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Summary

# How to classify: Remove or discard?

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Colorectal | Endoscopy | Nurses

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**A pathologist's perspective on classifying serrated polyps, their malignancy risk, and the rationale for the English Bowel Cancer Screening Programme's resect-and-discard strategy for small polyps.**

KEY POINTS

- In the English bowel cancer screening programme, approximately three-quarters of polyps are adenomas and about one-quarter are serrated polyps, with hyperplastic polyps being the most common serrated lesion, sessile serrated lesions accounting for about 6%, and traditional serrated adenomas being rare.
- The speaker stated that hyperplastic polyps have virtually no malignancy risk, while the serrated pathway to cancer is probably faster than the traditional adenoma-carcinoma pathway, with risk significantly higher if dysplasia is present in a sessile serrated lesion.
- UK guidance defines high-risk findings as including all serrated polyps apart from tiny hyperplastic polyps in the rectum, with advanced colorectal polyps defined as serrated polyps of 10mm or more or those with any dysplasia.
- The discard-three study showed high concordance between optical diagnosis and histopathological examination for polyps of 5mm or less, with very low numbers containing high-risk features, supporting the resect-and-discard strategy.
- NHS England's resect-and-discard strategy for the screening programme requires endoscopist accreditation including training, testing, photographic assessment by an optical diagnosis champion, and re-accreditation every two years, with Lynch syndrome patients excluded.

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