



US Multi-Society Task Force on Colorectal Cancer Recommendations for Diagnosis and Management of Serrated Polyposis Syndrome



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This summary reviews Rex DK, Anderson JC, Jacobsen BC, et al. Serrated polyposis syndrome: A review and consensus statement by the US Multi-Society Task Force on Colorectal Cancer. *Am J Gastroenterol*. Online ahead of print, Sep 2026.

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STRUCTURED ABSTRACT

Question: Given the high prevalence of serrated polyposis syndrome (SPS), the goal of this document was to provide physicians with recommendations for diagnosing and managing SPS.

Design: A consensus statement of experts designed to provide clinical recommendations for SPS. The US Multi-Society Task Force (USMSTF) consists of nine members, with 3 representatives from each of the 3 major gastroenterological societies: the American College of Gastroenterology, American Gastroenterological Association, and American Society for Gastrointestinal Endoscopy. The USMSTF follows a specific charter approved by the 3 Gastroenterology societies to develop its recommendations. The document creation includes drafting, incorporating leadership feedback, and obtaining independent approval from each organization's governing board.

Methods: This process operates completely independently from the individual

societies' own Clinical Guidelines, Practice Parameters, or Standards of Practice Committees. Because of these distinct development processes, the resulting consensus statements are officially called "recommendations" rather than "guidelines" to clearly differentiate them from the documents published separately by each individual society.

The USMSTF enlisted a research librarian to search MEDLINE, EMBASE, the Cochrane Database of Systematic Reviews, and the Database of Abstracts of Reviews and Effects for English-language literature published between January 1, 2005, and June 20, 2025. The search targeted subject headings related to serrated polyp syndrome, hyperplastic polyposis/polypoid syndrome, sessile serrated lesions/polyps/adenomas, traditional serrated adenomas/polyps, hyperplastic polyps, and general serrated adenomas/polyps. Review articles, meta-analyses, and editorials were included, while case reports and studies on patients with inflammatory bowel disease were excluded. The authors also manually screened the bibliographies of retrieved reviews, meta-analyses, and editorials for missing relevant references.

A new aspect of this document as opposed to the previous recommendations was the use of the Oxford Centre for evidence-based medicine 2011 levels of evidence. This scale is a 5-level grading system that ranks research based on the specific clinical question being asked (such as treatment, diagnosis, prognosis, or prevalence) rather than using a single rigid hierarchy. The committee made consensus recommendations as weak or strong based on the strength of the evidence, clinical impact and other factors such as patient perspective.

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Recommendations:

1. 2019 WHO criteria used for SPS diagnosis. (Strong recommendation, Oxford Level 5)
2. Germline genetic testing be performed only when there are concurrent non-serrated polyps or a family history suggesting a hereditary gastrointestinal cancer syndrome. (Strong recommendation, Oxford Level 3)
3. The number, size, and location of serrated polyps be described in the procedure report at least until an SPS diagnosis is established. (Strong recommendation, Oxford Level 4)
4. SPS colonoscopies be performed by endoscopists with documented adequate detection of SSLs (SSL detection rate > 6%). (Strong recommendation, Oxford Level 5)
5. SPS colonoscopies be performed with high-definition white light colonoscopy with or without virtual or dye spray chromoendoscopy. (Strong recommendation, Oxford Level 3)

6. In patients without concurrent colorectal cancer (CRC), endoscopic management is the preferred strategy over surgery for primary management of SPS. (Strong recommendation, Oxford Level 3)
7. SPS patients whose polyp burden is deemed endoscopically unmanageable be referred to an expert in advanced endoscopic resection prior to surgical resection. (Weak recommendation, Oxford Level 5)
8. Sessile serrated lesions and hyperplastic polyps in SPS patients be resected by cold snare, with or without submucosal injection for larger lesions, except when dysplastic areas are endoscopically evident. (Strong recommendation, Oxford Level 3)
9. Colonoscopy be performed in a clearance phase at an interval of 3–6 months followed by a surveillance phase of 1–2 years. (Strong recommendation, Oxford Level 3)
10. Patients with greatly reduced polyp burdens at surveillance can be considered for 3-yr intervals. (Weak recommendation, Oxford Level 5)
11. First degree relatives of individuals with SPS undergo colonoscopy at age 40 or 10 yr before the youngest age at CRC diagnosis or 5 yr before the youngest age at SPS diagnosis in the family, whichever is earlier. (Weak recommendation, Oxford Level 4)

COMMENTARY

Why Is This Important?

SPS is the most common colorectal polyposis syndrome, with an estimated prevalence of approximately 1%.¹ This means an endoscopist performing 1,000 colonoscopies per year should encounter up to 10 SPS patients annually. However, SPS remains underrecognized in clinical practice.² A major challenge is that its diagnosis as defined by the World Health Organization depends on the cumulative number, size, and location of serrated polyps over time, which defines whether a patient has Type 1 or Type 2 SPS.³ Because tracking these cumulative details is critical, the US Multi-Society Task Force strongly recommends that

physicians diligently document the exact size and location of all serrated polyps.⁴

The USMSTF recommendations emphasize that promptly diagnosing serrated polyposis syndrome is critical because of its strong link to CRC. The serrated neoplastic pathway is associated with up to 30% of all CRC cases.⁵ The serrated pathway includes hyperplastic polyps which are the most common, sessile serrated polyps which are also called sessile serrated lesions and traditional serrated adenomas.⁵

Type 1	≥ 5 SPs proximal to the rectum, all ≥ 5 mm and > 2 being ≥ 10 mm
Type 2	> 20 SPs throughout the colon with ≥ 5 being proximal to the rectum
SP: serrated polyp (hyperplastic polyp, sessile serrated lesion, or traditional serrated adenoma)	

Table 1. 2019 World Health Organization Criteria for Serrated Polyposis Syndrome

Diagnosis
• Obtain previous colonoscopy records • Careful exam with high- definition colonoscope • Maintain high SSPDR • Good bowel preparation • Careful documentation of serrated polyps with respect to size and location
Management
• Clearance phase every 3-6 months to remove serrated polyps > 5mm • Surveillance phase every 1-2 years which can be extended to every 3 years • Use of cold snare with overlapping approach for larger lesions • Cold snare not indicated for lesions having dysplastic features • For patients with challenging polyp burden, referral to expert be considered prior to surgery
Genetic Considerations
• No genetic screening unless other adenomatous polyposis syndromes likely • Screening first degree relatives

Table 2. Tips for SPS diagnosis and management

Key Findings

Because many patients already have CRC at the time of their SPS diagnosis,^{6,7} early detection is essential to preventing the disease. Fortunately, patients who enter a structured surveillance program face a low risk of developing colorectal cancer. This surveillance process is divided into 2 distinct phases: Clearance phase: Patients undergo initial colonoscopies at 3 to 6-month intervals to remove existing polyps; and surveillance/maintenance phase: Once cleared, patients transition to routine monitoring every 1 to 2 years. Extended intervals: Patients who maintain a significantly reduced polyp burden can eventually extend their surveillance to every 3 years.

The document highlights the need to optimize specific skills for endoscopists managing patients with SPS. First, endoscopists must maintain an adequate serrated polyp detection rate (SSPDR).⁸⁻¹¹ While current guidelines recommend a minimum rate of 6%,^{10,12} recent data suggests aiming for 8% to optimize detection and ensure accurate SPS diagnosis.⁸ Additionally, mastering optimal snaring and resection techniques for these polyps is crucial; nearly all serrated polyps up to 30 mm (and potentially larger) can be safely removed using a cold snare polypectomy approach. Finally, if an endoscopist cannot adequately manage the polyp burden, they should refer the patient to a tertiary expert before considering a surgical referral.

Caution

Some of the recommendations are supported by weak evidence.

My Practice:

Accurate diagnosis of SPS is critical given its strong association with colorectal cancer risk and the need for strict surveillance. To ensure a thorough evaluation, I review all historical colonoscopy data, focusing specifically on large or proximal serrated polyps > 5mm, sessile serrated polyps (SSPs), and traditional serrated adenomas. Maintaining a high SSPDR) is a personal quality benchmark; while the standard recommendation is 6%, I aim for 8% or higher. Furthermore, I adhere to the latest American College of Gastroenterology/American Society for Gastrointestinal Endoscopy task force quality guidelines, ensuring excellent bowel preparation and routine double-examination of the proximal colon. I carefully document the size and location of all serrated polyps detected during the colonoscopy. Once an SPS diagnosis is confirmed, I systematically clear the colon of all polyps and enroll the patient in surveillance matching the US Multi-Society Task Force guidelines.

For Future Research

Additional data are required to clarify CRC risks for patients with SPS under surveillance, alongside clearer guidelines for managing peri-appendiceal serrated polyps.

Conflict of Interest

Dr. Anderson had no financial conflict of interest.

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