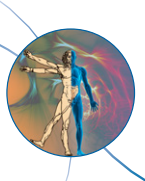

SESSION 2
DYSPLASIA SURVEILLANCE IN IBD

CASE-BASED BREAKOUT WORKSHOP

Neil is 25-year-old male with a known history of ulcerative colitis, extending to the hepatic flexure (diagnosed 5 years ago). He was initially treated with prednisone and 5-ASA, but had a flare of his disease within the first year and was started on vedolizumab. He is clinically in remission on vedolizumab 300 mg every 8 weeks with 1–2 formed stools daily, without blood. His CBC is normal, FCP is 162 mg/kg. His ALP is elevated and you perform a MRCP which confirms your suspicion of primary sclerosing cholangitis (PSC). You explain to him that he is at increased risk of developing colon cancer and you book him for a colonoscopy to screen for dysplasia.

Decision Node 1

- When do you start screening for dysplasia in patients with UC and concurrent PSC?
- What conditions should you optimize when performing screening?
- What technique if available, would you use to enhance your detection of dysplasia: high-definition white light, chromoendoscopy, or virtual (e.g., NBI/i-scan)?

Patient is prepared with a split-dose PEG preparation. Preparation is quite good but you wash a few small areas to improve visualization. He is in endoscopic remission with only a few pseudopolyps and minimal scarring identified on scope insertion.

You decide to use methylene blue for chromoendoscopy (your endoscopy unit does not stock indigo carmine), 0.04–0.1% concentration in the waterjet.

Decision Node 2

- Should you take biopsies? Non-targeted vs. targeted vs. staging?
- How do you describe any lesions found?

As you are using chromoendoscopy, you take staging/mapping biopsies to assess for disease activity as well as targeted biopsies for suspicious areas.

You use the Paris classification to describe any suspicious areas.

You identify a 12 mm flat lesion in the transverse colon and resect. No other lesions were found.

Decision Node 3

- Should you biopsy around the resection and send separately to pathology?
- Should you tattoo the surrounding area?

As you are confident that you resected the entire polyp, you do not take biopsies surrounding the polyp. Histology confirms high-grade dysplasia.

Decision Node 4

- Should you refer this patient for surgery?
- Should you recommend intensive surveillance strategy? If yes, what strategy would you employ?

You have a discussion with the patient (and his wife) and provide options of intensive surveillance (q6 months) vs. colectomy. He elects to have intensive surveillance.

At the next colonoscopy, you decide to perform targeted and non-targeted biopsies. You discover unifocal low-grade dysplasia on non-targeted biopsies.

Decision Node 5

- What is the risk of synchronous colorectal cancer?
- What is the risk of progression to HGD or colorectal cancer over time?
- Should you refer this patient for surgery or recommend continuing intensive surveillance?

You have a discussion with the patient. His brother also has PSC and colitis and is doing well with a colectomy and IPAA, and he elects to have surgery.

References

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