Dysplastic area in ulcerative Colitis Radical Colectomty or Conservative

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- The incidence of colon cancer is increased in ulcerative colitis (UC).
- It is estimated to occur in 1 of 333 to 1 of 400 patient-years.
- Approximately 18% of patients with an intact colon may develop colon cancer after 30 years of disease

Factors associated with an increased risk

- long duration of colitis
- extensive colonic involvement
- primary sclerosing cholangitis
- a family history of colorectal cancer

and according to some studies

- early disease onset
- more severely active inflammation

- One of the main objectives of physicians in patients with UC is to detect neoplasia at a surgically curative and preferably preinvasive stage, **Dysplasia**

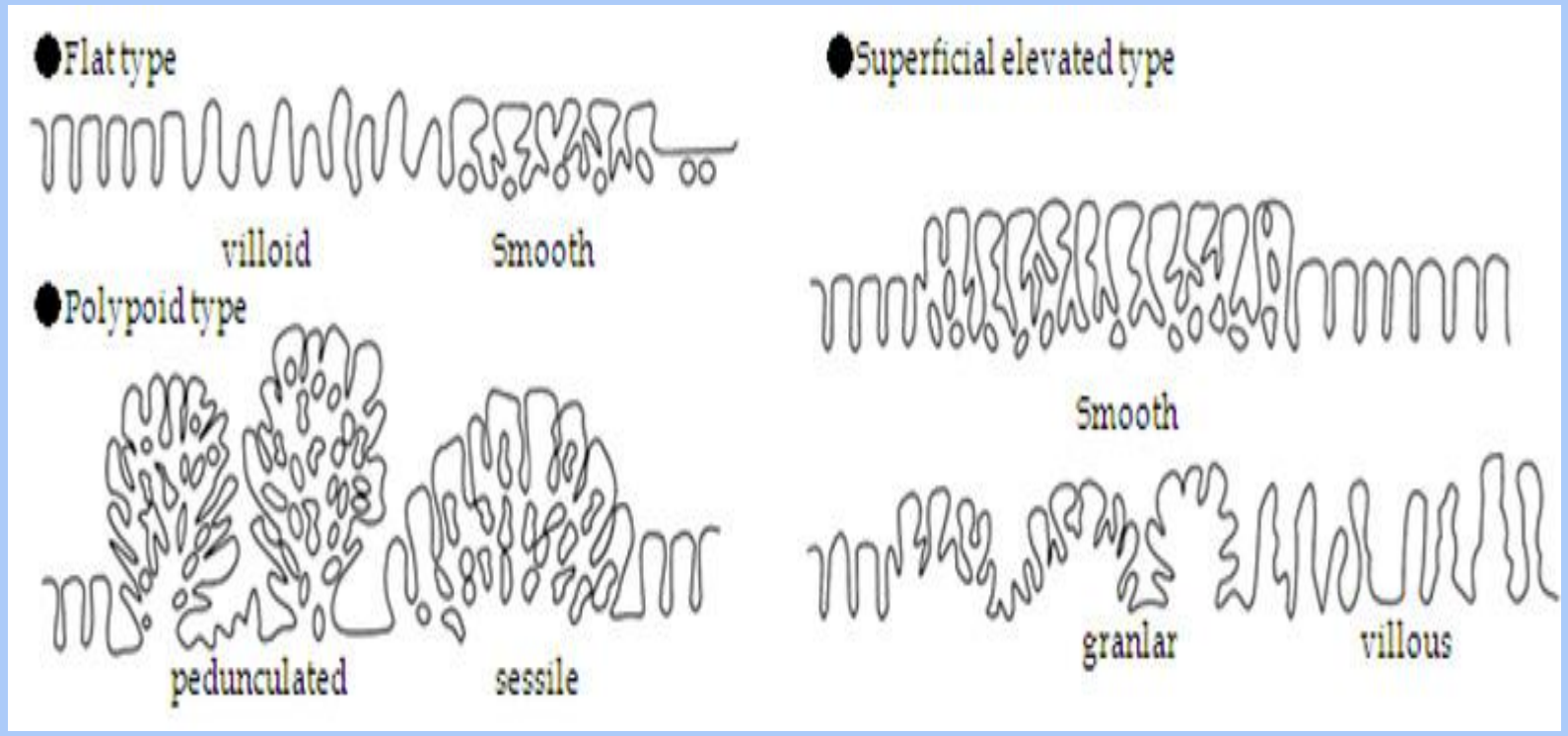
- Gastrointestinal dysplasia is defined microscopically as replacement of the native intestinal epithelium by an unequivocally neoplastic, but as yet noninvasive, epithelium

- The histological classification of dysplasia in IBD is
- negative for dysplasia
- indefinite for dysplasia
- low-grade dysplasia (LGD)
- high-grade dysplasia (HGD)

- Dysplasia is classified macroscopically as elevated or flat
- whether or not it corresponds to an endoscopically visible lesion

- Elevated lesions, **DALM** (dysplasia associated lesion or mass), span a broad spectrum that includes single and multiple polyps, bumps, plaques and velvety patches.
- Such lesions can easily be camouflaged among the varied gross inflammatory abnormalities with IBD,SO their endoscopic detection is a big challenge even for experienced endoscopists.

- Flat dysplasia is only detected microscopically in random biopsy .
- Its detection therefore depends critically on adequate sampling of the mucosa by the endoscopist, that is obtaining 2-4 biopsy specimens every 10 cm of diseased bowel


Flat type
villoid
Smooth
Polypoid type
pedunculated
sessile
Superficial elevated type
Smooth
granlar
villous

- In an effort to increase the sensitivity of detecting dysplasia colonoscopically,

- several enhanced colonoscopic surveillance techniques have been studied. These methods aim to increase the recognition of nearly flat, or minimally raised lesions and their associated mucosal pit patterns using mucosal dye spraying with either **carmine indigo or methylene blue** .
- Some series have used additional imaging technologies not widely available, including **confocal laser microscopy and magnification colonoscopy**

- These series have reported detection rates of dysplasia 1.5- to 5-fold greater than standard white light colonoscopy by endoscopists trained in the use of these techniques

RECOMMENDATIONS FOR CANCER SURVEILLANCE

American college of Gastroenterology

- After 8 – 10 years of colitis, annual or biannual surveillance colonoscopy with multiple biopsies at regular intervals should be performed **(Evidence B).**
- The finding of HGD in flat mucosa, confirmed by **expert pathologists** ' is an indication for colectomy, whereas the finding of LGD in flat mucosa may also be an indication for colectomy to prevent progression to a higher grade of neoplasia **(Evidence B).**

- **Traditionally,** if high grade dysplasia was found in any area (flat or DALM), the only treatment approach was total colectomy.

- DALM lesion with low grade dysplsia colectomy was recommended

- flat multifocal low grade dysplasia colectomy is also recommended
- flat unifocal low grade dysplasia surveillance is recommended

- Conservative endoscopic management is also a reasonable option for dysplasia, when it is found in an adenoma-like polyp.
- These polyps are endoscopically indistinguishable from sporadic sessile adenomatous polyps

- Histology has not provided a reliable means of making this distinction in individual cases, because dysplasia in the setting of colitis and in true adenomatous polyps can be virtually identical.
- As a result, the burden of deciding whether a polyp qualifies as DALM or true adenoma falls squarely on the shoulders of the endoscopist

- **It is important to emphasize that no surveillance programme rules out the risk of cancer.**

- **Only a total colectomy removes the neoplastic mucosa and the residual mucosa that is at risk for developing neoplasia. This removes both cancer risk and cancer fear**

- dysplasia of any grade detected in an endoscopically nonresectable polyp or DALM or highgrade dysplasia detected in flat mucosa are both strong indications for proctocolectomy.

- Further evidence suggests that the same may be true even of low-grade dysplasia in flat mucosa especially if it is multifocal.

- If dysplasia of either low or high grade is detected in a discrete adenoma-like polyp, that can be readily resected endoscopically and there is no flat dysplasia immediately adjacent to the polyp or elsewhere in the colon,
- polypectomy is sufficient followed by a careful surveillance programme.

Our current knowledge

- **Patients with LGD have a significant risk of devolping CRC**
- **Management is challenging due to marked variability in rate of progression to CRC**

- **Little data on endoscopic and histological characters of LGD associated with high risk of transformation to HGD and CRC**

- **LGD non polypodal, invisible, preceeded by indefinite ,dysplasia more than one cm is high risk or HGD and CRC**

- Chromoendoscopy is more effective than white light endoscopy

- Patient counseling about their management options including colectomy is a must .

THANK YOU