Table S1: List of Associations and Organisations that were contacted to participate in the survey.

Associations contacted	
North America	**Asia**
Canadian Association of Gastroenterology (CAG) [a]	Japanese Society of Gastroenterology (JSGE) [c]
Association des gastro-entérologues du Québec (AGEQ) [a]	Japan Gastroenterologial Endoscopy Society (JGES) [c]
American Gastroenterological Association (AGA) [c]	Asian Pacific Association of Gastroenterology (APAGE) [c]
American College of Gastroenterology (ACG) [a]	Chinese Society of Digestive Endoscopy (CSGE) [c]
American Society for Gastrointestinal Endoscopy (ASGE) [b]	Hong Kong Society of Digestive Endoscopy (HKSDE) [c]
Society of American Gastrointestinal and Endoscopic Surgeon (SAGES) [a]	New Zealand Society of Gastroenterology (NZSG) [a]
Canadian Association of General Surgeons (CAGS) [a]	
Canadian Society of Colon and Rectal Surgeons (CAGS) [a]	
Europe	**Social Media**
World Gastroenterology Organisation (WGO) [b]	Young GI Network [a]
United European Gastroenterology (UEG)[b]	Friends of Endoscopy [a]
European Association for Gastroenterology, Endoscopy and Nutrition (EAGEN)[c]	Group of International Therapeutic Endoscopy (GINTE) [a]
French National Society of Gastroenterology (SNFGE) [b]	
Société Française d'endoscopie digestive (SFED) [c]	
German Society of Gastroenterology and Metabolism (DGVS) [c]	
British Society of Gastroenterology (BSG) [c]	
Swiss Society of Gastroenterology (SGGSSG) [c]	
Gastroenterological Society of Australia (GESA) [c]	
European Society of Gastrointestinal Endoscopy (ESGE) [b]	
Danish Society of Gastroenterology and Hepatology (DSGH) [c]	
Estonian Society of Gastrointestinal Endoscopy (EGS) [c]	
Finnish Society of Gastroenterology (SGY) [c]	
Scandinavian Association for Digestive Endoscopy (SADE) [c]	
Irish society of gastroenterology (ISG) [c]	
Spanish Society of Gastrointestinal Endoscopy (SEED) [c]	

[a] Society accepted to participate in the study

[b] Society did not accept to participate in the study

[c] Society did not answer to our request to participate in the study

Table S2: **List of associations who distributed the survey and their number of members.**

Associations	Reached by	Members (n=31608)	Members reached (n=21807)
Gastroenterology Associations			
Canadian Association of Gastroenterology (CAG)	email	654	654
Association des gastro-entérologues du Québec (AGEQ)	email	250	250
American College of Gastroenterology (ACG)	email	12153	11783
New Zealand Society of Gastroenterology (NZSG)	email	129	129
General Surgery and Colorectal Surgery Associations			
Society of American Gastrointestinal and Endoscopic Surgeon (SAGES)	twitter/facebook	10703	1272
Canadian Association of General Surgeons (CAGS)	email	1000	1000
Gastroenterology related Facebook pages			
Young GI Network (page of the European Association of Gastroenterology (UEG))	facebook	2360	2360
Friends of Endoscopy	facebook	2265	2265
Group of International Therapeutic Endoscopy (GINTE)	facebook	2094	2094

Table S3: Participants perceptions of the resect and discard strategy according to their country of practice.

Resect and discard strategy	Australia n (%)	Australia/New Zealand n (%)	Canada n (%)	United States of America n (%)	Asia n (%)	Europe n (%)	South/Central America n (%)	Other n (%)
Have you heard about the resect and discard strategy?								
No	1 (20%)	4 (16.7%)	15 (18.8%)	71 (15.7%)	15 (24.6%)	9 (9.9%)	10 (18.2%)	5 (20.0%)
Yes	**4 (80%)**	**20 (83.3%)**	**65 (83.3%)**	**382 (84.3%)**	**46 (75.4%)**	**82 (90.1%)**	**45 (81.8%)**	**20 (80.0%)**
Are you using the resect and discard strategy in your current practice?								
No	**3 (60%)**	**21 (87.5%)**	**69 (86.2%)**	**431 (94.9%)**	**33 (55.0%)**	**56 (61.5%)**	**42 (76.4%)**	**14 (56.0%)**
Yes	2 (40%)[a]	3 (12.5%)[b]	11 (13.8%)[c]	23 (5.1%)[d]	27 (45%)[e]	35 (38.5%)[f]	13 (23.6%)[g]	11 (44.0%)[h]
Are you using the diagnose-and-leave strategy for rectosigmoid polyps up to 5mm in your current practice?								
No	1 (20.0%)	7 (29.2%)	39 (48.8%)	**239 (52.8%)**	30 (49.2%)	38 (41.3%)	**31 (57.4%)**	**17 (60.0%)**
Yes	**4 (80.0%)**	**17 (70.8%)**	**41 (51.2%)**	214 (47.2%)	**31 (50.8%)**	**54 (58.7%)**	23 (42.6%)	8 (32.0%)
Do you think using the resect and discard strategy for diminutive polyps increase the risk of cancer?								
No	**4 (80.0%)**	**21 (87.5%)**	**71 (89.9%)**	**360 (80.5%)**	**46 (75.4%)**	**80 (87.0%)**	**34 (61.8%)**	**19 (76.0%)**
Yes	1 (20.0%)	3 (12.5%)	8 (10.1%)	87 (19.5%)	15 (24.6%)	12 (13.0%)	21 (38.2%)	6 (24.0%)
Do you think that the current resect and discard approach is feasible to be used for all diminutive polyps in the complete colon and in a general practice?								
No	**3 (60.0%)**	**15 (62.5%)**	**45 (57.0%)**	**289 (63.7%)**	**32 (52.5%)**	42 (45.7%)	**33 (61.1%)**	**15 (60.0%)**
Yes	2 (40.0%)	9 (37.5%)	34 (43.0%)	165 (36.3%)	29 (47%)	**50 (54.3%)**	21 (38.9%)	10 (40.0%)
In the last 5 years are you increasingly use cold snare technique for polypectomy?								
No	0 (0.0%)	2 (8.3%)	5 (6.3%)	52 (11.5%)	17 (27.9%)	7 (7.6%)	11 (20.0%)	4 (16.0%)
Less than 25%	1 (20.0%)	1 (4.2%)	6 (7.6%)	43 (9.5%)	**24 (39.3%)**	16 (17.4%)	**15 (27.3%)**	6 (24.0%)
25% to 50%	0 (0.0%)	0 (0.0%)	15 (19.0%)	84 (18.6%)	11 (18.0%)	18 (19.6%)	13 (23.6%)	2 (8.0%)
More than 50%	**4 (80.0%)**	**21 (87.5%)**	**53 (67.1%)**	**273 (60.4%)**	9 (14.8%)	**51 (55.4%)**	16 (29.1%)	**13 (52.0%)**
Would you be interested in learning optical diagnosis technique?								
No	0 (0.0%)	0 (0.0%)	5 (6.3%)	65 (14.39%)	0 (0.0%)	0 (0.0%)	1 (1.8%)	1 (4.0%)
Yes	2 (40.0%)	11 (45.8%)	**55 (68.8%)**	**240 (52.9%)**	**45 (73.8%)**	**46 (50.5%)**	**33 (60.0%)**	**17 (68.0%)**
I already use it in my practice	**3 (60.0%)**	**13 (54.2%)**	20 (25.0%)	149 (32.8%)	10 (26.2%)	45 (49.5%)	21 (38.2%)	7 (28.0%)

[a] Yes, but only for polyps up to 5mm (0 (0.0%)). Yes, but only for rectosigmoid polyps (2 (40.0 %)). Yes, for polyps up to 10mm (0 (0.0%)).

[b] Yes, but only for polyps up to 5mm (0 (0.0 %)). Yes, but only for rectosigmoid polyps (3 (12.5%)). Yes, for polyps up to 10mm (0 (0.0%)).

[c] Yes, but only for polyps up to 5mm (4 (5.0 %)). Yes, but only for rectosigmoid polyps (6 (7.5%)). Yes, for polyps up to 10mm (1 (1.3%)).

[d] Yes, but only for polyps up to 5mm (9 (2.0%)). Yes, but only for rectosigmoid polyps (13 (2.9%)). Yes, for polyps up to 10mm (1 (0.2%)).

[e] Yes, but only for polyps up to 5mm (12 (20%)). Yes, but only for rectosigmoid polyps (3 (5%)). Yes, for polyps up to 10mm (12 (20%)).

[f] Yes, but only for polyps up to 5mm (26 (28.6 %)). Yes, but only for rectosigmoid polyps (2 (2.2%)). Yes, for polyps up to 10mm (7 (7.7%)).

[g] Yes, but only for polyps up to 5mm (8 (14.0%)). Yes, but only for rectosigmoid polyps (2 (3.6%)). Yes, for polyps up to 10mm (3 (5.5%)).

[h] Yes, but only for polyps up to 5mm (7 (28.0%)). Yes, but only for rectosigmoid polyps (2 (8.8%)). Yes, for polyps up to 10mm (2 (8.8%)).

Table S4: Participants perceptions on issues related to the resect and discard strategy according to their country of practice.

Issues related to the resect and discard strategy	**Australia n (%)**	**Australia/New Zealand n (%)**	**Canada n (%)**	**United States of America n (%)**	**Asia n (%)**	**Europe n (%)**	**South/Central America n (%)**	**Other n (%)**
What are the issues that might make the resect and discard approach not feasible in your clinical practice?								
-It is too complex	0 (0.0%)	2 (8.3%)	7 (8.8%)	13 (2.9%)	7 (11.5%)	2 (2.2%)	2 (3.6%)	2 (8.0%)
-It requires too much training	0 (0.0%)	1 (4.2%)	5 (6.3%)	8 (1.8%)	10 (16.4%)	7 (7.6%)	2 (3.6%)	6 (24.0%)
-I have no image enhancing modality like NBI or FICE available	0 (0.0%)	2 (8.3%)	8 (10.0%)	30 (6.6%)	13 (23.3%)	16 (17.4%)	15 (27.3%)	7 (28.0%)
-I am afraid of making a wrong diagnosis	**3 (60.0%)**	9 (37.5%)	47 (58.8%)	219 (48.2%)	**23 (37.7%)**	36 (39.1%)	10 (18.2%)	10 (40.0%)
-It is too time consuming	0 (0.0%)	0 (0.0%)	11 (13.8%)	33 (7.3%)	8 (13.1%)	7 (7.6%)	1 (1.8%)	3 (12.0%)
-It has a negative impact on the procedure time and reimbursement	0 (0.0%)	3 (12.5%)	12 (15%)	46 (10.1%)	5 (8.2%)	6 (6.5%)	5 (9.1%)	4 (16.0%)
-I am afraid of giving incorrect surveillance interval recommendations for my patients	**3 (60.0%)**	**15 (62.5%)**	**48 (60.0%)**	298 (65.6%)	19 (31.1%)	**43 (46.7%)**	**23 (41.8%)**	**16 (64.0%)**
-I am afraid of possible medico-legal issues	1 (20.0%)	13 (54.2%)	44 (55.0%)	**305 (67.2%)**	19 (31.1%)	23 (25.0%)	18 (32.7%)	11 (44.0%)

Table S5: Participants perceptions on the cancer risk of diminutive polyps according to their country of practice.

Participants perceptions	Australia n (%)	Australia/New Zealand n (%)	Canada n (%)	United States of America n (%)	Asia n (%)	Europe n (%)	South/Central America n (%)	Other n (%)
Cancer risk in a diminutive polyp is so low that such polyps can be left unresected until the next follow-up colonoscopy								
Disagree	**3 (60.0%)**	4 (16.7%)	17 (21.3%)	93 (20.5%)	18 (29.5%)	14 (15.2%)	15 (27.3%)	3 (12.0%)
Partly disagree	1 (20.0%)	4 (16.7%)	12 (15.0%)	78 (17.2%)	5 (8.2%)	16 (17.4%)	8 (20.0%)	5 (20.0%)
Partly agree	1 (20.0%)	**13 (54.2%)**	**39 (48.8%)**	**239 (52.8%)**	**23 (37.7%)**	**49 (53.5%)**	**22 (40.0%)**	**14 (56.0%)**
Completely agree	0 (0.0%)	3 (12.5%)	12 (15.0%)	43 (9.5%)	15 (24.6%)	13 (14.1%)	10 (18.2%)	3 (12.0%)
If you would leave diminutive polyps unresected, the next colonoscopy should be within a maximum of: (years)								
1	0 (0.0%)	0 (0.0%)	3 (3.8%)	15 (3.3%)	24 (39.3%)	22 (24.2%)	19 (35.2%)	7 (29.2%)
3	1 (33.3%)	9 (40.9%)	26 (32.9%)	97 (21.7%)	**29 (47.5%)**	**46 (50.5%)**	**22 (40.7%)**	**12 (50.0%)**
5	**2 (66.7%)**	**12 (54.5%)**	**42 (53.2%)**	**280 (62.5%)**	6 (9.8%)	21 (23.1%)	12 (22.2%)	5 (20.8%)
10	0 (0.0%)	1 (4.5%)	8 (10.1%)	56 (12.5%)	2 (3.3%)	2 (2.2%)	1 (1.9%)	0 (0.0%)
Do you think leaving diminutive polyps (up to 5mm) increase the risk of cancer?								
No	**5 (100%)**	**18 (78.3%)**	**50 (63.3%)**	219 (48.7%)	25 (41.1%)	**53 (58.2%)**	25 (45.5%)	**13 (52.0%)**
Yes	0 (0.0%)	5 (21.7%)	29 (36.7%)	**231 (51.3%)**	**36 (59.0%)**	38 (41.8%)	**30 (54.5%)**	12 (48.0%)
Do you think that current CT colonoscopy practice, which ignores polyps up to 5mm, leads to an increased risk of colon cancer for the patients?								
No	0 (0.0%)	0 (0.0%)	12 (15.0%)	32 (7.0%)	5 (8.2%)	5 (5.4%)	4 (7.3%)	1 (4.0%)
Probably not	**4 (80.0%)**	10 (41.0%)	**42 (52.5%)**	180 (39.6%)	17 (27.9%)	36 (39.1%)	8 (14.5%)	5 (20.0%)
Probably yes	0 (0.0%)	**13 (54.2%)**	20 (25.0%)	**181 (39.9%)**	**23 (37.7%)**	**38 (41.3%)**	**35 (63.6%)**	**11 (44.0%)**
Yes	1 (20%)	1 (4.2%)	6 (7.5%)	61 (13.4%)	16 (26.2%)	13 (14.1%)	8 (14.5%)	8 (32.0%)
Do you leave diminutive polyps (up to 5 mm) in place in your current practice?								
-Always	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	2 (3.3%)	1 (1.1%)	1 (1.8%)	0 (0.0%)
-In the majority of cases	0 (0.0%)	1 (4.2%)	2 (2.5%)	23 (5.1%)	8 (13.1%)	7 (7.6%)	5 (9.1%)	4 (16%)
-Sometimes	2 (40%)	11 (45.8%)	**44 (55.0%)**	211 (46.5%)	**31 (50.8%)**	41 (44.6%)	17 (30.9%)	12 (48.0%)
-If you have a follow up colonoscopy scheduled	1 (20.0%)	2 (8.3%)	21 (26.3%)	36 (7.3%)	6 (9.8%)	22 (23.9%)	4 (7.3%)	5 (20.0%)
-If the patients have severe comorbidities	1 (20.0%)	6 (25.0%)	27 (33.8%)	70 (15.4%)	11 (18.0%)	27 (29.3%)	14 (25.5%)	4 (16.0%)
-If the patient is on anticoagulation medication	0 (0.0%)	7 (29.2%)	20 (25.0%)	69 (15.2%)	17 (27.9%)	30 (32.6%)	20 (36.4%)	5 (20.0%)
-If the appearance of the polyp suggests it is non-adenomatous	**4 (80.0%)**	**15 (62.5%)**	**44 (55.0%)**	**250 (55.1%)**	23 (37.7%)	**44 (47.8%)**	**24 (43.6%)**	**13 (52.0%)**

If a diminutive polyp (up to 5 mm) cannot be removed, do you schedule the next colonoscopy within (year maximum):								
1	0 (0.0%)	1 (4.2%)	5 (6.3%)	51 (11.3%)	**36 (59.0%)**	31 (33.7%)	**23 (41.8%)**	**13 (52.0%)**
3	1 (20.0%)	11 (45.8%)	36 (45.0%)	121 (28.2%)	19 (31.1%)	**46 (50.0%)**	21 (38.2%)	7 (28.0%)
5	**4 (80.0%)**	**12 (50.0%)**	**39 (48.8%)**	**272 (60.4%)**	6 (9.8%)	15 (16.3%)	11 (20.0%)	5 (20.0%)

Appendix 1: Survey advertisement full text

Dear colleague,

We are a group of researchers from the University of Montreal with interest in current clinical practice in GI endoscopy. We would like to invite you to participate in a survey capturing current polypectomy and polyp management strategies. This survey takes only 3 minutes to complete and we would greatly appreciate your participation.

Please click on the link below to access and complete the survey.

COMPLETE SURVEY (link)

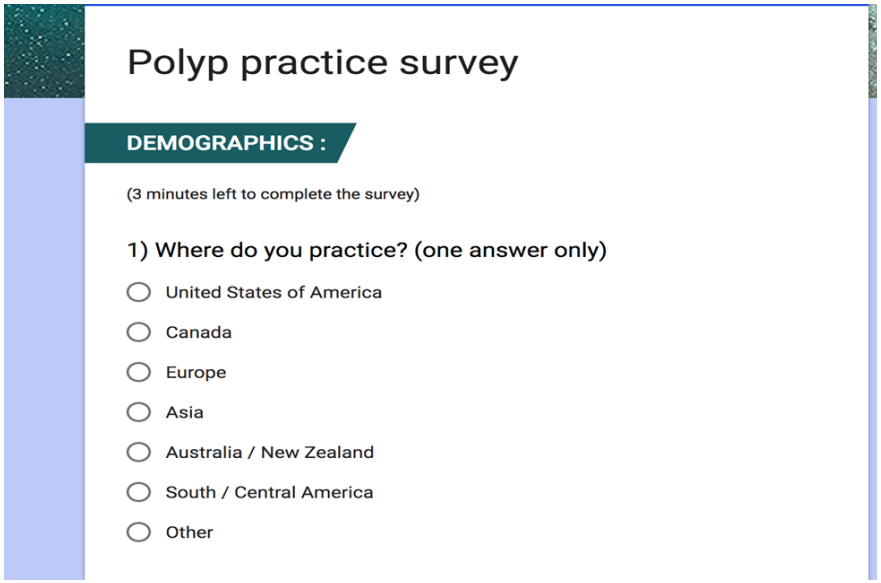
The online survey is optimized for iPhone, iPad and tablet use and can be completed in 3 minutes between your endoscopy cases:

For any inquiries about the study, feel free to contact Dr Daniel von Renteln.

Thank you very much,

Daniel von Renteln, MD

Appendix 2: Polyp practice survey questionnaire



Polyp practice survey

DEMOGRAPHICS :

(3 minutes left to complete the survey)

1) Where do you practice? (one answer only)

- ◯ United States of America
- ◯ Canada
- ◯ Europe
- ◯ Asia
- ◯ Australia / New Zealand
- ◯ South / Central America
- ◯ Other

2) What is your practice setting? (one answer only)

- ◯ Private
- ◯ Academic
- ◯ Community Hospital
- ◯ Mixed

3) Indicate your training speciality and level. (one answer only)

- ◯ Gastroenterologist
- ◯ General Surgeon
- ◯ Colorectal Surgeon
- ◯ Internal medicine
- ◯ Resident / Fellow in training (any specialty)
- ◯ Nurse endoscopist

4) Please indicate when you completed your most advanced training. (one answer only)

- ◯ Less than 10 years ago
- ◯ Between 10 - 20 years ago
- ◯ More than 20 years ago

5) How many colonoscopies do you perform each year? (one answer only)

- ◯ Less than 100
- ◯ 100 - 300
- ◯ 301 - 500
- ◯ More than 500

6) How is your colonoscopy practice reimbursed. (one answer only)

- ◯ Salary
- ◯ Fee per colonoscopy procedure
- ◯ Mixed

RESECT AND DISCARD

7) Have you heard about the resect and discard strategy?

- ◯ Yes
- ◯ No

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Information

In 2015, in reaction to some literature showing that polyps of less than 5 mm, or diminutive polyps, are almost never cancerous, the American Society of gastroenterology (ASGE) recommended in one of his PIVI (Preservation and Incoporation of Valuable endoscopic Innovations) that diminutive polyps whom appearance is typical of a benign polyp could be resected and discarded without further histopathological assessment: the resect and discard approach. The conditions were that the optical diagnosis of the polyp must be made by a trained physician and with high confidence.

RESECT AND DISCARD

(2 minutes left to complete the survey)

8) Are you using the resect and discard strategy in your current practice? (one answer only)

- ◯ Yes, but only for polyps up to 5 mm
- ◯ Yes, for polyps up to 10 mm
- ◯ Yes, but only for rectosigmoid polyps
- ◯ No

9) Are you using the diagnose-and-leave strategy for rectosigmoid polyps up to 5 mm in your current practice?

- ◯ Yes
- ◯ No

10) Do you think the current resect and discard approach is feasible to be used for all diminutive polyps in the complete colon and in a general practice?

- ◯ Yes
- ◯ No

11) What are the issues that might make the resect and discard approach not feasible in your clinical practice? Select all the answers that apply.

- [ ] It is too complex
- [ ] It requires too much training
- [ ] I have no image enhancing modality like NBI, iScan or FICE available
- [ ] I am afraid of making a wrong diagnosis
- [ ] It is too time consuming
- [ ] It has a negative impact on the procedure time and reimbursement
- [ ] I am afraid of giving incorrect surveillance interval recommendations for my patients
- [ ] I am afraid of possible medico-legal issues

12) Would you be interested in learning optical diagnosis technique for your practice?

- ◯ Yes
- ◯ No
- ◯ I am already using optical diagnosis in my practice

13) What do you think about this statement? " Cancer risk in a diminutive polyp is so low that such polyps can be left unresected until the next follow-up colonoscopy " (one answer only).

- ○ I completely agree
- ○ I partly agree
- ○ I partly disagree
- ○ I disagree

14) If you would leave diminutive polyps unresected, the next colonoscopy should be within a maximum of:

- ○ 1 year
- ○ 3 years
- ○ 5 years
- ○ 10 years

15) Do you think that leaving diminutive polyps (up to 5mm) increase the risk of cancer of patients?

- ○ Yes
- ○ No

16) Do you think that using the resect and discard strategy for diminutive polyps increase the risk of cancer of patients?

- ◯ Yes
- ◯ No

17) Do you think that current CT colonoscopy practice, which ignores polyps up to 5 mm, leads to an increased risk of colon cancer for the patient? (one answer only)

- ◯ Yes
- ◯ Probably Yes
- ◯ Probably Not
- ◯ No

18) Do you leave diminutive polyps (up to 5 mm) in place in your current practice? Select all the answers that apply.

- ☐ Always (no further choices)
- ☐ In the majority of cases
- ☐ Sometimes
- ☐ If I have a follow up colonoscopy already scheduled
- ☐ If the patient has severe comorbidities
- ☐ If the patient is on anticoagulation medication
- ☐ If the appearance of the polyp suggests it is non adenomatous

19) If a diminutive polyp (up to 5 mm) cannot be removed for any reason and solely based on this finding, do you schedule the next colonoscopy for this patient within: (one answer only)

- ◯ 1 year max
- ◯ 3 years max
- ◯ 5 years max