooing for clinical surveillance and surgical localization.

#### Who wrote it?

US Multi Society Task Force on Colorectal Cancer. Nine gastroenterology specialists who represent:

- American College of Gastroenterology.
- American Gastroenterological Association.
- American Society for Gastrointestinal Endoscopy.

#### Objective:

- To provide recommendations to optimize the complete and safe endoscopic removal techniques for colorectal lesions, based on available literature.

#### Methods:

- Guidance statements were developed by a consensus process through email correspondence and multiple teleconferences.
- The final manuscripts were reviewed and approved by the governing boards of the three participating societies.

## New 2022 Guidelines for Endoscopic Removal of Colorectal Lesions<sup>1</sup>

### Documenting Lesion Marking

Documentation of the details of the tattoo injection (i.e., material, volume, position relative to the lesions) in the colonoscopy report, as well as photo documentation of the tattoo in relation to the colorectal lesion is recommended.

### The Bleb Technique

To ensure the tattoo injection is created safely within the submucosa, it is safest to first create a submucosal bleb using saline and then once the submucosal plane is confirmed, switch to the tattoo injection and inject a volume of at least 0.5-0.75 mL at each site.

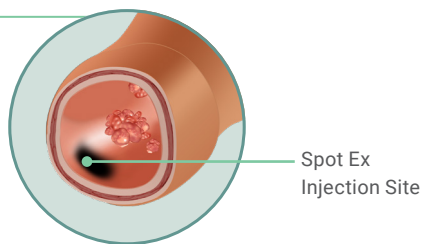
We recommend the use of tattoo, using sterile carbon particle suspension, to demarcate any lesion that may require localization at future endoscopic or surgical procedures<sup>1</sup>



# Guide to Endoscopic Tattooing

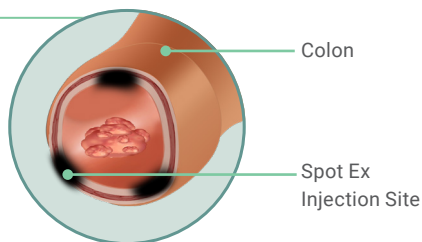
## Marking for EMR/ESD<sup>2</sup>

If the lesion is being marked for future endoscopic resection, place the tattoo on the same side of the bowel 3 cm distal.



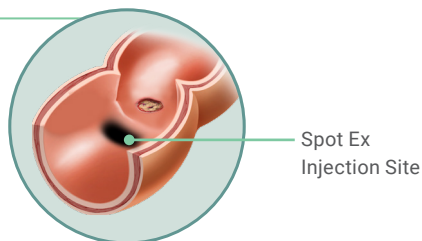
## Marking for Surgical Resection<sup>3</sup>

If the lesion is being marked for surgical resection, mark the lesion on the distal side and place the tattoos 2-3 cm from the lesion in 3-4 quadrants circumferentially.



## Marking for Surveillance of difficult to detect or large polyps<sup>3</sup>

After lesion removal, place one injection adjacent (next to site) to the resection defect. Location should be noted on the endoscopy report.



“We suggest endoscopists and surgeons establish a standard location of tattoo injection relative to the colorectal lesion site<sup>1</sup> of interest at their institution.”

## Surveillance: Post Colonic Lesion Removal Site<sup>3</sup>

- Intensive follow up in patients after piecemeal EMR (lesion 20 mm) with the first surveillance colonoscopy at 6 months, and the intervals for the next colonoscopy at 1 year and then 3 years.
- There is a very high prevalence of synchronous disease in patients with lesions 20 mm.
- To assess for local recurrence, careful examination of the post-mucosectomy scar site using enhanced imaging is recommended
- Local neoplastic recurrence after endoscopic resection of large colorectal lesions has been reported in several longitudinal outcome studies to be approximately 16%.
- In surveillance cases with suspected local recurrence, we suggest endoscopic resection therapy with repeat EMR, snare or avulsion method performed at 6-12 months until there's no local recurrence. After no sign of recurrence, follow ups are performed at 1-year and then 3-year intervals.

1. Kaltenbach, Tonya; Anderson, Joseph C; Burke, Carol A; Dominitz, Jason A; Gupta, Samir; Lieberman, David; Robertson, Douglas J; Shaukat, Aasma; Syngal, Sapna; Rex, Douglas K, The American Journal of Gastroenterology: March 2020 - Volume 115 - Issue 3 - p 435-464

2. Kaltenbach et al. Endoscopic Removal of Colorectal Lesions – Recommendations by the US Multi Society Task Force on Colorectal Cancer. Feb 2020

3. Medina-prado, et al. When and how to use endoscopic tattoo in the colon Clinical Gastroenterology and Hepatology 2021;19:1038–1050

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