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Surveillance colonoscopy in patients with sessile serrated adenoma

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I read the scientifically significant paper by Park et al.[1] titled "Clinical outcomes of surveillance colonoscopy for patients with sessile serrated adenoma," which described endoscopic findings of sessile serrated adenoma (SSA) and clinicopathological results on surveillance colonoscopy for those patients. The authors showed that approximately two-thirds of SSAs were found in the proximal colon during complete colonoscopy, and that 5.8% of SSA patients were confirmed to have synchronous colorectal cancer (CRC) at baseline colonoscopy. Meanwhile, no metachronous cancer was detected during follow-up surveillance. The study highlighted the need for meticulous examination of the proximal colon to detect SSAs and confirmed that at least annual colonoscopy surveillance is not necessary in such patients.

In the past decade, the sessile serrated lesion has been an engaging topic of scientific interest as a premalignant lesion of CRC, and is known to be associated with interval cancer.

There is confusion about the nomenclature and pathologic criteria for a serrated lesion. The most commonly used terminology is that of the World Health Organization (WHO),[2] which has adopted the term "sessile serrated adenoma/polyp (SSA/P). The terms "sessile serrated adenoma (SSA)," "sessile serrated polyp," and "sessile serrated lesion" are considered synonymous and are widely accepted. However, "sessile serrated adenoma" without dysplasia does not exhibit true cytological dysplasia. I am curious about "UD, undetermined" SSA used in this article. I think that UD SSA may mean SSA/P without dysplasia.

This study highlights the interest in serrated polyps with regard to recently identified malignant potential and the need for surveillance. The data used to guide surveillance strategy followed by resection of SSA/P have been limited until now. There are no high-quality prospective data currently available or are likely to be available in the next few years. This study suggested that patients with SSAs do not need to be monitored by colonoscopy annually. In determining a surveillance interval, it is important to know how long after polypectomy the advanced polyps are found. The follow-up period in their study was less than 3 years on average and thus it seems difficult to determine the proper interval for surveillance colonoscopy to prevent new CRCs. Recent guidelines recommend that the surveillance interval should be based on polyp size and histology.[2-5] A U.S. Multi-Society Task Force guideline suggested 5-, 3-, and 1-year colonoscopic follow-up for SSA/P with no dysplasia, SSA/P with dysplasia or size ≥10 mm, and serrated polyposis syndrome, respectively. However, prospective data to support the surveillance intervals are lacking and these recommendations are based on expert opinion.

The data in this study showed a relatively high detection rate for SSA during surveillance colonoscopy despite short interval follow-up colonoscopy (total polyps: 44.8% at 1st follow-up, 47.4% at 2nd follow-up; SSA: 17.8% at 1st follow-up, 22% at 2nd follow-up). This finding may be due to missed lesions on screening colonoscopy for several reasons, as described by the authors (high-quality surveillance and resultant increase in detection rate, expertise of colonoscopists, and the extent of bowel preparation). However, incomplete resection could be another cause. The most common size of an SSA was 5 to 10 mm in this study, but nearly half of the

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lesions were resected using cold biopsy. Recent guidelines recommend that *en bloc* resection of a 6- to 9-mm colon polyp should be performed using snare polypectomy.[6]

In a recent Korean study, no SSA/P was detected during follow-up colonoscopy in patients who underwent endoscopic mucosal resection (mean follow-up duration, 11.8 month).[7]

Of note, SSAs are endoscopically characterized by a flat shape, an indiscrete edge, and color similar to the surrounding mucosa, and are often covered with mucus. These morphological features make it difficult to detect SSAs and is why we focus on the need for active surveillance in patients with SSAs. Although current screening and surveillance colonoscopy is proven to reduce CRC incidence and mortality, interval cancers following negative colonoscopy still contribute to CRC burden. Interval CRC is more likely found in the proximal colon and is related to microsatellite instability and CpG island methylator phenotype.[3] These clinical and biological features of interval cancers are also characteristic of the serrated pathway of CRC, starting with serrated adenomas.[8] Accordingly, a careful examination as well as an appropriate screening interval are warranted to find SSAs that can be missed and are likely to become interval cancers later. I am curious about the molecular characteristics of the 8 adenocarcinomas in this study.

In summary, Park et al.[1] supported current recommendations for the surveillance interval in patients with SSAs based on the descriptive analysis of surveillance outcomes. A high-quality prospective study is warranted to determine the optimal post-polypectomy surveillance protocol for SSA/P.

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CONFLICT OF INTEREST

No potential conflict of interest relevant to this article was reported.

AUTHOR CONTRIBUTION

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