Do SCENIC Guidelines Affect Terminology We Use for IBD Dysplasia? If So, Then What Should We Use?

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SCENIC Consensus

Surveillance for Colorectal Endoscopic Neoplasia Detection and Management in Inflammatory Bowel Disease Patients: International Consensus Recommendations

Gastroenterology 2015;148:639–651

CONSENSUS STATEMENT

SCENIC International Consensus Statement on Surveillance and Management of Dysplasia in Inflammatory Bowel Disease

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CONSENSUS STATEMENT

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SCENIC international consensus statement on surveillance and management of dysplasia in inflammatory bowel disease

Table 1. Terminology for Reporting Findings on Colonoscopic Surveillance of Patients With Inflammatory Bowel Disease (modified from Paris Classification[15])

Term	Definition
Visible dysplasia	Dysplasia identified on targeted biopsies from a lesion visualized at colonoscopy
Polypoid	Lesion protruding from the mucosa into the lumen ≥2.5 mm
Pedunculated	Lesion attached to the mucosa by a stalk
Sessile	Lesion not attached to the mucosa by a stalk: entire base is contiguous with the mucosa
Nonpolypoid	Lesion with little (<2.5 mm) or no protrusion above the mucosa
Superficial elevated	Lesion with protrusion but <2.5 mm above the lumen (less than the height of the closed cup of a biopsy forceps)
Flat	Lesion without protrusion above the mucosa
Depressed	Lesion with at least a portion depressed below the level of the mucosa
General descriptors	
Ulcerated	Ulceration (fibrinous-appearing base with depth) within the lesion
Border	
Distinct border	Lesion's border is discrete and can be distinguished from surrounding mucosa
Indistinct border	Lesion's border is not discrete and cannot be distinguished from surrounding mucosa
Invisible dysplasia	Dysplasia identified on random (non-targeted) biopsies of colon mucosa without a visible lesion

The terms "dysplasia-associated lesion or mass (DALM), adenoma-like, and non-adenoma-like" should be abandoned

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Table 2. Summary of Recommendations for Surveillance and Management of Dysplasia in Patients With Inflammatory Bowel Disease

Management of dysplasia discovered on surveillance colonoscopy

7. After complete removal of endoscopically resectable polypoid dysplastic lesions, surveillance colonoscopy is recommended rather than colectomy (strong recommendation, very low-quality evidence).
8. After complete removal of endoscopically resectable nonpolypoid dysplastic lesions, surveillance colonoscopy is suggested rather than colectomy (conditional recommendation, very low-quality evidence).
9. For patients with endoscopically invisible dysplasia (confirmed by a GI pathologist) referral is suggested to an endoscopist with expertise in IBD surveillance using chromoendoscopy with high-definition colonoscopy (conditional recommendation, very low-quality evidence).

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Survey Question 1

- According to the SCENIC guidelines in 2015, the terms “dysplasia-associated lesion or mass (DALM), adenoma-like and non-adenoma-like” should be abandoned.
- Has this recommendation for changes in endoscopic descriptors and patient management of IBD dysplasia changed the terminology you use in your reports for IBD-associated dysplasia?

Survey Results

Answer	Count	%
No, not at all	26	34
Yes	50	66
Total	**76**	**100**

Survey Question 2

- In a patient with ulcerative colitis, the endoscopist sends you targeted biopsies of a polypoid, pedunculated lesion and samples from the mucosa around the lesion. You see what looks like an adenoma, but it arises from the background of active ulcerative colitis. What do you report?

Survey Results

Answer	Count	%
Polypoid LGD	34	48
Adenoma	14	20
Adenoma/LGD	9	13
LGD	7	10
Adenoma-like LGD	3	4
LGD with a tubular architecture	1	1
Depends	1	1
Indefinite for dysplasia	1	1
DALM	1	1
Total	**71**	**100**

LGD: low-grade dysplasia

Survey Results

Answer	Count	Comment
Polypoid LGD	34	Arising in background of UC (8); sporadic adenoma vs IBD dysplasia (7); favor IBD dysplasia (3); see comment (3); favor sporadic adenoma (2); IHC to confirm IBD dysplasia (1)
Adenoma	14	Arising in background of UC (7); may represent IBD dysplasia (1); see comment (1)
Adenoma/LGD	9	Sporadic adenoma vs IBD dysplasia (2); arising in background of UC (2); favor IBD dysplasia (1); see comment (1)
LGD	7	Sporadic adenoma vs IBD dysplasia (3); clinically polypoid (1); see comment (1)
Adenoma-like LGD	3	Sporadic adenoma vs IBD dysplasia (1)
LGD with a tubular architecture	1	
Depends	1	
Indefinite for dysplasia	1	
DALM	1	
Total	**71**	

Survey Question 3

- If the endoscopist sends you targeted biopsies of what was a flat lesion and you see low-grade dysplasia arising from active ulcerative colitis, what do you report?

Survey Results

Answer	Count	%
LGD	54	76
Flat LGD	6	9
Adenoma/LGD	4	6
Adenomatous mucosa	3	4
Adenoma-like LGD	1	1
Non-polypoid LGD	1	1
LG dysplastic lesion	1	1
Depends	1	1
Total	**71**	**100**

Survey Results

Answer	Count	Comment
LGD	54	Arising in background of UC (16); IBD-associated (3); likely IBD-associated (2); IBD dysplasia vs sporadic adenoma (2); IHC to confirm IBD dysplasia (1); May not be completely excised because it is flat (1); see comment (1)
Flat LGD	6	Arising in background of UC (2)
Adenoma/LGD	4	Arising in background of UC (2); sporadic adenoma vs IBD dysplasia (1)
Adenomatous mucosa	3	Arising in background of UC (1); see comment (1)
Adenoma-like LGD	1	
Non-polypoid LGD	1	
LG dysplastic lesion	1	Sporadic adenoma vs IBD dysplasia
Depends	1	
Total	**71**	

Our Answers to Survey Questions at UCLA

- Question #1: According to the SCENIC guidelines in 2015, the terms “dysplasia-associated lesion or mass (DALM), adenoma-like and non-adenoma-like” should be abandoned. Has this recommendation for changes in endoscopic descriptors and patient management of IBD dysplasia changed the terminology you use in your reports for IBD-associated dysplasia?
  - Yes and No
  - The terminology “DALM” has already been abandoned before the SCENIC consensus in our institution

Question #2:

- In a patient with ulcerative colitis, the endoscopist sends you targeted biopsies of a polypoid, pedunculated lesion and samples from the mucosa around the lesion. You see what looks like an adenoma, but it arises from the background of active ulcerative colitis. What do you report?

Histopathologic Diagnoses of Colorectal Polyps in Patients Undergoing Endoscopic Surveillance for Ulcerative Colitis during 2016-2018 at UCLA (n=368)

Diagnosis	N (%)		Diagnosis	N (%)
Inflammatory polyp / pseudopolyp	167 (45)		LGD favor sporadic adenoma****	1 (0.3)
Adenoma*	85 (23)		LGD/LG adenomatous change****	1 (0.3)
Hyperplastic polyp	83 (23)		Invasive carcinoma arising in a serrated polyp	1 (0.3)
SSA/P**	13 (4)		Low-grade NET (carcinoid)	1 (0.3)
Lymphoid aggregates	10 (3)		Submucosal lipoma	1 (0.3)
Mucosal prolapse	2 (0.5)		Pneumatosis	1 (0.3)
LGD with tubulovillous architecture***	2 (0.5)			

*TA=77, TVA=7, VA=1, with focal HGD=3
**One with focal LG cytologic dysplasia
***Both diagnosed in 2016, one with focal HGD
****Diagnosed in 2016

Our Answers to Question #2 at UCLA

- In a patient with ulcerative colitis, the endoscopist sends you targeted biopsies of a polypoid, pedunculated lesion and samples from the mucosa around the lesion. You see what looks like an adenoma, but it arises from the background of active ulcerative colitis. What do you report?
  - Adenoma

Question #3

- If the endoscopist sends you targeted biopsies of what was a flat lesion and you see low-grade dysplasia arising from active ulcerative colitis, what do you report?

Histopathologic Diagnosis of Low-grade Dysplasia in Colorectal Biopsies from Patients Undergoing Endoscopic Surveillance for Ulcerative Colitis during 2016-2018 at UCLA (n=19)

Diagnosis	N (%)	Endoscopy
LGD*	15 (79)	Random biopsy
LGD with tubulovillous architecture with focal HGD**	1 (5)	Polypectomy
LGD with tubulovillous architecture**	1 (5)	Targeted biopsy of a 12 cm polypoid lesion
LGD favor sporadic adenoma**	1 (5)	Polypectomy
LGD/LG adenomatous change**	1 (5)	Polypectomy

*One with extensive HGD, one with invasive adenocarcinoma in a separate biopsy from a mass lesion
**All diagnosed in 2016

Our Answers to Question #3 at UCLA

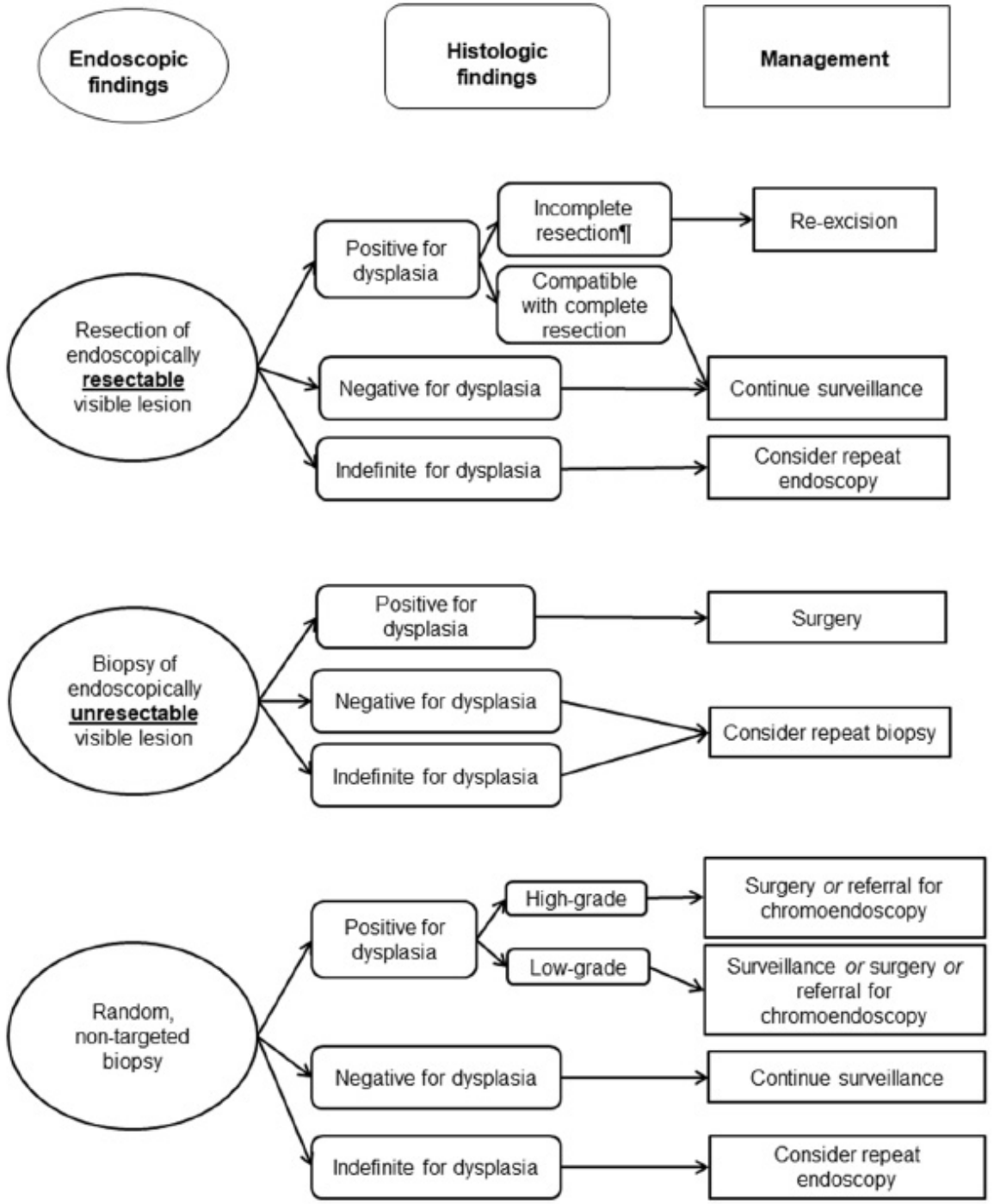
- If the endoscopist sends you targeted biopsies of what was a flat lesion and you see low-grade dysplasia arising from active ulcerative colitis, what do you report?
  - Low-grade dysplasia

Total Colectomies for Ulcerative Colitis during 2016-2018 at UCLA (n=51)

Indication	N (%)	Preoperative Biopsy/Polypectomy	Postoperative Diagnosis
Refractory UC	36 (71)	No dysplasia/adenoma	Focal LGD (1)
Dysplasia/malignancy	15 (29)	Multifocal LGD	Focal LGD
		Multifocal LGD	Multifocal HGD
		Multifocal LGD	Invasive adenocarcinoma
		Extensive HGD	3 foci of invasive adenocarcinoma
		At least HGD	Invasive adenocarcinoma
		LGD with tubulovillous architecture (12 cm polypoid lesion); also LGD on random bx	Villous adenoma
		Villous adenoma (2 cm sessile polyp)	No residual adenoma, no dysplasia
		TVA with HGD (6.1 cm mass)	Invasive adenocarcinoma
		Invasive adenocarcinoma arising in a 1.5 cm serrated polyp	No residual carcinoma or dysplasia
		Atypical cells concerning for adenocarcinoma (13 cm mass)	Mucinous adenocarcinoma
		Adenocarcinoma (5.5 cm mass), also LGD on random bx	HG neuroendocrine carcinoma
		Invasive adenocarcinoma (2.8 cm mass)	No residual carcinoma or dysplasia (s/p neoadjuvant chemotherapy)
		Invasive adenocarcinoma (3 cm mass), also TVA with HGD	Invasive adenocarcinoma
		Invasive adenocarcinoma (2 cm mass), also HGD on random bx	Invasive adenocarcinoma
		Invasive adenocarcinoma (4.1 cm mass)	PD neuroendocrine carcinoma

Sporadic Adenoma vs Polypoid IBD Dysplasia

- Histologic distinction is unreliable or impossible
- Continued endoscopic surveillance is appropriate if a polypoid lesion is completely excised endoscopically



Chiu K, et al. Mod Pathol 2018; 31:1180-90

THANK YOU!