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Summary

How to recognise and treat a dysplastic SSL in the proximal colon?

Maria Pellisé Urquiza

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Colorectal | Digestive Oncology | Education & Training | Endoscopy

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The speaker reviewed recognition and management of sessile serrated lesions with dysplasia, emphasizing that these rare but important lesions require careful detection, complete resection, and close surveillance to prevent interval cancers.

KEY POINTS

- The WHO revised definition now diagnoses sessile serrated lesions when only one distorted crypt is present, which the speaker stated will likely increase diagnosis in endoscopic units
- Sessile serrated lesions with dysplasia are found in approximately one in every 250 FIT-positive screening colonoscopies and account for 20-30% of colorectal cancers through the serrated pathway
- The speaker stated that dysplasia can occur in very small lesions (1-5mm in 21% of cases) and is more related to patient age and lesion location than to lesion size
- Key endoscopic features suggesting dysplasia include surface elevation, contour changes, nodular components, redness, double elevation, and adenomatous patterns, typically located in the lesion periphery
- The speaker recommended cold snare resection for sessile serrated lesions without dysplasia but stated that when dysplasia is suspected, treatment should follow adenoma protocols with hot snare techniques to reduce recurrence risk
- Surveillance is critical because the speaker noted these patients have high risk of metachronous advanced neoplasia, with intervals of 6 months and 1 year after piecemeal resection or 3 years after en bloc resection of small lesions

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