Tattoo-Colonoscopy – Full Clinical Guideline - UHDB

Reference no.: CG – ENDO/2024/002

The following should be routinely tattooed

- Any cancer (apart from in the rectum/recto sigmoid junction)
- Any polyp >2cm
- Any polyp that has high risk features for malignancy (central depression, non-lifting kudo type V, crypt pattern.
- Any polyp that is likely to require surgical resection for other reasons
- Any polypectomy sites that will require 3 month site check, except when these are in the rectum
- Any polyp (apart from in the rectum) that is subsequently confirmed as adenocarcinoma on histology. A repeat procedure and tattooing to be requested and arranged urgently by the requesting consultant.
- All Caecal lesions (cancers and polyps fulfilling above criteria) should be tattooed

Technique

- Tattooing should be done with “Spot” ink
- Initial injection should be with saline to raise a bleb. This is to avoid injecting tattoo ink into peritoneum
- Spot can then be injected into the bleb and then flushed through with saline

The number of tattoos placed depends on the indication for tattooing

To mark an area for subsequent colonoscopy - 1 tattoo 3 cm below the lesion (anatomically distal) i.e. *closer to the anus*

To mark an area for subsequent surgery – 3 tattoos anatomically distal to the lesion i.e. *closer to the anus*. These should be 120 degrees apart and as close to lesion as possible, but separate from it (usually 3cm)

Tattooing of recto-sigmoid junction lesions is not required as the downstream/distil tattoo would lie in the rectum.

Tattooing is not recommended in the rectum because it might disrupt the mesorectal plane For all rectal lesions where tattooing not undertaken specify the distance from the anorectal junction (i.e. the top of the anal canal/top of the sphincters) as accurately as possible. A retroflexed photograph should also be taken of low rectal lesions, so that the relationship of the tumour to the anal verge can be clearly seen.

Documentation

The number and position of the tattoos relative to the lesion should be carefully documented in the endoscopy report with photographs if possible.

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