an increased risk of diverticulosis. While there are evidence-based benefits to dietary fiber intake, our work does not question those benefits. Instead, our findings question the belief that inadequate fiber and constipation are risk factors for asymptomatic diverticulosis, for which there is no good evidence.

Dr Fernandes’s first concern that diet should be evaluated longitudinally was addressed in our paper. As we stated in our discussion, “the prevalence of diverticulosis increases with age, and the pathogenesis of diverticula may begin several decades before the disease manifests. Therefore, bowel habits and nutrition during a younger age may be more relevant than our data.” However, nutritional research [not hypothetical] has shown that diets do not change greatly over time and for many people recent diet is a reasonable reflection of lifetime diet.

As for his second concern that total fiber intake did not reach the “recommended allowance,” the American Dietetic Associations (ADA) position paper on dietary fiber states that there are no data available to determine a “recommended dietary allowance” for dietary fiber intake. Instead, the “adequate intake” recommendation was developed and is based on the intake that might be needed to reduce the risk of coronary heart disease. Interestingly, the ADA concludes that the evidence that dietary fiber is beneficial in cardiovascular disease is only fair, and that benefits may occur with 12 to 33 g of dietary fiber intake per day. In our analysis, the mean total fiber intake in the highest quartile was 25 g vs 8 g in the lowest quartile. Thus, we assessed a wide range of dietary fiber intakes and found no association with diverticulosis.

Regarding Dr Fernandes’s final concern that subjects may have changed their survey answers because they knew the results of the colonoscopy, our paper clearly stated that we limited our analysis to participants with no knowledge of their diverticular status to reduce the risk of biased responses.

Is One Colonoscopy Sufficient to Diagnose Serrated Polyposis Syndrome?

Dear Editor:

The review on sessile serrated adenomas by Crockett et al provides clear recommendations for further research in this field. The authors offer novel insight as they state that information on the number of polyps to establish the diagnosis of serrated polyposis syndrome (SPS) according to 2010 World Health Organization criteria should be collected during a single colonoscopic screening exam. The original publication on the diagnostic criteria for SPS does not stipulate a number of colonoscopies that may be used to collect information on the proportion of serrated polyps. The most recently published epidemiologic data are based on a cohort in whom a diagnosis was made after single screening colonoscopy. However, there are several arguments to suggest that a single colonoscopy is not always sufficient to confirm the diagnosis of SPS.

Previous reviews state that the number of serrated polyps harvested during several subsequent procedures may be used to provide a cumulative total number because most polyps are likely to be new rather than recurrent polyps. Jass added that this relaxed definition of hyperplastic polyposis syndrome was to investigate whether relatively small numbers of serrated polyps are clinically important, particularly if polyps are large and proximally located. Most of the information on SPS stems from clinical genetic studies, and it is often unclear how many colonoscopies were needed to collect information on the proportion of detected polyps. For example, one study reported that in 45% of SPS patients, the diagnosis could not be made at first colonoscopy.

Another problem with relying on the first colonoscopy for diagnosis is that the time allotted to the procedure does not allow comprehensive removal of all polyps, and some of these may still be overlooked. To make an adequate diagnosis of SPS, all polyps need to be investigated histologically to distinguish conventional adenomas and serrated polyps. This issue is illustrated by a study that shows a large cohort of patients from which 55% required a follow-up colonoscopy to remove all lesions.

Until a genetic basis for SPS reveals more specific phenotypes with associated cancer risks for SPS, it is unclear which patients qualify for the diagnosis. It is necessary to use inclusive criteria to identify patients in the spectrum of SPS to better define both the genotypic and phenotypic features of this group of patients. We think that a single screening colonoscopy is not sufficient to identify all patients at increased risk for colorectal cancer.

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Reply. We thank Van Herwaarden et al for their interest in our recently published review on the management of sessile serrated adenomas.1 Van Herwaarden et al ask whether the diagnosis of serrated polyposis syndrome (SPS) should be based on a single examination or multiple examinations. This is an interesting question for which there is not yet a clear answer, but the topic merits careful consideration.

Van Herwaarden et al point out good reasons why multiple colonoscopic examinations should be allowed to contribute to the criteria for this syndrome. Serrated polyps (especially sessile serrated adenomas and hyperplastic polyps) have a subtle endoscopic appearance and can be missed during colonoscopy. Also, because SPS patients are believed to be at increased cancer risk (although the magnitude is uncertain), the use of inclusive diagnostic criteria will improve the sensitivity for the recognition of SPS phenotypes to guide clinical management. We add, as a point of analogy, that the determination of other high-risk colorectal cancer syndromes (eg, familial adenomatous polyposis or MUTYH-associated polyposis) generally is cumulative and can be based on multiple colonoscopies.

However, SPS is qualitatively different from other polyposis syndromes. Because genetic testing is not available, the World Health Organization (WHO) diagnostic criteria for SPS2 are based solely on clinical (endoscopic) features that are fairly arbitrary and already represent a low bar. The number of polyps needed to qualify for polyposis in SPS is substantially smaller than other polyposis syndromes (as few as 5 vs >100 in familial adenomatous polyposis). Allowing for polyps found on multiple colonoscopies introduces its own questions. What if the colonoscopies are 5 years apart? Or 10 years apart? Because we do not know much about the dwell time of hyperplastic polyps or serrated polyps in general, this could be problematic, and near-threshold polyp totals on multiple widely spaced colonoscopies may not necessarily connote increased genetic risk. The literature is mixed, as van Herwaarden et al point out, as to whether studies use 1 or more colonoscopies to determine a diagnosis of SPS, further supporting the notion that this remains an unresolved question.

Although the WHO criteria will have the highest specificity when applied to the results of a single colonoscopy, we agree with van Herwaarden et al that a patient’s full colonoscopic history should be taken into account when considering a diagnosis of SPS. Persons with a history of 20 or more serrated polyps (or ≥5 proximal serrated polyps) can be given a tentative clinical diagnosis of SPS depending on the number of polyps, polyp size, and length of the colonoscopy interval, even if they do not meet the traditional diagnostic criteria on a single examination. This, of course, highlights the importance of accurate recording of the number of polyps seen at colonoscopy and avoidance of vague quantitative jargon such as “many” or “multiple” in procedure reports. In contrast, for research purposes, use of lax criteria and resulting heterogeneity could hinder progress; specific phenotypic definitions (eg, WHO criterion 1 based on a single examination) may be required to avoid diluting potentially important genetic associations. We remain hopeful that, eventually, this question will be rendered moot by advances in the understanding of the genetic basis for this disorder and the spectrum of findings associated with it.

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