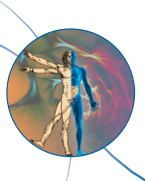

# SESSION 2

# DYSPLASIA SURVEILLANCE IN IBD

## Approaches to Dysplasia

*Talat Bessissow, MD CM FRCPC*

Longstanding ulcerative colitis caries an increased risk of colorectal neoplasia. The risk is more significant in patients with a family history of colorectal cancer before the age of 50, in patients with previous history of dysplasia and those with primary sclerosing colitis. Several endoscopic techniques for dysplasia surveillance have been developed. Surveillance must be performed in a patient with endoscopic healing and with a very good colonic preparation to ensure excellent visualization of the mucosa. In addition, it must be performed using high-definition endoscopes, as it has been shown that high-definition white light is clearly superior to standard definition white light. The use of random 4-quadrant biopsies every 10 cm in addition to targeted biopsies is the most widely used technique, however the yield of identifying dysplasia from random biopsies is very low and most dysplastic lesions are identified on targeted biopsies. When the expertise is available, dye-assisted chromoendoscopy is considered the gold standard for dysplasia detection. Virtual chromoendoscopy using narrow band imaging, iScan or FICE has been demonstrated in a few studies to have a comparable rate of dysplasia detection, therefore is a reasonable alternative to dye-assisted chromoendoscopy. Other advanced imaging techniques are under investigation (confocal endomicroscopy, fluorescence, etc.). Once identified, lesions are characterized using the Kudo pit pattern classified as polypoid (pedunculated or sessile), non-polypoid (flat elevated, flat, or flat depressed) or invisible. Notwithstanding the degree of dysplasia, identified lesions that are well demarcated must be resected endoscopically and then followed by close surveillance.

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