**EDUCATIONAL OBJECTIVE:** Readers will understand the role of the recently recognized serrated neoplasia pathway in the development of colorectal cancer.

**Sessile serrated polyps: Cancer risk and appropriate surveillance**

**ABSTRACT**
Sessile serrated polyps are a recently recognized type of neoplastic polyp that develops along a molecular pathway different from that of conventional adenomas. While the clinical significance of the serrated pathway to colorectal cancer is clear, further study is needed to understand a patient’s lifetime colorectal cancer risk posed by serrated neoplasms and the optimal postpolypectomy surveillance interval.

**KEY POINTS**
From 20% to 30% of colorectal cancers arise through the serrated polyp pathway (the serrated neoplasia pathway.)

Histologically, serrated polyps have a serrated or saw-tooth appearance from the folding in of the crypt epithelium. Types of serrated polyps include hyperplastic polyps, traditional serrated adenomas, and sessile serrated polyps (also known as sessile serrated adenomas).

Guidelines for surveillance after polypectomy of serrated lesions recommend that patients with a large (≥ 10-mm) or a sessile serrated polyp with cytologic dysplasia or a traditional serrated adenoma be followed more closely than patients with a sessile serrated polyp smaller than 10 mm. Patients with small rectosigmoid hyperplastic polyps should be followed the same as people at average risk.

Sessile serrated polyps are a type of polyp recently recognized to be a precursor of colorectal cancer. They arise from a pathway of genetic alterations different from the pathway that causes the more common and well-understood conventional adenomas (also called tubular adenomas, tubulovillous adenomas, and villous adenomas).

We do not yet know enough about the lifetime colorectal cancer risk for individuals with sessile serrated polyps, nor do we know the optimal surveillance interval for patients who have these polyps on colonoscopy. It is believed that sessile serrated polyps may be the cause of a substantial number of “interval” colorectal cancers—ie, cancers that occur after colonoscopy but before the next scheduled examination.

Serrated polyps get their name from their jagged appearance on microscopy. In the past, all serrated colorectal lesions were called hyperplastic polyps. But with the advent of molecular and genetic diagnostics and with the ability to recognize the subtle morphologic differences of serrated lesions, they have been reclassified into those without malignant potential (hyperplastic polyps) and those that are neoplastic (sessile serrated polyps and traditional serrated adenomas) (TABLE 1).

In this article, we discuss the evolving understanding of the different types of serrated polyps, and we offer our thoughts on a reasonable postpolypectomy surveillance plan in patients with these lesions. We focus on sessile serrated polyps, the most common form of serrated polyp with cancerous potential, since it may be one of our greatest challenges in optimal colorectal cancer prevention.
SESSILE SERRATED POLYPS

CLINICAL SCENARIO
A 65-year-old woman with no family history of colorectal cancer undergoes screening colonoscopy, during which three polyps are found and removed—a 3-mm tubular adenoma in the sigmoid colon, an 8-mm sessile serrated polyp at the hepatic flexure, and a 2-mm hyperplastic polyp in the rectum. When should she undergo follow-up colonoscopy?

Based on the number, size, and pathologic makeup of the polyps in this patient, we would recommend follow-up surveillance colonoscopy in 5 years.

THE SERRATED POLYP PATHWAY: A DIFFERENT PATH TO COLORECTAL CANCER

Colorectal cancer is the third most common cancer in the United States. From 70% to 80% of these cancers arise from adenomatous polyps via the adenoma-carcinoma pathway. This molecular pathway develops through chromosomal instability (CIN) and involves the loss of heterozygosity (the loss of function of one allele). This leads to the progressive accumulation of mutations in tumor-suppressor genes such as adenomatous polyposis coli (APC) and p53, and oncogenes such as KRAS. The result of these mutations is the development of adenomatous polyps that lead to microsatellite-stable colorectal cancers (FIGURE 1).

More recently, studies have shown that the other 20% to 30% of colorectal cancers likely arise through a separate pathway, called the serrated polyp pathway or serrated neoplasia pathway. In contrast to CIN, this pathway is characterized by methylation of CpG islands (CIMP–CpG island methylation phenotype, CIMP) in the promoter regions of specific genes. Central to the serrated polyp pathway is progressive methylation in colonic mucosa; mutation in the BRAF oncogene, activating cell proliferation leading to a sessile serrated polyp; and epigenetic silencing of the DNA mismatch repair gene hMLH1, which is a key step in the progression to a sessile serrated polyp with dysplasia, which may rapidly become a microsatellite-unstable colorectal cancer. Histologically, serrated polyps have a serrated or sawtooth appearance from the folding in of the crypt epithelium, and they include hyperplastic polyps, traditional serrated

From 20% to 30% of colorectal cancers likely arise via the serrated polyp pathway

TABLE 1
Colorectal lesions and their characteristics

<table>
<thead>
<tr>
<th>Lesion</th>
<th>Shape</th>
<th>Size</th>
<th>Prevalence</th>
<th>Location</th>
<th>Precancerous?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LESIONS OF THE ADENOMA-CARCINOMA PATHWAY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adenoma</td>
<td>Sessile, pedunculated, flat</td>
<td>Variable</td>
<td>Extremely common</td>
<td>Right colon more than left colon</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>LESIONS OF THE SERRATED NEOPLASIA PATHWAY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hyperplastic polyp</td>
<td>Flat, sessile</td>
<td>Small, often ≤ 5 mm</td>
<td>Very common</td>
<td>Rectosigmoid colon</td>
<td>No</td>
</tr>
<tr>
<td>Sessile serrated polyp</td>
<td>Flat, sessile</td>
<td>Size varies, but often ≤ 10 mm</td>
<td>Common</td>
<td>Proximal colon</td>
<td>Yes</td>
</tr>
<tr>
<td>Traditional serrated adenoma</td>
<td>Sessile</td>
<td>&lt; 10 mm</td>
<td>Rare</td>
<td>Distal colon</td>
<td>Yes</td>
</tr>
</tbody>
</table>

adenomas, and sessile serrated polyps (sessile serrated adenomas).

Sessile serrated polyps and traditional serrated adenomas (which are rare) are thought to be precancerous, whereas hyperplastic polyps do not have malignant potential.

■ COMMON, BUT PREVALENCE IS NOT CLEARLY ESTABLISHED

The histologic criteria for sessile serrated polyps and traditional serrated adenomas have been elucidated,4–7 but the epidemiology of these serrated polyps is not clear. Small studies have shown that sessile serrated polyps account for 2% to 9% of all polyps removed at colonoscopy8–10; however, larger studies are needed to determine the prevalence because detection by an endoscopist and pathologic diagnosis of these polyps are both operator-dependent.

Traditional serrated adenomas are the least common type of serrated polyp, with a reported prevalence of 0.3%.7 Hyperplastic polyps are by far the most common, accounting for 20% to 30% of all polyps removed at colonoscopy.9,11 Sessile serrated polyps have a predilection for the proximal colon and are associated with female sex and with smoking,12,13 but no consistent effect of other factors on their formation has been reported. In contrast, Wallace et al13 found that obesity, cigarette smoking, dietary fat intake, total caloric intake, and the consumption of red meat were associated with an increased risk of distal (but not proximal) serrated polyps, including hyperplastic polyps, sessile serrated polyps, and traditional serrated adenomas.

■ HYPERPLASTIC POLYPS

Hyperplastic polyps usually occur in the recto-sigmoid colon. They appear as slightly elevated, whitish lesions with a diameter less than 5 mm (FIGURE 2). Microscopically, the serrated architecture is present in the upper half of their crypts (FIGURE 3). The proliferative zone is more or less normally located in the basal half of the crypt (the nonserrated portion), with nuclei that are small, uniform, and basally located.14 The bases of the crypts have a rounded contour and do not grow laterally along the muscularis mucosae.

■ SESSILE SERRATED POLYPS

Endoscopically, sessile serrated polyps are often subtle, appear flat or slightly elevated, and can be covered by yellow mucus (FIGURE 4). They are typically found in the proximal colon and are usually larger than typical adenomas, with 50% being larger than 10 mm.10

Histologically, the serrations are more prominent than those of hyperplastic polyps and involve the entire length of the crypt (FIGURE 5). The crypt bases are often dilated and display lateral growth along the lamina muscularis mucosae, resembling a letter t or l. The lamina muscularis mucosae is often thinner than normal. Crypts from sessile serrated polyps are occasionally found beneath the muscularis mucosae, a condition called pseudo-invasion.7

■ TRADITIONAL SERRATED ADENOMAS

Traditional serrated adenomas are usually left-sided. In contrast to the other types of serrated polyps, they are histologically often villiform and are lined by cells with elongated nuclei and abundant eosinophilic cytoplasm (FIGURE 6). Unlike those in sessile serrated polyps, the crypt bases do not display an abnormal architecture; rather, traditional serrated adenomas have abundant ectopic crypts (“budding crypts”) in the long, slender villi.7

Traditional serrated adenomas also appear
SESSILE SERRATED POLYPS

One study found that large serrated polyps were associated with a threefold higher risk of synchronous advanced neoplasia.

to be genetically distinct from sessile serrated polyps. They are most often characterized by a KRAS (or less commonly, BRAF) mutation and commonly have methylation of the DNA repair gene MGMT (O-6-methylguanine-DNA methyltransferase) rather than hMLH1.

CHALLENGES TO EFFECTIVE COLONOSCOPY

Colonoscopic polypectomy of adenomatous polyps reduces the incidence of colorectal cancer and the rate of death from it. However, recent data show that colonoscopy may not be as effective as once thought. As many as 9% of patients with colorectal cancer have had a “normal” colonoscopic examination in the preceding 3 years. In addition, the reduction in incidence and mortality rates was less for cancers in the proximal colon than for cancers in the distal colon.

Possible explanations for this discrepancy include the skill of the endoscopist, technical limitations of the examination, incomplete removal of polyps, and inadequate bowel preparation. Several studies have shown that interval colorectal cancers are more likely to be found in the proximal colon and to have the same molecular characteristics as sessile serrated polyps and the serrated colorectal cancer pathway (CIMP-high and MSI-H). Therefore, it is now thought that sessile serrated polyps may account for a substantial portion of “postcolonoscopy cancers” (ie, interval cancers) that arise in the proximal colon.

Two large studies of screening colonoscopy confirmed that the ability to detect sessile serrated polyps depends greatly on the skill of the endoscopist. Hetzel et al studied the differences in the rates of polyp detection among endoscopists performing more than 7,000 colonoscopies. Detection rates varied significantly for adenomas, hyperplastic polyps, and sessile serrated polyps, with the greatest variability noted in the detection of sessile serrated polyps. Significant variability was also noted in the ability of the pathologist to diagnose sessile serrated polyps.

In the other study, a strong correlation was found between physicians who are “high detectors” of adenomas and their detection rates for proximal serrated polyps. There is widespread acceptance that screening colonoscopy in average-risk patients age 50 and older should detect adenomas in more than 25% of men and more than 15% of women. There is no current minimum recommended detection rate for sessile serrated polyps, but some have suggested 1.5%.

POLYPS AS PREDICTORS OF CANCER RISK

Certain polyp characteristics predict the risk of metachronous, advanced neoplasia. Advanced neoplasms are defined as invasive carcinomas,
adenomas 10 mm or larger, or adenomas with any villous histology or high-grade dysplasia. Patients with one or two small tubular adenomas have a much lower risk of metachronous advanced neoplasia than do patients with more than two adenomas or advanced neoplasms. Current recommended surveillance intervals vary on that basis (TABLE 2).

People who harbor serrated neoplasms are at high risk of synchronous serrated polyps and advanced adenomatous neoplasia. Pai et al found that patients with one sessile serrated polyp were four times more likely to have additional serrated polyps at the same time than an unselected population. The authors suggested that this indicates a strong colonic mucosal-field defect in patients with sessile serrated polyps, thereby predisposing them to the development of synchronous serrated polyps.

Li et al found that large serrated polyps (ie, > 10 mm) are associated with a risk of synchronous advanced neoplasia that is three times higher than in patients without adenomas. Schreiner et al determined that patients with either a proximal or a large serrated polyp were at higher risk of synchronous advanced neoplasia compared with patients who did not have those lesions. Vu et al found that patients who have both sessile serrated polyps and conventional adenomas have significantly larger and more numerous lesions of both types. In addition, these lesions are more likely to be pathologically advanced when compared with people with only one or the other type.

In the only study of the risk of advanced neoplasia on follow-up colonoscopy, patients with advanced neoplasia and proximal serrated polyps at baseline examination were twice as likely to have advanced neoplasia during subsequent surveillance than those with only advanced neoplasia at baseline examination.
Further study is needed on the lifetime risk to patients with serrated neoplasms and the surveillance interval.

Therefore, it seems clear that the presence of large or proximal serrated polyps or serrated neoplasms predicts the presence of synchronous and likely metachronous advanced neoplasms.

Guidelines for postpolypectomy surveillance for individuals with serrated lesions of the colon have recently been published. Patients with large serrated lesions (≥ 10 mm) or an advanced serrated lesion (a sessile serrated polyp with or without cytologic dysplasia or a traditional serrated adenoma) should be followed closely. Patients with small (< 10-mm) rectosigmoid hyperplastic polyps should be followed as average-risk patients. If a patient with a sessile serrated polyp also has adenomas, the surveillance interval should be the shortest interval recommended for either lesion.

### SURVEILLANCE FOR OUR PATIENT

In our patient, given the number, size, and histologic features of the polyps found, surveillance colonoscopy should be considered in 5 years. Although the clinical significance of the serrated pathway to colorectal cancer cannot be argued, further study is required to understand the lifetime risk to patients with serrated neoplasms and the optimal surveillance interval.

### REFERENCES


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