Letter to editor: piecemeal cold snare polypectomy versus conventional endoscopic mucosal resection for large sessile serrated lesions

With great interest, we read the recent study by van Hattem *et al*, which compared the utility in large sessile serrated lesions (L-SSL) management between piecemeal cold snare polypectomy (p-CSP) and endoscopic mucosal resection (EMR).[1] We congratulate the authors for this innovative study that demonstrated the security and effection of p-CSP in the management of L-SSL and opened the door to determine the best treatment for endoscopically resecting L-SSL. Although the data and methodology of the study are impressive, there are several questions, which should be highlighted.

First, this study divided patients with L-SSL at two different times into p-CSP and EMR group. Compared with the early stage, with the development and maturity of technology, technical success will be improved and adverse events may be reduced. Thus, the study concluded that the higher incidence of adverse events in the EMR group is debatable and may overestimate the incidence of adverse events. We think that the conclusion will be more credible if the study was randomly grouping.

Second, the primary outcome of the study is technical success, which was defined as complete removal of all polypoid tissue. However, the authors did not illustrate the evaluation method and criteria of complete removal. And the complete resection is always defined as 'the absence of tumour cells at the lateral and basal resection margins in an en-bloc resected specimen'.[2–4] Notably, most lesions were used segmental resection in this study, so pathological results could not accurately evaluate the horizontal margin. Kimoto *et al* confirmed complete resection by biopsy specimens obtained from the margins of the post-polypectomy defect.[5] Therefore, we are curious about the evaluation method and criteria of complete resection.

Next, the samples were inconsistent at baselines between the two groups, such as age, lesion size and dysplasia. Some studies indicate that lesion size is closely related to adverse events after endoscopic resection.[2 6] Additionally, Burgess *et al* showed that bleeding after 48 hours is associated with older age.[7] And Buchner *et al* demonstrated evidence of increased rates of recurrence for larger lesions, lesions removed by using the piecemeal method, and the presence of high-grade dysplasia.[8] Thus, we could not neglect the impacts of inconsistent baselines on adverse events and recurrence. In such a case, the results should be interpreted with caution.

Finally, we believe that the clarification of these issues mentioned above by the authors would make the study more apprehensible and credible.

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