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Letter to the Editor

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Type C Mucosa in Pouch Surveillance: How Real is the Risk?

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Reply to:

Current Practices in Ileal Pouch Surveillance for Patients With Ulcerative Colitis: A Multinational, Retrospective Cohort Study. Samaan *et al*. *Journal of Crohn's and Colitis* 2019;**13**(6):735–43.

Dear Editors,

We read with great interest the article by Samaan *et al.*, reporting on pouch surveillance in a large cohort of inflammatory bowel disease [IBD] patients. Their primary findings were a wide variation in surveillance practice, with a relatively high rate of colorectal neoplasia development in low-risk patients. Therefore, the authors advocate for uniform pouch surveillance recommendations. We confirm the wide variety in pouch surveillance in our own cohort [27.4% >1 pouchoscopy/3 years, 21% <1 pouchoscopy/10 years] and endorse the need for uniform surveillance guidelines.[1]

Two low-risk patients out of 272 IBD patients with ileal pouch-anal anastomosis [IPAA] [0.7%] developed a pouch carcinoma in their cohort. Therefore, the authors recommend a more intensive pouch surveillance strategy in low-risk patients compared to current guidelines. They suggest a pouchoscopy 1 year after IPAA construction in order to stratify patients based upon the presence of type C pouch mucosa, characterized by persistent atrophy and inflammation.[2] A type C mucosa might be predictive for subsequent development of pouch neoplasia. However, we question the use of type C mucosa for risk stratification due to the following concerns.

First, there is no clear histological definition of type C mucosa. Villous surface density is used for grading, but quantitative cut-offs are not described.[2] The assessment of type C mucosa is not part of routine histological evaluation in most centres, and limits the implementation of this factor in daily practice. In addition, the evidence for type C mucosa as a high-risk feature for pouch neoplasia is based on a few now dated studies that reported conflicting results.[2–4] The reported neoplasia risk for type C mucosa varied between 0% and 71% in these studies.

Second, type C mucosa is frequently accompanied by severe pouch inflammation. It is thought that chronic pouch inflammation results in mucosal atrophy with subsequent malignant transformation.[3] However, in the two largest cohort studies to date [$n = 1200$ and $n = 3203$ patients], pouchitis was not identified as a risk factor for pouch neoplasia.[1]

Third, it is not clear in which time frame type C mucosa develops. As such, one may develop type C mucosa after the first pouchoscopy 1 year following IPAA construction. On the other hand, most patients with severe pouch atrophy immediately after ileostomy loop closure showed [partial] regression of the atrophic mucosa after 3 years of follow up.[2]

In conclusion, we confirm a wide variety in pouch surveillance as seen by the authors, emphasizing the pressing need for optimization and standardization of pouch surveillance practices. However, we advocate a different strategy as previously discussed, without stratification based on type C mucosa.[5]

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Conflict of Interest

The authors state no conflicts of interest.

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Author contributions

M.G.: letter design and drafting of the manuscript, final approval of the submitted version; F.H., L.D.: letter design and critical revision of the manuscript, final approval of the submitted version.

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