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Risk-stratified surveillance in inflammatory bowel disease

To the Editor: We read with interest Dr Wright's correspondence on the follow-up of patients with inflammatory bowel disease (IBD).[1] We concur that persistent intestinal inflammation is an important determinant of colorectal neoplasia in IBD, but believe that there are several additional factors that merit consideration when determining the appropriate role and frequency of surveillance.

The recent ECCO-ESGAR-ESP-IBUS guidelines[2,3] emphasise regular assessment of disease activity using clinical review, biomarkers and endoscopy where appropriate, with therapeutic escalation directed towards achieving sustained inflammatory remission. The ultimate objective is not merely symptom control, but modification of the natural history of disease and reduction of long-term complications, including colorectal cancer.

Surveillance strategies for IBD-associated colorectal cancer are similarly evolving and should not simply be determined by disease duration. They should be individualised according to cumulative inflammatory burden, disease extent, previous dysplasia, primary sclerosing cholangitis (PSC), family history of colorectal cancer and the achievement of sustained mucosal healing.[3] The recent British Society of Gastroenterology guideline[4] provides a contemporary framework for this risk-stratified approach, with surveillance intervals ranging from annual examinations in selected high-risk patients to substantially longer intervals, up to 10 years in the lowest-risk patients.[4] The situation is therefore more nuanced than the use of a 1-year surveillance interval being regarded as outdated might suggest: annual surveillance remains appropriate for some high-risk patients and should not be dismissed, but it should not be regarded as a default interval for the majority of patients with IBD.

This changing understanding of colorectal cancer risk has also altered the purpose of surveillance. Rather than simply detecting dysplasia, surveillance now forms part of an integrated strategy that combines objective assessment of inflammatory control with targeted detection of neoplasia in those patients who remain at greatest risk.

The application of these principles in South Africa (SA) is, however, influenced by the realities of our healthcare system. Although biological agents and small-molecule therapies have transformed IBD management internationally, access within much of the public sector remains limited. Consequently, many patients continue to receive conventional therapy, and may experience persistent or recurrent inflammation despite optimal management within these constraints. Their cumulative inflammatory burden, and therefore their long-term risk of colorectal neoplasia, may remain higher than that of patients managed in healthcare systems where advanced therapies are more readily available.

Risk stratification has a further important advantage: it can improve the effectiveness of surveillance itself. High-definition colonoscopy with dye-based or virtual chromoendoscopy has substantially improved the detection and characterisation of dysplastic lesions, and forms an important component of contemporary IBD surveillance.[4] However, the value of advanced imaging is likely to be greatest when surveillance is directed towards patients with meaningful residual risk of neoplasia. Directing limited endoscopic capacity towards such patients should increase the yield of surveillance and make more effective use of chromoendoscopy and other advanced imaging techniques.

Surveillance and disease control should therefore be regarded as complementary rather than competing strategies. In SA, where both advanced medical therapy and endoscopic capacity remain constrained, the greatest benefit is likely to be achieved through evidence-based risk stratification. This approach allows annual surveillance to be retained for patients at genuinely high risk, while avoiding unnecessary repeated colonoscopy in those whose risk has been substantially reduced through sustained inflammatory control. At the same time, it reinforces the need to improve equitable access to therapies capable of achieving and maintaining remission.

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