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# Endoscopic Evaluation of Inflammatory Bowel Disease With High-Grade Dysplasia Should Not Be Delayed During the COVID-19 Pandemic: A Case Report

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A 63-year-old woman with long-standing ulcerative colitis was found by routine, high-definition white light surveillance colonoscopy to have high-grade dysplasia (HGD)

on a random biopsy of flat, erythematous mucosa of the rectosigmoid colon. Several previous surveillance colonoscopies had consistently shown mild-moderate pancolitis and pseudopolyposis without dysplasia. The patient's bowel complaints were moderately controlled by oral mesalamine, with multiple previous refusals to escalate therapy to achieve mucosal healing. After a second gastrointestinal pathologist review confirming HGD, the case was discussed at our institution's multidisciplinary inflammatory bowel disease (IBD) conference, after which the patient was offered colectomy. The patient, however, refused and was referred to the advanced endoscopy service for chromoendoscopy and possible endoscopic resection. Shortly after the referral, the novel coronavirus disease 2019 (COVID-19) pandemic arose, and the patient chose to postpone her colonoscopy by 3 months because of the fear of contracting the novel coronavirus. When it was finally performed, a new 3 cm sessile lesion (Paris class IIb) in the rectosigmoid colon was identified (Figure 1). It was removed via endoscopic mucosal resection with snare tip coagulation of the resection border. Pathology revealed moderately differentiated adenocarcinoma. The patient was referred to colorectal surgery for colectomy.

Dysplasia identified on random (non-targeted) biopsies of the colon mucosa without a visible lesion is defined as invisible dysplasia (1). The risk of undetected, synchronous colorectal cancer (CRC) in a patient with invisible HGD has been estimated to be as high as 42% (2). This high CRC risk prompted early guidelines and expert opinion to recommend that invisible

HGD proceed immediately to colectomy. The 2015 Surveillance Colorectal Endoscopic Neoplasia Detection and Management in Inflammatory Bowel Disease Patients: International Consensus Recommendations (SCENIC) however suggests that patients with IBD and invisible dysplasia may be referred to an expert endoscopist for image-enhanced colonoscopy using chromoendoscopy to better guide decision-making for treatment or surveillance plans (1). If a visible dysplastic lesion is found by chromoendoscopy at the site of previously invisible dysplasia, this may allow for endoscopic resection and further surveillance rather than colectomy.

The COVID-19 pandemic has halted the practice of endoscopy throughout the world. The concern for infection transmission during endoscopy, the need to conserve personal protective equipment, and the availability of endoscopy unit infrastructure had to be weighed against the ongoing need for endoscopic evaluation and therapy. The American Gastroenterology Professional Associations released a joint statement that briefly defined elective vs urgent/emergent procedures and provided their recommendations for which types of procedures should be delayed (3). The statement recommends that evaluation of IBD with dysplasia should not be delayed. Despite these recommendations, many procedures are being delayed because of resources being diverted to the care for patients with COVID-19 or patient preference/fear, as occurred in this case.

This case demonstrates that patients with IBD and HGD referred for possible endoscopic resection should not be delayed



**Figure 1.** Rectosigmoid adenocarcinoma in an area of previously invisible high-grade dysplasia as seen on follow-up colonoscopy in (a) high-definition white light, (b) narrow-band imaging, and (c) after endoscopic mucosal resection.

during the COVID-19 pandemic. Compared with the dysplasia to cancer progression in sporadic CRC, HGD in IBD has a much more rapid progression (4). Proper patient education is required to inform them of the risks of delayed endoscopic evaluation for IBD with HGD during the COVID-19 pandemic.

#### CONFLICTS OF INTEREST

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**Consent statement:** The patient provided informed consent to discuss her case in this correspondence.

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