BC CANCER
Provincial Health Services Authority

Surgery Network Newsletter

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Introduction to Regional Surgical Leads

BC Cancer has recently hired a Regional Surgical Lead (RSL) for each of B.C.'s five regional health authorities. The RSLs will work collaboratively with surgeons, hospital administration, regional health authority executives and BC Cancer regional and provincial leadership to implement strategic quality initiatives and enhance communication between the region's surgeons and BC Cancer medical providers.

Dr. Cailan MacPherson Island Health Region

Dr. MacPherson is a colorectal and general surgeon at Royal Jubilee Hospital and Victoria General Hospital. Fellowship-trained in colon and rectal surgery at the University of Calgary, with a focus in quality improvement in the diagnosis and management of rectal cancer, his practice is focused on colorectal oncology, inflammatory bowel disease and endoscopy. He is the UBC Island Medical Program Discipline Specific Site Leader for Surgical Education. Furthermore, Dr. MacPherson is also the Island Health Authority representative for the Colorectal Surgical Tumour Group and General Surgeons of BC.

Dr. Shawn MacKenzie Fraser Health Region

Dr. MacKenzie is a fellowship-trained hepato-pancreatico-biliary (HPB) surgical oncologist. He has developed a reputation as a high quality HPB surgeon at Royal Columbian Hospital and is Chair of the HPB Surgical Tumor Group. His experience developing cancer programs within integrated healthcare systems, where the focus is high-quality multidisciplinary cancer care, will assist in providing leadership in this new role.

Dr. Guy Paterson Northern Health Region

Dr. Paterson was born and raised in Edmonton, Alberta. He attended the University of Alberta for his medical degree, followed by a residency in urology. He has practiced as a urologist in Prince George since 2007. When not working, he enjoys his small hobby farm with chickens and a few cows, or can be found fishing some of his favorite rivers.

IN THIS ISSUE

Dr. Jason Park Vancouver Coastal Health Region

Dr. Park is a surgical oncologist at Vancouver General Hospital and a Clinical Associate Professor at UBC, specializing in colorectal cancer. Fellowship-trained in surgical oncology at Memorial Sloan-Kettering Cancer Center in New York City, Dr. Park serves as an Expert Clinical Advisor to the Canadian Institute for Health Information (CIHI), is the Associate Editor for the Canadian Journal of Surgery, alongside holding the role of Assistant Chair of the Royal College of Physicians and Surgeons of Canada Surgical Oncology Exam Committee and President Elect of the Canadian Society for Surgical Oncology.

Dr. Chris Baliski Interior Health Region

Dr. Baliski is a surgical oncologist at BC Cancer - Kelowna and Division Head of General Surgery at Kelowna General Hospital. He is involved in the Melanoma and Endocrine Surgical Tumour Groups. Fellowship-trained at the University of Alberta and the University of Toronto, his clinical interests are breast, melanoma and endocrine surgery. His focus on health outcomes research, relating to quality of cancer surgical care and patient reported outcomes will be an asset as he takes on this new role. Outside of work, he enjoys spending time biking, running, drinking wine, while dreaming of a day when he can play 18-holes of golf on a weekly basis.

Introduction to Surgery Network Committee Chairs

Dr. Janice Kwon - Chair, Research & Outcomes Evaluation Committee

Dr. Kwon is a gynecologic oncologist and Vice Head and professor in the Department of Obstetrics and Gynecology at UBC. She serves as Chair of the Priority and Evaluations Committee at BC Cancer and Chair of the National BRCA Collaborative. Her expertise is in hereditary cancer syndromes and conducting cost-effectiveness analyses of testing criteria and risk-reducing interventions. Her background includes a Master in Public Health from Harvard University and an appointment at the University of Texas M.D. Anderson Cancer Center in Houston. She currently holds a Health Professional Investigator Award from the Michael Smith Foundation for Health Research.

Dr. Heather Stuart - Chair, Continuing Professional Development & Knowledge Transfer Committee

Heather Stuart is a surgical oncologist at BC Cancer and Vancouver General Hospital, with an interest in gastrointestinal and cutaneous malignancies. She completed her surgical oncology training at the University of Miami and a Master of Science at UBC. Her current clinical and research foci include optimizing outcomes for patients with gastroenteropancreatic neuroendocrine tumors and cutaneous malignancies. She is the co-chair of the BC Cancer Gastrointestinal Clinical Outcomes Unit and the research chair for the general surgery residency training program.

Vacant - Chair, Clinical Practice & Quality Assurance Committee

The CPQA Chair is designed to improve practices and increase knowledge within surgical oncology throughout the province by promoting and championing surgical quality improvement endeavors and standards. The Chair will work collaboratively with BC Cancer Surgery executive leadership, BC Cancer regional leadership, Health Authority Regional Surgical Leads, surgeons and hospital administration to advocate surgical quality assurance/improvement, ensuring cancer patients in B.C. have access to the highest quality surgical cancer care.

CLICK HERE TO VIEW CPQA POSTING – CLOSES DECEMBER 17TH

(Best viewed in Chrome browser)

Introduction: Surgical Oncology Fellow – Stephanie Marcil

Dr. Stephanie Marcil graduated from McGill University medical school and completed her general surgery training at the University of Montreal in Quebec, Canada. She is currently in her first-year of fellowship in complex surgical oncology at the University of British Columbia. She has a special interest in the management of advanced gastrointestinal malignancies, specifically in treatment advances of patients with gastric cancer. She is currently a co-investigator in a prospective Canadian phase II clinical trial to further clarify the role of gastrectomy, combined with cytoreductive surgery and hyperthermic intraperitoneal chemotherapy (HIPEC) for the management of locally advanced gastric cancer and gastric cancer presenting with limited peritoneal disease.

Gastric cancer is 14th in incidence in Canada, which translates into ~4200 new cases per year, with most patients presenting with locally advanced or metastatic disease. Since its introduction as a treatment modality, cytoreductive surgery and HIPEC has been established as a treatment option for the management of peritoneal disease from colorectal, ovarian, and appendiceal origin. Its role in the management of peritoneal disease, in the clinical context of gastric cancer, has yet to be established. The poor overall survival of patients with peritoneal disease from gastric cancer with the present standard care, and the significant incidence of peritoneal carcinomatosis as treatment failure after surgery with curative intent are the foundation of this clinical trial. Accrual for this study is expected to begin in early 2022.

For more information, please email stephanie.marcil@mail.mcgill.ca

Sentinel Lymph Node Biopsy for Melanoma in B.C.

Dr. Sita Ollek, Surgical Oncologist & General Surgeon, SITE & BC Cancer

The incidence of cutaneous malignant melanoma continues to rise worldwide, and in Canada, melanoma accounts for 80% of skin cancer related morality.[1] Given that the majority of patients will present with clinically node negative disease, a sentinel lymph node biopsy (SLNB) plays a central role in the management of melanoma.

The importance of a SLNB has been long established and the landmark MSLT-I trial demonstrated that a SLNB provides important prognostic information.[2] Although a positive SLNB was previously a routine indication to proceed with a completion lymph node dissection (CLND), there has been a shift away from this approach after two key trials (MSLT-II and DeCog-SLT) failed to show a survival benefit with CLND.[3,4] Furthermore, these trials demonstrated increased morbidity with CLND.

Despite this shift in the surgical management of a positive SLNB, accurate staging of the nodal basin has arguably never been more relevant as in the current era of adjuvant systemic therapy in melanoma. There is now strong evidence for and a well-established role of adjuvant systemic therapy, with both immunotherapy and targeted therapy, in stage III melanoma. Studies have demonstrated significantly improved survival outcomes with adjuvant systemic therapy, including improved overall survival, recurrence free survival and distant metastasis free survival.[5–7] However, if the nodal basin is not staged with a SLNB, patients will not have the opportunity to benefit from these therapies.

The indications for a SLNB are outlined in several major societal guidelines (Table 1). In general, a SLNB is recommended for patients with a melanoma with Breslow depth >1.0mm (i.e. pT2a or greater). A SLNB should be discussed and considered for those with a melanoma with Breslow depth <0.8mm with ulceration or 0.8 – 1.0mm regardless of ulceration (i.e. pT1b). As always, consideration should be given to individual patient age and co-morbidities that may impact the benefit of a SLNB or candidacy for adjuvant systemic therapy.

Despite widely available guidelines on the indications for a SLNB and the known prognostic and therapeutic implications of a positive sentinel node, SLNB remains underutilized.[8] A study in British Columbia, which included 759 patients with melanoma, found that a SLNB was performed in only 54% of cases when indicated.[9] The rate of SLNB was lowest in patients with stage IIC melanoma, amongst which only 35% of patients underwent a SLNB. This is particularly concerning given the inherently high risk nature of these patients.

Staging of the nodal basin with a SLNB remains central in the management of patients who present with clinically node negative melanoma. Efforts should be made to ensure all specialists treating melanoma understand the indications and relevance of a SLNB.

References for this article can be found on the BC Cancer Surgery Network website.

Table 1. Society SLNB recommendations

Society	Year	Breslow depth	SLNB Recommendation
NCCN[a]	2021	<0.8mm without ulceration	Not recommended
		<0.8mm with ulceration	Discuss and consider
		0.8 – 1.0mm	Discuss and consider
		>1.0mm	SLNB recommended
ASCO-SSO[b]	2017	<0.8mm without ulceration	Not recommended
		<0.8mm with ulceration	Discuss and consider
		0.8 – 1.0mm	Discuss and consider
		1.01 – 4.0mm	SLNB recommended
		>4.0mm	SLNB may be recommended
ESMO[c]	2020	<0.8mm without ulceration	Not recommended
		<0.8mm with ulceration	Discuss and consider
		0.8 – 1.0mm	Discuss and consider
		>1.0mm	SLNB recommended
CCO[d]	2019	<0.8mm without ulceration	Not recommended
		<0.8mm with high risk features[e]	Discuss and consider
		0.8 – 1.0mm	Discuss and consider
		>1.0mm	SLNB recommended

a – National Comprehensive Cancer Network
b – American Society of Clinical Oncology and Society of Surgical Oncology
c – European Society of Medical Oncology
d – Cancer Care Ontario clinical practice guideline
e – High risk features include Clark level IV/V, mitotic rate ≥1/mm^2, ulceration or microsatellites

Surgical Oncology Network Travel Award Recipients

Accuracy of Preoperative Imaging Estimates: Optimizing the Planning for Breast Conserving Surgery

Hannah Kapur

Breast cancer is the most common cancer in Canadian women, with 1 in 8 women expected to develop breast cancer in their lifetime. Fortunately, widespread mammography screening has helped to catch breast cancers at an earlier stage, often when they are non-palpable. Surgery is a critical first line treatment for early-stage breast cancer, for which there are two surgical options: *total mastectomy* and *breast conserving surgery (BCS)*. Research has found that there is no difference in survival between these two surgical methods for early-stage breast cancer. Therefore, BCS provides an opportunity to de-escalate surgical treatment when adequate margins and cosmesis can be achieved.

However, despite these findings, there has been a trend noted towards mastectomy and even elective bilateral mastectomy, perhaps due to fear of cancer recurrence and perception of improved survival. In response, American (NAPBC) and European (EUSOMA) Breast Societies have published surgical Quality Indicators (QIs) for BCS rates to guide breast centres to reduce the overtreatment of breast cancer. QIs are based on preoperative imaging size (PIS), since an increasing number of breast cancers are non-palpable. PIS modalities include mammography, ultrasonography and MRI.

Our study aimed to determine if PIS are able to accurately inform surgical decision making and reliably form the basis for QI recommendations by comparing to postoperative pathology sizes. Our study evaluated all patients having breast cancer surgery between 2013-2017 at our institution. We compared imaging size, based on mammography, ultrasonography and MRI to post-operative tumour sizes.

Our results found that mammography and MRI tended to overestimate tumour sizes less than 20mm but ultrasonography did not. Furthermore, for tumour sizes larger than 20mm, mammography and ultrasonography underestimated tumour size.

In summary, patients can be reassured that imaging size can be used dependably by surgeons to plan lumpectomy for clinical T1 tumors. Since tumour sizes less than 20mm are typically recommended to undergo BCS based on QI recommendations, breast surgeons can be confident in recommending BCS based on imaging sizes. For larger tumors, underestimation by PIS should be considered in surgical planning.

Time to First Adjuvant Treatment After Oncoplastic Breast Reduction

Shivani Mysuria

Last summer, I had the opportunity to conduct a research project looking at an overview of oncoplastic breast reduction (OBR) surgery at Providence Breast Centre. This surgery combines oncology and plastic surgery principles to allow surgical removal of tumors while maintaining aesthetic appearance, which can be very important to patients. Compared to traditional breast conservation surgery (BCS), OBR can allow more breast tissue to be removed and often only involves one surgery, making it a favourable surgical option for patients with large breasts or those wanting a breast reduction to begin with.

Through my work on this project, we analyzed the time to first adjuvant therapy after OBR surgery. The relative start date (RST) was calculated as time between OBR surgery and the earliest start date of a first adjuvant therapy.

We looked at the following three adjuvant treatments: *chemotherapy*, *radiation* and *endocrine therapy*. In total, 88.9% of patients received adjuvant therapy. The average relative start date was 7.0 weeks for chemotherapy, 9.4 weeks for radiation, 8.0 weeks for endocrine and 8.4 weeks for any type of adjuvant therapy. 97.2% had adjuvant therapy by 16 weeks. None of the OBR patients required readmission or reoperation due to complications after the surgery.

In conclusion, the average time to a first adjuvant treatment post-OBR conformed to local recommendations for post-BCS. This research is important because it can tell us whether access to adjuvant treatment is delayed or not at our centre, and whether any complications played a role in receiving adjuvant treatment on time.

Breast Fibroepithelial Lesions - When is it still necessary?

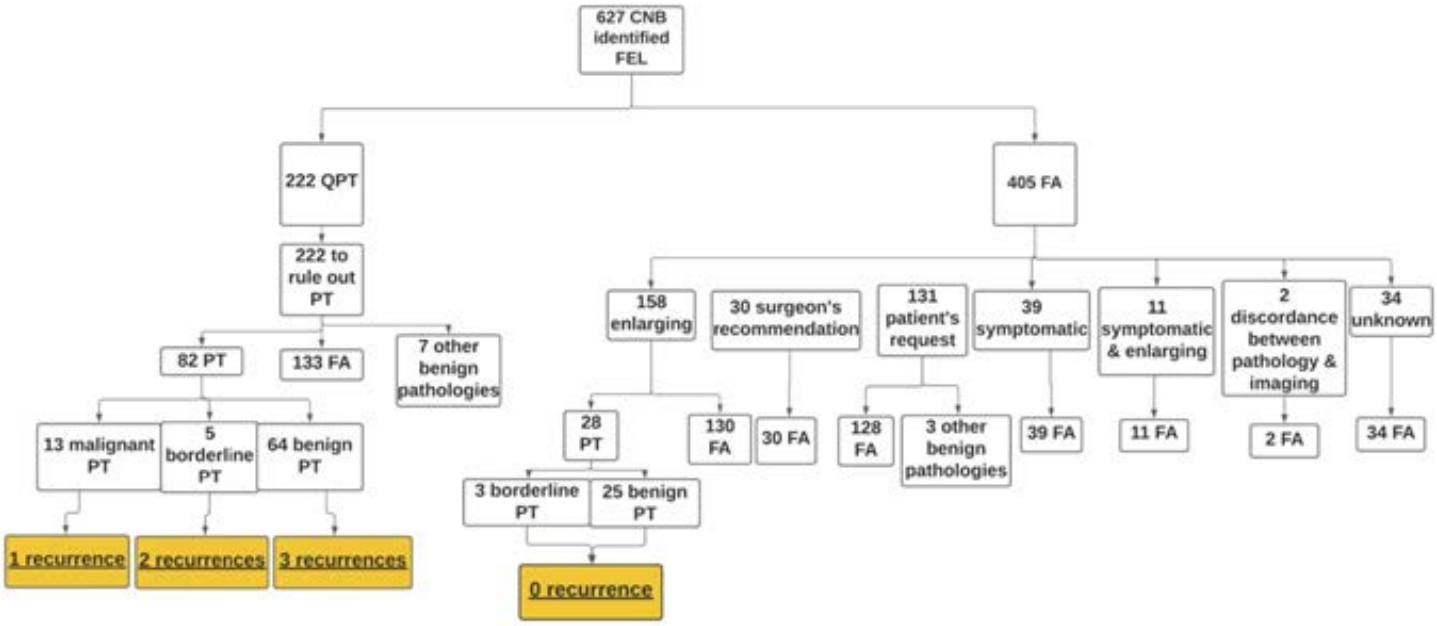
Dorsa Mousa-Doust

Breast fibroepithelial lesions (FEL) range from benign fibroadenoma (FA) to malignant phyllodes tumor (PT). While FAs are benign and do not require routine excision, PTs require excision due to concerns about potential for malignant transformation. It can be difficult to distinguish FA from PT on core needle biopsy (CNB) due to overlapping histological features. In such instances, pathologists may add a comment of concern to FEL such as “cannot rule out phyllodes” (QPT).

The current guidelines recommend excision of FA over 3 cm in size to avoid missing PT**.** The purpose of this study was to assess whether the 3 cm threshold is justified, and to identify a low-risk group that can be spared surgery.

Patients having surgery with FEL on CNB at Mount St. Joseph Hospital between 2009-2018 were identified from a prospective database and chart review was used to obtain clinical and follow-up data. CNB results were classified as FA or QPT. The association of clinical, radiological and pathological characteristics as risk factors for upstaging to PT were also evaluated. Of 627 cases of FEL, 405 had CNB of FA. A total of 110 cases of PT were identified upon surgical excision, 28 patients had CNB of FA and the remainder had QPT. The overall upstage rate to PT was 17.5%. Follow-up was available for 86 patients with a mean of 56 months; 6 patients had recurrence of PT, all of whom had QPT on CNB . All patients diagnosed with PT following CNB of FA had enlarging lesions. The finding of PT was associated with increasing age and size on multivariate logistic regression.

In conclusion, our data does not support routine excision of FA larger than 3 cm and we recommend that the threshold for excision of FA be 4 cm based on size alone or 3 cm and enlarging. Patients with CNB of QPT should continue to have excision due to high risk of upstage to PT and association with recurrence.



FALL TRAVEL AWARDS DEADLINE

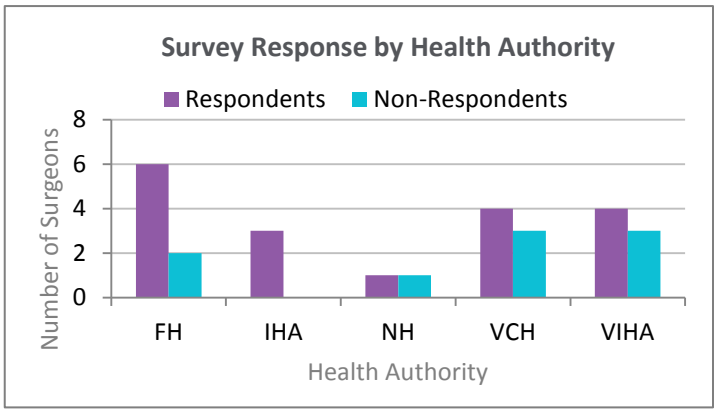
Applications for travel awards may be submitted for conferences that are being held virtually. Costs for registration or membership fees to present are eligible for reimbursement. For more information, click here or email SurgeryNetwork@bccancer.bc.ca.

Applications must be submitted by December 15th

Multidisciplinary Cancer Conference for Rectal Cancer Patients

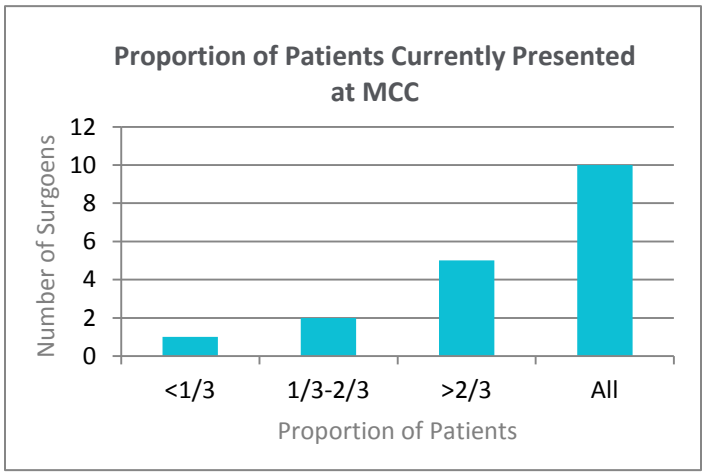
Dr. Carl Brown, Program Medical Director, Provincial Surgical Oncology, BC Cancer

In July 2021, BC Cancer Surgery conducted a survey to understand the current-state of Multidisciplinary Cancer Conference (MCC) use for rectal cancer patients in BC, as well as to gain an estimated proportion of rectal cancer patients that are presented at MCC. The survey was sent to 27 surgeons across the province who perform rectal cancer surgery; with the 18 responding surgeons constituting 90% of the rectal cancer surgery volume in 2019/2020.



Surveyed surgeons were asked about the number of rectal cancer surgery patients they presented at MCC, whether MCC improves patient care, ideal criteria for selecting patients to present at MCC and surgeons' overall access to MCC, including barriers and areas for improvement.

- 83% of respondents presented at least 2/3rds of their patients at MCC, with 56% presenting all of their patients at MCC.
- 94% of respondents felt that presenting rectal cancer patients at MCC improved patient care.
- 72% of responding surgeons felt that all rectal cancer patients should be discussed at MCC. Suggested guidelines were also provided by those who felt only selected patients be presented at MCC based on clinical features.



Survey results demonstrated that surgeons believe presenting their patients at MCC improves patient care and most felt all cases should be discussed. However, common barriers to access include: *MCC timing conflicts with other obligations, MCCs include non-rectal cancer patients irrelevant to surgeon practice and unavailability of critical collaborators (i.e. radiology, pathology) to attend.*

In addition to identifying barriers, the responding surgeons provided in-depth feedback and suggestions to improve the MCC. Suggestions included: *changing conference timing, providing a formalized written summary of recommendations for those unable to attend and creating a rectal cancer MCC separate from the general GI conference.*

The BC Cancer Surgery Network will use the information gathered to work closely with leadership and providers to address the identified barriers, as well as to improve and measure access for rectal cancer patients in the province.

SAVE THE DATE - SPRING 2022

ANNUAL SURGICAL ONCOLOGY NETWORK SPRING UPDATE

Oncologic Liver Transplant

Dr. Peter Kim, Head, Liver Transplant Program of B.C.
Dr. Phil Leung, Liver Transplant Fellow, VGH


Dr. Kim


Dr. Leung

As experience and expertise with liver transplantation have grown, efforts have been made to evaluate additional indications outside of liver failure. There has been particular interest in utilizing liver transplant in the context of oncology, as liver transplant is a potentially curative treatment for patients with liver malignancies. This is complicated by the scarcity of livers, as the potential benefits to oncology patients must be weighed against the risk of displacing other prospective recipients on the waitlist. At present, the use of liver transplant in the management of a limited number of primary and secondary liver malignancies has been studied.

Primary Liver Malignancies

The most well-defined oncologic indication for liver transplant is hepatocellular carcinoma (HCC). First reported in 1996, the Milan criteria continue to be utilized to select patients with HCC who are likely to benefit from liver transplant.[1] These include: one lesion ≤ 5 cm or three lesions ≤ 3 cm, in the absence of macrovascular invasion or extrahepatic metastasis.[1,2] Subsequent long-term outcomes have been found to be favourable, with 5-year overall survival (OS) at 75% and a recurrence rate of 10 – 15% in these patients. [2,3]

The next most common indication for liver transplant is hilar cholangiocarcinoma. Patients are typically enrolled in an institution-specific neoadjuvant chemoradiotherapy protocol popularized by the Mayo transplant team ("Mayo Protocol").[4]

The criterion for inclusion involves unresectable hilar cholangiocarcinoma measuring less than 3 cm, with no regional lymph node involvement.[4] In addition, patients with primary sclerosing cholangitis accompanied with a suspected malignant stricture and CA19-9 > 100 U/ml may also be offered neoadjuvant chemoradiotherapy.[4] The 5-year OS (65%) and recurrence rate (20%) in these patients compared favorably to outcomes following conventional therapy for cholangiocarcinoma.[4]

Intrahepatic cholangiocarcinoma (ICC) is a relatively rare indication for liver transplant. Initial studies demonstrated poor overall outcomes, although survival and recurrence were notably improved with lesions ≤ 2 cm.[5] More recent evidence suggests that liver transplant may benefit select ICC patients proven to have stable disease on neoadjuvant therapy, although larger studies are required.[6]

Secondary Liver Malignancies

Metastatic neuroendocrine tumors (NET) have become an increasingly common indication for liver transplant, with excellent outcomes reported in highly select patients, including a 5-year survival approaching 97% and recurrence rate of 13%.[7,8] Many of these studies follow the Milan criteria for NET, which requires that patients undergoing liver transplant for metastatic NET have the following: confirmed carcinoid with a primary tumour drained by the portal vein, no extrahepatic disease, evidence of stable disease, and no more than 50% hepatic replacement by tumor.[7,8] More recent literature suggests that outcomes may be somewhat less favourable, with one review reporting 5-year survival at 63% and recurrence rate ranging from 31-56%.[9] Taken together, this suggests that additional study is required to delineate the outcomes from liver transplant for metastatic NET.

Oncologic Indications for Liver Transplant

	HCC	Hilar Cholangiocarcinoma	NET	CLM	ICC
5-year survival	75%	65%	97%	60%	45-65%
Recurrence rate	10-15%	20%	13%	90%	13-55%
Burden on wait list	20%	1%	<1%	<1%	<1%

There has been growing interest in utilizing liver transplant in the management of colorectal liver metastases (CLM). Several studies originating from Norway have evaluated the use of liver transplant in the context of extensive or unresectable liver-only colorectal metastases.[10,11] These have demonstrated some improvement in OS for select patients when compared to conventional therapies, including resection following portal vein resection or chemotherapy, with 5-year survival reaching 60%.[10,11] The recurrence rate when liver transplant is performed for CLM has been reported to be as high as 90%; however, the majority of these involve lung metastases, which are often amenable to resection.[11,12] In North America, liver transplant for CLM is rare and is only offered at a number of institutions as part of a study protocol.

Overall, the application of liver transplant to the field of oncology remains an area of ongoing investigation. At present, apart from HCC, the oncologic indications for liver transplant have not been well established. While there is some evidence to support consideration of liver transplant in highly selected patients with cholangiocarcinoma, metastatic NET or CLM, given the scarce nature of livers, further studies are required to support routine listing of these patients for liver transplant.

References for this article can be found on the BC Cancer Surgery Network website.

Endoscopy Update: Sessile Serrated Lesions – New Name, Same Challenges

Dr. Jason Park, Regional Surgical Lead, Vancouver Coastal Health Region
Surgical Oncologist and General Surgeon, Vancouver General Hospital

Surgeon endoscopists may see the term "sessile serrated lesion" in pathology reports of colon polypectomy specimens and may wonder what these are and how they relate to sessile serrated "adenomas" or "polyps". The terminology and classification of these lesions have evolved in recent years, which can lead to confusion.

Serrated lesions of the colon or rectum were once considered to be benign lesions with no malignant potential. As understandings of these lesions have evolved, it is now recognized that 15-30% of sporadic colorectal cancers (CRCs) arise from serrated lesions via the serrated neoplasia pathway, a distinct carcinogenesis pathway separate from the traditional adenoma-carcinoma sequence. Moreover, the serrated neoplasia pathway is thought to account for higher proportion of post colonoscopy (potentially missed) CRCs.

Serrated lesions of the colon or rectum include all non-malignant epithelial neoplastic lesions that show a serrated (saw tooth folding pattern) morphology in their crypt epithelium. The World Health Organization (WHO) recently updated their classification of serrated lesions and introduced new terminology. The most important change in terminology for surgeon endoscopists to know is adoption of the term "sessile serrated lesion" (SSL). The SSL term replaces previously used "sessile serrated adenoma" or "sessile serrated polyp" terms. These latter terms fell out of favor because 1) most are not adenomatous (do not show cytologic dysplasia, an essential component of adenomas) and 2) many do not have a polypoid morphology.

SSLs are considered premalignant lesions, as about 15% of SSLs can show dysplastic features. Under the new WHO classification system, the pathologist should explicitly report dysplasia within an SSL when it is present. Previously, when the "adenoma" term was included, it could be unclear for non-pathologists to know whether dysplasia was present or not. In most cases, it was not present unless specified, but this new system eliminates any potential confusion.

The presence of dysplasia within an SSL impacts surveillance recommendations. SSLs with dysplasia are considered higher risk lesions. Dysplasia in an SSL can be graded as low or high grade. However, the clinical significance of this distinction is unknown and they are currently managed in the same way. An SSL with any dysplasia is managed with earlier surveillance, similar to high-grade dysplasia in a conventional adenomatous polyp. Other SSL higher risk features requiring earlier surveillance include size > 10 mm and number ≥ 3.

SSLs may be harder to detect and remove endoscopically than other polyps. They are commonly found in the right colon and may have a flat morphology with indistinct borders. They produce excessive mucin and can be covered with a thin mucus cap, with a rim of debris, which may make them even harder to see. Authors have previously tried to characterize the most common morphologic descriptors of SSLs. The most common "sentinel signs" that first captured the endoscopists' attention were a mucous cap (25%), alteration of the contour of a mucosal fold (25%), a rim of debris or bubbles (22%), and a dome-shaped protuberance (20%). Even when detected, studies have shown that SSLs have a higher rate of incomplete resection compared to conventional adenomas, which can be associated with higher recurrence risks. Submucosal injection of methylene blue may help endoscopists better visualize a SSL's borders to ensure complete removal (Figure 1).

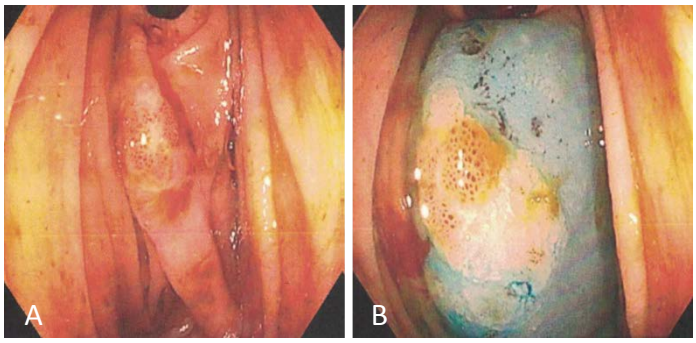


Figure 1

A sessile serrated lesion (A) prior to submucosal injection, the size and borders can be hard to appreciate, (B) after submucosal injection of methylene blue, the borders are clearer and it is easier to tell the size, which is larger than initially appreciated.

CLINICAL PRACTICE POINTS

1. The "sessile serrated lesion" (SSL) term has replaced the previously used sessile serrated "adenomas" or "polyps" terms
2. SSL are harder to detect because of their paler appearance, flatter shape and indistinct borders, which may require additional maneuvers to detect and completely remove.
3. Most guidelines recommend a surveillance interval of 3 years after endoscopic removal of SSLs with:
    a. Size ≥ 10 mm
    b. ≥ 3 lesions
    c. Any dysplasia*
4. Otherwise, Canadian and U.S. guidelines recommend a 5 year surveillance interval after endoscopic removal of < 3 SSLs or size < 10 mm

**The Canadian Association of Gastroenterology Working Group and the US Multisociety Task Force. The International Serrated Lesions Expert Panel recommends a surveillance interval of 1-3 years for SSL with dysplasia.*

References for this article can be found on the BC Cancer Surgery Network website.

BC Cancer Surgery Network News

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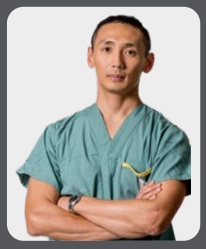

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BC CANCER SURGERY NETWORK NEWSLETTER

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VISIT THE SURGERY NETWORK WEBSITE

The BC Cancer Surgery Network exists to promote and advance quality cancer surgery throughout the province, enable the integration of quality surgical oncology services into the formal cancer care system and ensure that patients have the best possible outcomes through consistent access to high quality multidisciplinary care. In enhancing appropriate, equitable and timely access to surgical services for cancer patients as close to home as possible, the Network supports communication and sharing of knowledge between subspecialty and community surgeons, their respective hospitals and BC Cancer.