

SPC

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2014-12-27



# Patient 000

- 59 y/ o , Male
- No symptoms , iFOBT(+) 76.7 ng/ml
- Past History :
  - Hypertension without regular treatment for about 4 years.
- Visited GI OPD , and colonoscopy was done.



## Lab. Data

- CBC , DC : Normal ( no anemia )
- Biochemistry test : Almost Normal  
( except cholesterol 221 mg/dl )
- CEA : 3.8 ng/ml



# Studies

- Colonoscopy ( 103-11-3 ) : A big polypoid lesion about 1.5 cm in size at sigmoid colon.
- Ba. Enema ( 103-11-11 ) : A polypoid filling defect at S-colon.
- Abdominal CT ( 103-11-12 ) : A protruded lesion 16 \* 11 mm in size at sigmoid colon.



# Differential Diagnosis of Colon Polyps

## ○ NON-NEOPLASTIC POLYPS

Hyperplastic

Mucosal

Inflammatory pseudopolyps

Submucosal, some of which may be neoplastic (eg, lipomatous, leiomyoma)

Hamartomatous

## ○ NEOPLASTIC POLYPS

Adenomatous polyps

Serrated polyps

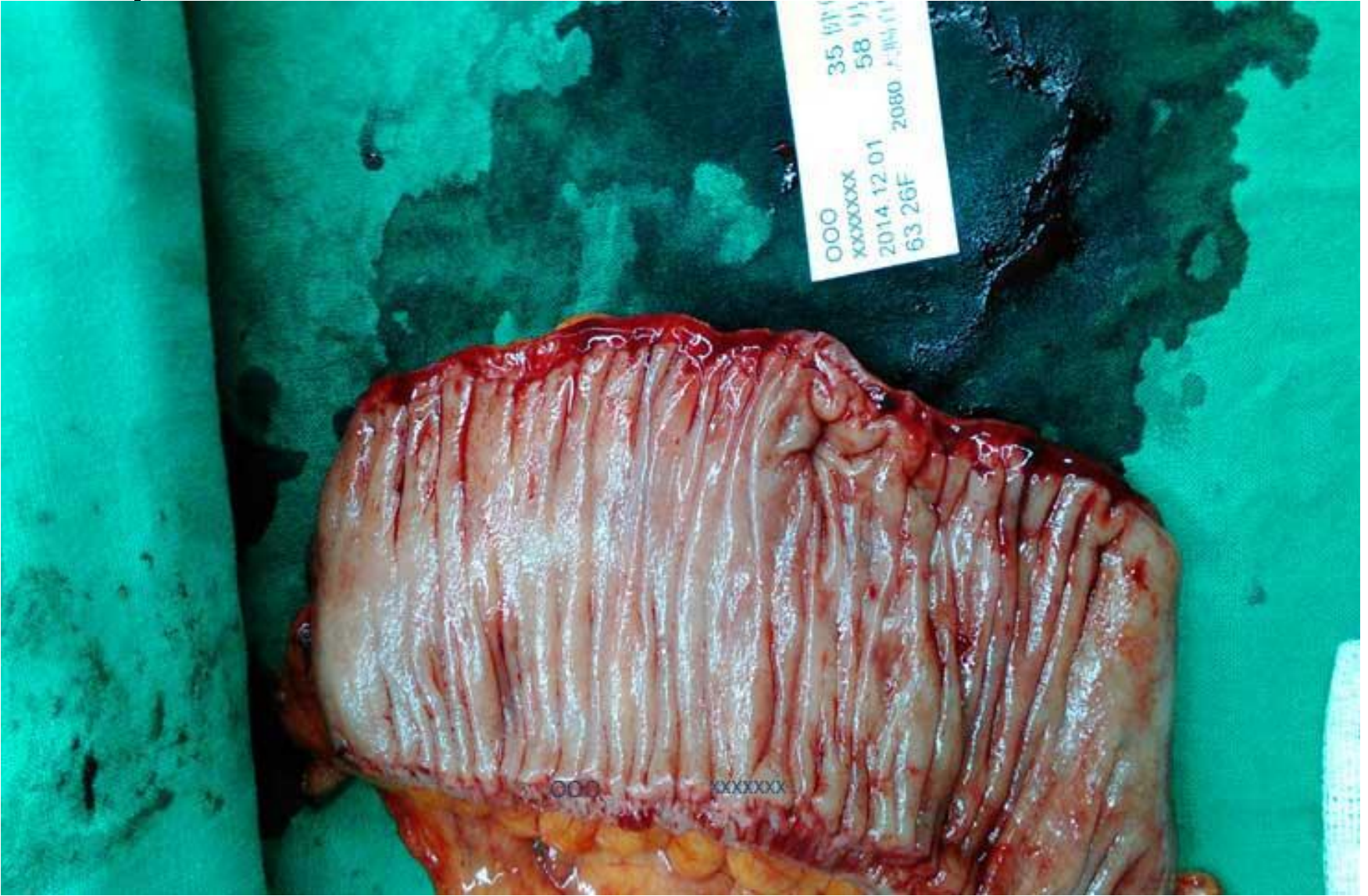


# Management

- Colonoscopic Polypectomy ( by GI ) on 103-11-13.

Pathology Report !

- Surgery , Anterior Resection ( by CRS ) on 103-12-4.



# Discussion



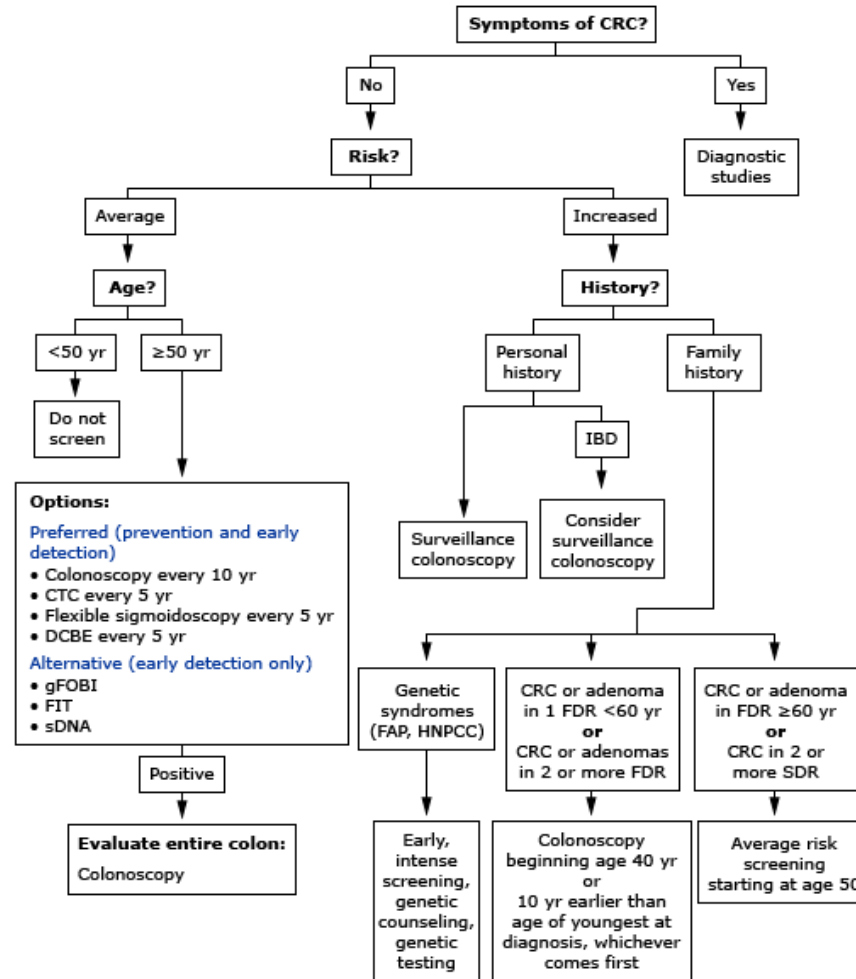




# Polypectomy 病理報告

- Colonoscopic polypectomy -----  
Invasive adenocarcinoma associated  
with sessile serrated adenoma

## Algorithm for CRC screening and surveillance in average-risk and increased-risk populations



IBD: inflammatory bowel disease; CRC: colorectal cancer; FDR: first degree relative; SDR: second degree relative; CTC: computed tomographic colonography; FAP: familial adenomatous polyposis; HNPCC: hereditary nonpolyposis colorectal cancer; DCBE: double-contrast barium enema; gFOBT: guaiac fecal occult blood test; FIT: fecal immunochemical tests; sDNA: stool DNA tests.

Recommendations reflect joint multi-society guidelines 2008. Adapted from: Winawer, SW, Fletcher, RH, Mille, L, et al, AGA guidelines: Colorectal cancer screening: Clinical guidelines and rationale. *Gastroenterology* 1997; 112: 594.

## WHO classification and their commonly used synonyms in histopathological interpretation of serrated polyps and serrated polyposis

(Bosman FT et al. WHO Classification of Tumours of the Digestive System; 2010:417.)

WHO classification	Synonyms commonly used in histopathological practice
Microvesicular hyperplastic polyp (MVHP) Goblet-cell-rich hyperplastic polyp (GCHP) Mucin-poor hyperplastic polyp (MPHP)	Hyperplastic polyp
Sessile serrated adenoma/polyp	Sessile serrated lesion (SSL)
Sessile serrated adenoma/polyp with cytological atypia	Mixed hyperplastic/adenomatous polyp Or Mixed SSL/serrated adenoma (usual type)
Traditional serrated adenoma	Traditional serrated adenoma
Serrated polyposis syndrome	Hyperplastic polyposis syndrome Or Serrated polyposis syndrome

Proportion of serrated lesion is around 35% of all polyps:

HPs = 23.8% to 30%

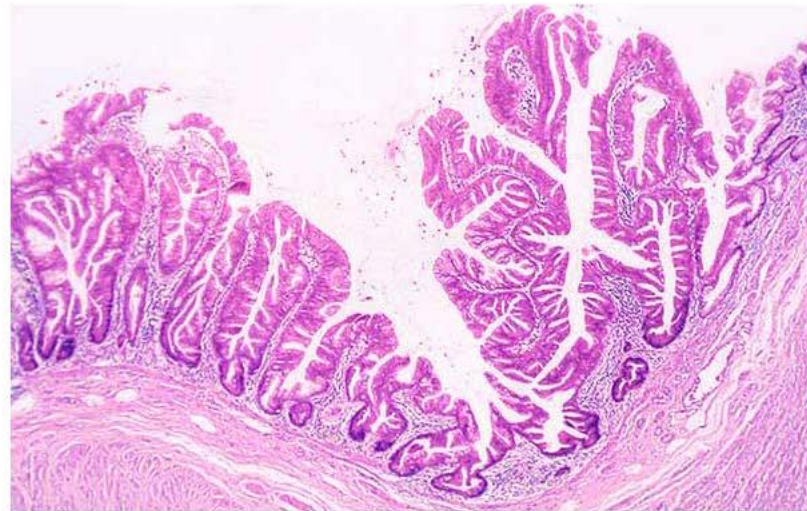
SSLs = 2.2% to 9%

Mixed polyps = 0.8% to 1.7

TSAAs = 0.7% to 1.9%

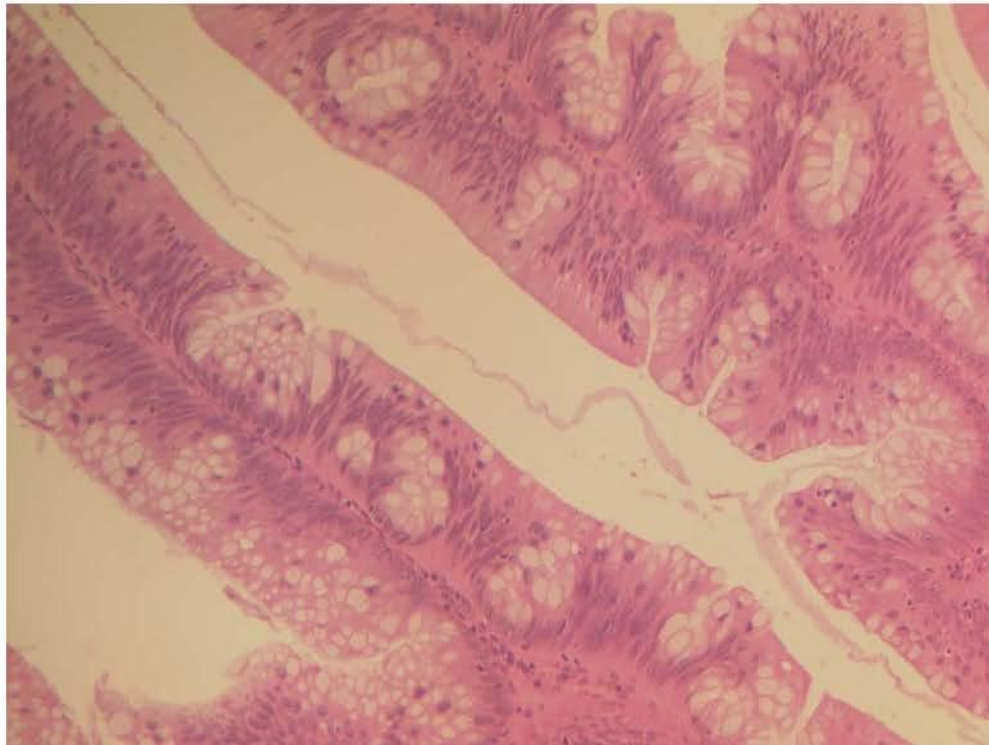
# Sessile Serrated Lesion/Polyp

- Nomenclature?
- Right side, large, sessile, covered by mucin cap/ adherent stools and are poorly defined.



# Traditional serrated adenomas

- More in females and the elderly.
- Pedunculated and almost always on the left.



# Serrated (hyperplastic) polyposis syndrome

- At least 5 serrated polyps proximal to the sigmoid colon with two or more of these being larger than 10 mm in diameter.

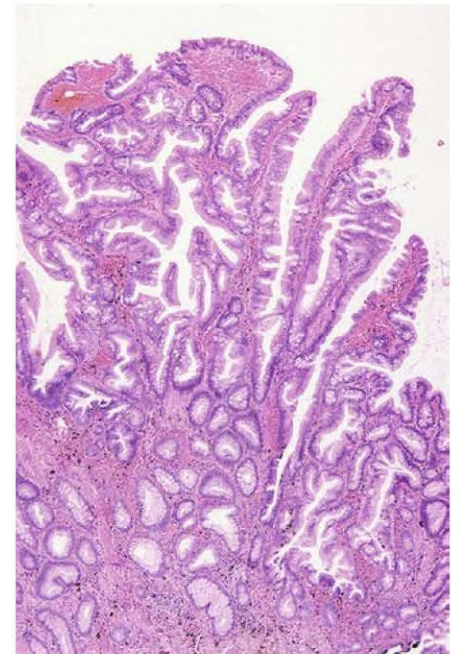
or

- >20 serrated polyps of any size but distributed throughout the colon.

Or

- Any number of serrated polyps proximal to sigmoid colon in an individual who has a first-degree relative with known HPS.

- Risk ?? (MSI positive cancer in ~25%)



# Management of serrated polyposis

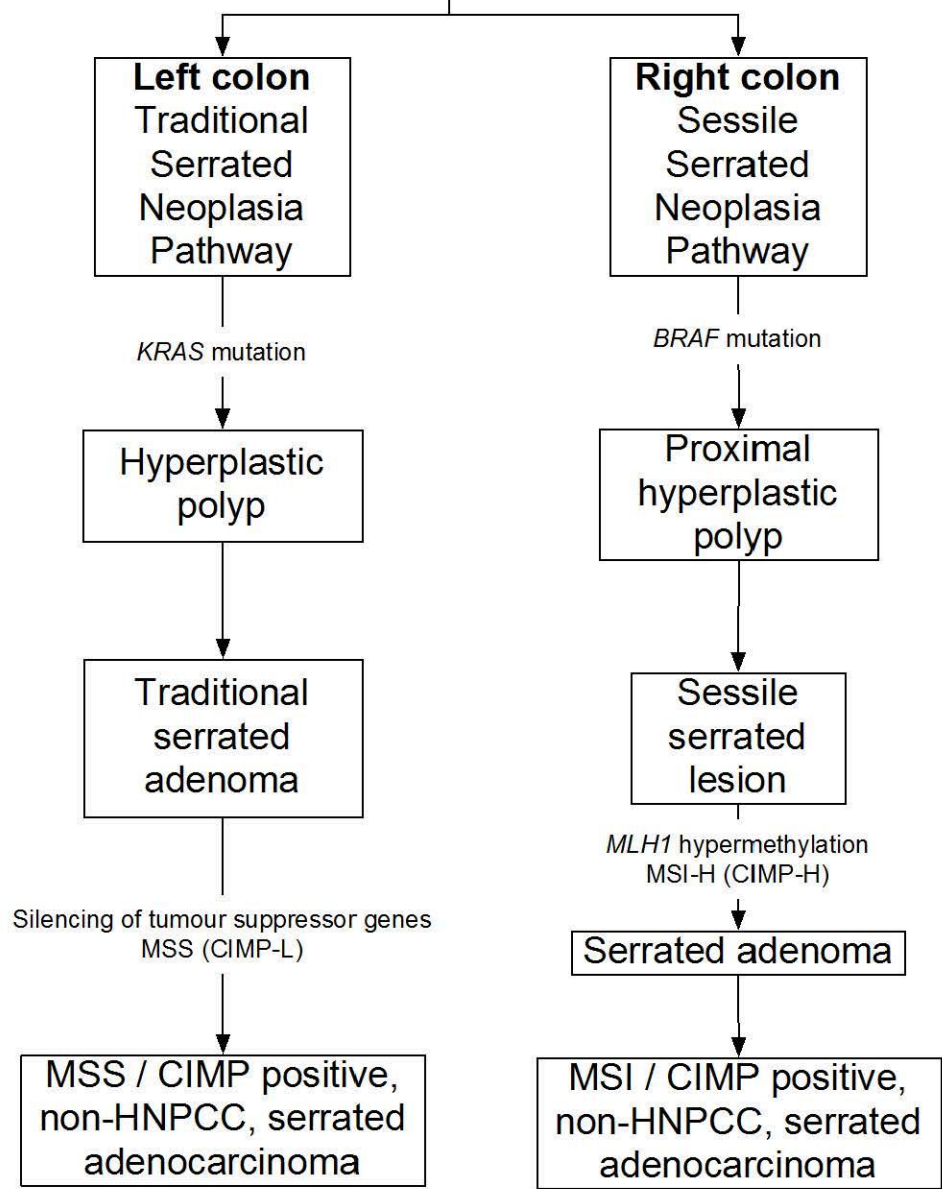
- Colonoscopic surveillance with polyp excision every 1-3 years depending on number of polyps.
- Polyps >3-4mm should be excised (smaller lesions can be observed with annual colonoscopy).
- If colonoscopic management is difficult then colectomy with ileo-rectal anastomosis and follow up of rectal stump.
- First-degree relatives should be offered a screening colonoscopy (? aged > 40 years).

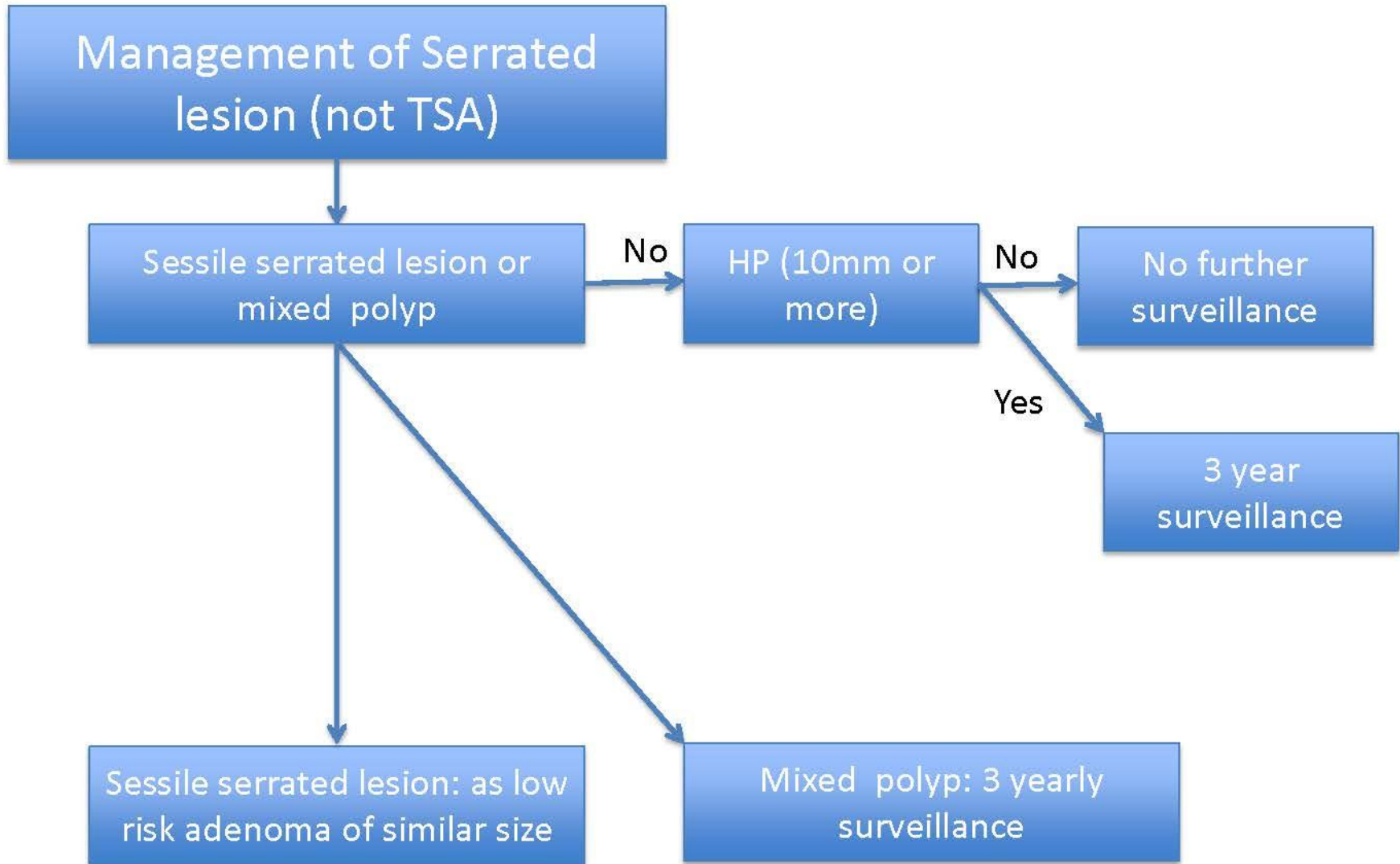
# Serrated Adenocarcinoma

- **Subtypes:**
  1. Distal (~80%):
    - Precursor: traditional serrated adenomas
    - Microsatellite Stable (MSS)
    - Poor prognosis (30% 5-year survival)
  1. Proximal (~20%):
    - Precursor: sessile serrated lesions
    - Microsatellite Instability (MLH1 loss)
    - Good prognosis (70% 5-year survival)



# The serrated neoplastic pathways





Leedham S, East JE, Chetty R. Diagnosis of sessile serrated polyps/adenomas: what does this mean for the pathologist, gastroenterologist and patient? J Clin Pathol. 2013;66:265-268.

American Gastroenterological Association guidelines issued for surveillance intervals after endoscopic resection of any number serrated polyps (excluding hyperplastic / serrated polyposis).

Serrated lesion	Size of the lesion	Recommended surveillance by Lieberman et al. [57]
Hyperplastic polyp	<10 mm	10 years
Sessile serrated lesion (SSL)	<10 mm	5 years
SSL	>10 mm	3 years
Mixed hyperplastic/adenomatous polyp Or Mixed SSL/serrated adenoma	Any size	1 year
Traditional serrated adenoma	Any size	1 year
Hyperplastic/serrated polyposis syndrome	Any size	1 year

Lieberman DA *et al.* Guidelines for colonoscopy surveillance after screening and polypectomy: a consensus update by the US Multi-Society Task Force on Colorectal Cancer. *Gastroenterology*. 2012;143:844-857.