

## ASGE and AGA Issue Consensus Statement on Surveillance and Management of Dysplasia in Patients With Inflammatory Bowel Disease

**DOWNERS GROVE, Ill., (March 5, 2015)** — The American Society for Gastrointestinal Endoscopy (ASGE) and the American Gastroenterological Association (AGA) have issued updated [recommendations](#) for the surveillance and management of dysplasia in patients with inflammatory bowel disease (IBD). The consensus statement was published in the March issues of *GIE: Gastrointestinal Endoscopy* and *Gastroenterology*.

Patients with ulcerative colitis or Crohn’s disease involving the colon have an increased risk of colorectal cancer (CRC). Most cases are believed to arise from areas of dysplasia, or abnormal cellular changes, in the colon mucosa.

Traditionally, detection of dysplasia has relied upon examination of the mucosa with targeted biopsies of visible lesions and extensive random biopsies to identify invisible dysplasia. With the advent of new endoscopic technologies, however, most dysplasia discovered in patients with IBD is visible. The evolving nature of evidence on this issue has resulted in variation across guideline recommendations.

This document represents an effort to develop unifying consensus recommendations to address two primary issues: 1) how should surveillance to detect dysplasia be performed, and 2) how should dysplasia be managed.

The new recommendations were developed by an international group of experts and stakeholders in IBD surveillance, in accordance with suggested standards from the Institute of Medicine. Existing guidelines on this topic, which have been written by numerous expert groups, were considered, and in some cases, accepted in the new consensus statement.

The Consensus Statement addresses the optimal types of endoscopic procedures and equipment to be used, recommended practices for removal of lesions, or referral for the more invasive surgical procedure known as colectomy. In particular, the updated recommendations reflect a shift to using chromoendoscopy for patients with IBD during screening and surveillance in order to better visualize the tissue. Chromoendoscopy involves the use of dye sprayed onto the mucosa during the procedure, and it often is used in conjunction with other advances in endoscopic imaging.

“In the field of gastrointestinal endoscopy, we are fortunate to have new types of equipment and technology that provide high-definition visualization of the colon. In addition, gastrointestinal endoscopists are continually updating their skills to stay abreast of the latest techniques for surveillance, as well removal of lesions. These procedures contribute greatly to the evolving ability of the health care team to help patients with IBD achieve optimal health and minimize their risk for colon cancer,” said ASGE President Colleen M. Schmitt, MD, MPH, FASGE.

“A diagnosis of inflammatory bowel disease is often overwhelming and frightening for patients,” according to John I. Allen, MD, MBA, AGAF, president of the AGA Institute. “These patients not only have the immediate concern of how the disease affects their life, they also face an increased risk of

developing colorectal cancer, which needs intense surveillance. We hope these guidelines will help gastroenterologists and their patients develop the most appropriate and effective monitoring system to reduce their risk of developing colorectal cancer.”

Recommendations for both detection and management of lesions are included in the statement, along with the strength of each, its status as a recommendation, and background discussion. For surveillance and detection, the following statements are included:

Statement 1: When performing surveillance with white-light colonoscopy, high definition is recommended rather than standard definition.

Statement 2: When performing surveillance with standard-definition colonoscopy, chromoendoscopy is recommended rather than white-light colonoscopy.

Statement 3: When performing surveillance with high-definition colonoscopy, chromoendoscopy is suggested rather than white-light colonoscopy.

Statement 4: When performing surveillance with standard-definition colonoscopy, narrow-band imaging (NBI) is not suggested in place of white-light colonoscopy.

Statement 5: When performing surveillance with high-definition colonoscopy, narrow-band imaging is not suggested in place of white-light colonoscopy.

Statement 6: When performing surveillance with image-enhanced high-definition colonoscopy, narrow-band imaging is not suggested in place of chromoendoscopy.

In addition, the expert group considered the question of whether random biopsies should be performed when endoscopists use high-definition white-light colonoscopy or chromoendoscopy; however, panelists did not reach consensus.

The panel also developed several statements aimed at defining the optimal management of IBD patients when dysplasia is identified, in the absence of endoscopically non-resectable lesions. Statements related to management of dysplasia in these patients with IBD included:

Statement 7: After complete removal of endoscopically resectable polypoid dysplastic lesions, surveillance colonoscopy is recommended rather than colectomy.

Statement 8: After complete removal of endoscopically resectable nonpolypoid dysplastic lesions, surveillance colonoscopy is suggested rather than colectomy.

Statement 9: For patients with endoscopically invisible dysplasia (confirmed by a GI pathologist) referral is suggested to an endoscopist with expertise in IBD surveillance using chromoendoscopy with high-definition colonoscopy.

Loren Laine, MD, AGAF, Yale School of Medicine and VA Connecticut Healthcare System, West Haven, CT, who led the consensus group, said the process for creating these recommendations included representatives of all stakeholder groups – endoscopists, pathologists, nurses, IBD experts, patients and more—in an open and transparent process.

In addition to evidence comparing management strategies, the stakeholder group also considered patient preference as a factor in their recommendations. For example, patients diagnosed with dysplasia are much more likely to refuse or delay colectomy (removal of all or part of the colon) and to choose surveillance colonoscopy. While patients might accept colectomy at a later time, the average patient will do so only when the risk of colorectal cancer is high.

According to Dr. Laine, “We are now seeing more and more of what used to be considered ‘invisible’ lesions. Given that, and the fact that we can remove many of the lesions endoscopically, we have a higher comfort level in using surveillance with these patients, rather than more invasive treatment. This is good news for IBD/colitis patients, particularly those who have a significant portion of the colon involved.”

Tonya Kaltenbach, MD, FASGE, Veterans Affairs Palo Alto Healthcare System and Stanford University School of Medicine (Affiliate), Palo Alto, CA, an expert in advanced endoscopic imaging who also served on the panel, said the time is now for the profession to incorporate available technology as widely as possible. “The technology is optimal, it is available, and it allows us to see lesions in real time.” Before chromoendoscopy, random biopsies were used to detect dysplasia in IBD patients; however, this method has a lower yield and often is less efficient than chromoendoscopy. Dr. Kaltenbach added that the data showing increased incidence of colon cancer among young people only adds to the urgency.

As part of the process to create this consensus statement, the expert panel developed free educational resources and tools to assist endoscopy professionals as they incorporate the recommendations. ASGE’s “Chromoendoscopy with Targeted Biopsy to Detect Nonpolypoid Colorectal Neoplasms” [video](#) is available online and as open access at the ASGE Online Learning Center.

The experts stated that more resources are needed for future training of endoscopists to maximize IBD surveillance, and further research would be valuable for most of the issues addressed in the statement, including: larger trials of chromoendoscopy using high-definition colonoscopy; determination of appropriate surveillance intervals for this procedure; and the natural history of both visible and endoscopically invisible dysplasia.

The consensus statement is a product of the Surveillance for Colorectal Endoscopic Neoplasia Detection and Management in Inflammatory Bowel Disease Patients: International Consensus Recommendations (SCENIC). This document was reviewed and approved by the Governing Boards of the American Society for Gastrointestinal Endoscopy and the AGA Institute. It appears simultaneously in *GIE: Gastrointestinal Endoscopy* and *Gastroenterology*. The SCENIC international consensus statement also was reviewed and endorsed by the Asian Pacific Association of Gastroenterology, British Society of Gastroenterology, Canadian Association of Gastroenterology, European Society of Gastrointestinal Endoscopy, and Japan Gastroenterological Endoscopy Society.

*Two non-profit charitable foundations, the Maxine and Jack Zarrow Family Foundation and the William K. Warren Foundation, provided unrestricted gifts to support the meeting of the expert group and guideline development process. The funding sources had no involvement at any stage of the development process, no representation at the consensus meeting, and no role in the drafting or approval of the manuscript.*

###

### **About Gastrointestinal Endoscopy**

Gastrointestinal endoscopic procedures allow the gastroenterologist to visually inspect the upper gastrointestinal tract (esophagus, stomach and duodenum) and the lower bowel (colon and rectum) through an endoscope, a thin, flexible device with a lighted end and a powerful lens system. Endoscopy has been a major advance in the treatment of gastrointestinal diseases. For example, the use of endoscopes allows the detection of ulcers, cancers, polyps and sites of internal bleeding. Through endoscopy, tissue samples (biopsies) may be obtained, areas of blockage can be opened and active bleeding can be stopped. Polyps in the colon can be removed, which has been shown to prevent colon cancer.

### **About the American Society for Gastrointestinal Endoscopy**

Since its founding in 1941, the American Society for Gastrointestinal Endoscopy (ASGE) has been dedicated to advancing patient care and digestive health by promoting excellence and innovation in gastrointestinal endoscopy. ASGE, with more than 13,000 members worldwide, promotes the highest standards for endoscopic training and practice, fosters endoscopic research, recognizes distinguished contributions to endoscopy, and is the foremost resource for endoscopic education. Visit [www.asge.org](http://www.asge.org) and [www.screen4colonand](http://www.screen4colonand) is the foremost resource for endoscopic education. Visit [www.asge.org](http://www.asge.org) and [www.screen4coloncancer.org](http://www.screen4coloncancer.org) for more information and to find a qualified doctor in your area.

### **About the AGA Institute**

The American Gastroenterological Association is the trusted voice of the GI community. Founded in 1897, the AGA has grown to include more than 16,000 members from around the globe who are involved in all aspects of the science, practice and advancement of gastroenterology. The AGA Institute administers the practice, research and educational programs of the organization. [www.gastro.org](http://www.gastro.org).

Contacts:

Jennifer Michalek, MS, CAE  
Chief Communications Officer  
American Society for Gastrointestinal Endoscopy  
630-570-5632  
jmichalek@asge.org

Aimee Frank  
AGA Institute  
301-941-2620  
media@gastro.org