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Sessile serrated polyps and colorectal cancer

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To the Editor

The comprehensive review by Dr Lieberman and colleagues addressed evolving issues in the field of colorectal cancer (CRC) screening.[1] However, I take issue with the brief discussion of serrated polyps and their effect on the practice of CRC screening.

As mentioned by the authors, the pathway from serrated polyps to CRC (an alternative route to the better known “adenoma-carcinoma sequence”) accounts for 20–30% of sporadic CRC cases. The most important and prevalent precursor lesions of this pathway are sessile serrated polyps (SSPs), which are present in up to 10–15% of patients undergoing colonoscopy.[2] These polyps are clinically, genetically, and histologically distinct from conventional adenomas. Sessile serrated polyps are flat or minimally raised, have a subtle endoscopic appearance, and are most frequently located in the proximal colon. Sessile serrated polyps are also less likely to hemorrhage compared with similarly sized conventional adenomas. For these reasons, SSPs are more difficult than adenomas to detect with current tests. Mention of these issues is absent from the review. The sensitivity of fecal immunochemical tests (FIT) for detecting even large SSPs is negligible.[3] Sigmoidoscopy does not examine the proximal colon where the majority of SSPs reside. The authors stated that “the ability of [computed tomographic colonography (CTC)] to detect flat serrated colon lesions is unknown,” although one study found that CTC misses at least 80% of large (≥ 1cm) SSPs.[4] Colonoscopy, although imperfect, offers the best chance for finding SSPs with screening due to direct visualization. Although wide variability in SSP detection exists among endoscopists, this is improving over time with increased awareness of the importance of these lesions and attention to colonoscopy quality.[2]

There is also emerging data that patients harboring SSPs are at heightened risk of developing metachronous advanced adenomas and CRC, and that this risk may be greater than that associated with conventional adenomas.[5] This is an important issue for surveillance, yet SSPs are largely missing from Lieberman and colleagues’ discussion of risk stratification and follow-up recommendations.

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It is important to disseminate that SSPs are not rare; most CRC screening tests detect SSPs poorly or not at all; and patients harboring SSPs are at risk of future neoplasia and require careful surveillance.

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