CORRESPONDENCE

The Origins of Colorectal Carcinoma: Specific Nomenclature for Different Pathways and Precursor Lesions

by Prof. Dr. med. Andrea Tannapfel, Dr. med. Matthias Neid,
PD Dr. med. Daniela Aust, Prof. Dr. med. Gustavo Baretton in volume 43/10

Terminology Is Unclear

From the perspective of general pathology and its terminology, several terminological unclarities remain. The term dysplasia is not completely replaced by intraepithelial neoplasia (IEN), because there are two dimensions to it. On the one hand it describes attributes of cells and tissues that are not limited to neoplasias; on the other hand it is used to describe entities such as pre-neoplasias, among others. And only in this respect it is less misleading than dysplasia. An IEN always refers to an entity, never an attribute. Using the term IEN indicates certainty that the finding is a neoplasia. If this certainty does not exist, the problem with nomenclature arises. Those hyperplastic polyps that degenerate are undoubtedly pre-neoplasias but not (yet) recognizable as such. One therefore should not do without terms such as atypical cells or cellular or tissue dysplasia when describing a morphological entity whose prospective potential is not known at the time when the lesion is diagnosed. The umbrella term for the colorectal lesions under discussion is intraepithelial proliferative lesion. From a certain (now well defined) stage of abnormality of tissues or cells (atypia, dysplasia), the assumption should be of an intraepithelial neoplasia, for example, and adenoma, which—the more it deviates from the norm (adenoma with light and moderate dysplasia corresponds to LGIEN, adenoma with severe dysplasia and intramucosal carcinoma corresponds to HGIEN) the higher the probability that it will degenerate into an invasive neoplasia, meaning that the monitoring and treatment options are different.

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Conflict of interest statement

The author declares that no conflict of interest exists according to the guidelines of the International Committee of Medical Journal Editors.

In Reply:

We thank our correspondent for his contribution and for the opportunity to discuss the term intraepithelial neoplasia again, against the background of the correctly stated and therefore required transparency between endoscopy and pathology. In contradiction to the opinion expressed by Dr Haroske, it is the new WHO classification that dictates the appropriate use of the terms.

The term “intraepithelial neoplasia” is used for lesions with certain cytological and architectural characteristics that reflect the underlying molecular changes. However, the reverse is not necessarily true: such molecular changes do not necessarily result in changes that are visible on histology or cytology—which underlines the precursor character of colorectal adenomas, for example. For this reason the term intraepithelial neoplasia is more widely defined and includes all possibilities: precursor lesions with “dysplasias” or without “atypias” (for example the sessile serrated adenoma [SSA]). The malignant potential is the one factor that all intraepithelial neoplasias have in common (1).

We have to contradict Dr Haroske where the term dysplasia is concerned. The WHO classification defines unequivocally that dysplasias are histologically defined as “unequivocal neoplastic epithelium without evidence of tissue invasion”. Even though as pathologists we sometimes appreciate creative freedom, we cannot ignore the international definitions. The monitoring strategies that were mentioned are clearly defined in the S3 guideline “colorectal carcinoma,” which was substantially developed by pathologists (the authors, among others). The different entities are discussed and acknowledged there (2).

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