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CO-ORGANIZED EVENT

# 13th International Conference on Clinical Gastroenterology & Hepatology

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# 2nd International Conference on Digestive Diseases

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## *Rani Kanthan*

*University of Saskatchewan, Canada*

## Dysplasia in inflammatory bowel disease in 2017

Despite increased general awareness, colorectal cancer (CRC) remains the second leading cause of cancer-related death in Canadian men and with a third of CRC patients dying from this disease. These are grim statistics given that this cancer is a well-studied malignancy with defined risk factors, a slow progression, and pre neoplastic lesions that can be detected and treated by colonoscopy. In this context, it is well-recognized that patients with long-standing inflammatory bowel disease (IBD) colitis have a 2.4-fold higher risk of developing colorectal cancer (CRC) than the general population. Surveillance colonoscopy is recommended to detect dysplasia, the precursor of CRC, in order to potentially prevent or cure CRC. Colonoscopy is the gold standard examination to screen for colorectal neoplasms in patients without IBD in whom it has relied on careful examination of the mucosa for 'polyps' "*visible dysplasia*" to interrupt the 'adenoma-carcinoma' sequence. In contrast, routine colonoscopy for surveillance of dysplasia in IBD has relied on extensive random biopsies to identify "*invisible dysplasia*" to interrupt the "inflammation-dysplasia-carcinoma sequence". Traditionally, dysplasia is classified microscopically as low-grade (LGD), high-grade (HGD), or indefinite dysplasia (IND). HGD is associated with a high risk of synchronous or metachronous CRC and is therefore generally considered an unambiguous indication for colectomy in a setting of IBD where the process is felt to be multifocal. Decision-making in case of flat LGD and IND, however, is not straightforward. Progression rates of flat LGD to HGD or CRC vary greatly in previous reports, ranging from no progression to 5-year progression rates of more than 50%. Additionally, dysplasia in the indefinite and low-grade categories in particular is associated with a poor inter observer agreement. The term DALM 'dysplasia associate lesion/mass' can be very confusing as it is not specific. A DALM can be a polyp, non-polypoid lesion or mass. Recently, the Scenic International Consensus [SCENIC] has developed two recommendations on a) how should dysplasia be described macroscopically; and b) how should the statement be implemented into practice. A subgroup of SCENIC panelists have developed a new set of terms to describe the macroscopic appearance of dysplasia using descriptive terms with a recommendation to abandon the term 'DALM". In this presentation, the new recommended classification for dysplasia in IBD will be shared that will result in the paradigm clinical shift from random biopsy techniques to targeted high definition chromoendoscopic biopsy techniques for the identification of "*visible and invisible dysplasia*" in IBD.

### Biography

Rani Kanthan is a Consultant Anatomical Pathologist in the Dept. of Pathology and Laboratory Medicine at the University of Saskatchewan with a focused interest in Surgical Oncology including breast and gastrointestinal tract. She has published 120 peer reviewed manuscripts that are indexed in PubMed/Google scholar and serves as an Editorial Board Member in various journals. She is an active medical educator and continues to participate and present at various national and international meetings with more than 125 conference abstract presentations to her credit.

rani.kanthan@saskatoonhealthregion.ca

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