



Conference Report

48th Conference of the German Society for Endoscopy and Imaging Procedures (DGE-BV)

Together with the learned societies of CAES, CATC, DEGEA, DEGUM, DGBMT, DGD, ÖGGH and bng

March 15 – 17, 2018; Munich

Chairman: Dr. Peter N. Meier, FASGE, Hannover

Ovesco products were presented in six workshops on two different topics (hemostasis techniques held by M. Mühleck and S. Loeffler, respectively, and management of complications held by C. Hamperl and S. Loeffler, respectively). Additionally, several talks and posters discussed products of Ovesco.

FTRD® System

Diagnosis of amyloidosis with FTRD full-thickness rectal tissue sampling

A. Braun and H. Dawson, Gastroenterology and Endoscopy, SRO Langenthal, Switzerland and Institute of Pathology, University of Bern, Switzerland, presented their study on amyloidosis diagnosis with the FTRD System. This is the first description of FTRD use in this indication.

Amyloidosis is a heterogeneous group of diseases with accumulation of abnormal protein, known as amyloid fibrils, which build up in interstitial tissue, leading to manifold clinical problems. The GI tract is also affected. Diagnosis must be confirmed by biopsy and histological examination and samples must contain submucosal vessels and muscularis propria. There is currently no reliable minimally invasive sampling technique. The study investigated feasibility, performance and safety of endoscopic full-thickness resection with the FTRD System in the rectum for gastrointestinal amyloidosis diagnosis.

Between 2015 and 2017, full-thickness excision of rectal wall with the FTRD System was performed in 12 patients (5 female, median age 73 years (29-81)) with suspected amyloidosis. Sigmoidoscopy was performed under light sedation in all patients. Biopsies were taken from the upper third of the rectum 14 – 18 cm ab ano. FTRD application and full-thickness resection were successful in all cases. Maximal procedure time was 20 minutes. No adverse events occurred and the clinical course was uneventful in all cases. Clear diagnosis was possible in all histological examinations. In 7 of the 12 patients (m=5, f=2) amyloid fibril accumulation was found in small submucosal vessels and in the muscularis propria layer, confirming the diagnosis of amyloidosis. The authors conclude that FTRD application for diagnosis of gastrointestinal amyloidosis is a safe and very effective method and mitigates the diagnostic challenges that amyloidosis can pose.

Amyloidose-Diagnostik durch Full-Thickness Resection Device (FTRD). Braun A, Langenthal and Dawson H, Bern.

Neoplasms, which were not accessible for EMR, in over 90 % resected with the FTRD System

A. von Helden and colleagues, Community Hospital Bonn, presented a case series on endoscopic full-thickness resection (EFTR) with the FTRD System in colorectal neoplasms with difficult localisation or extensive fibrosis. In 27 patients minor adenomas were found, which were not accessible for endoscopic mucosal resection (EMR) due to localisation (5 x appendix, 1 x diverticulum) or extensive fibrosis in consequence of prior attempts of endoscopic resection or chronic inflammatory bowel disease. 74 % of the reported lesions were located in the right colon, 15 % in the left colon, and 11 % in the rectum. All interventions were performed with the FTRD System on standard colonoscope with peri-interventional antibiotics (2g Ceftriaxon) and under analgo-sedation. Technical success was achieved in 25/27 patients (92,59 %), the target lesion could not be reached with FTRD cap in two cases due to distal stenosis. The size of the resected specimen was median 27 mm (12 – 33 mm). Histopathological examination showed 2 carcinomas (8 %; 1 x curative, 1 x elective oncological resection due to high-risk histological findings), 6 high-grade intra-epithelial neoplasms (24 %), 11 low-grade intra-epithelial neoplasms (44 %) and 6 serrated adenomas (24 %). R0-resection-rate was 76 % (19/25). Two perforations occurred (8%), one was treated by emergency surgery. In one patient with native appendix, appendicitis developed after two days and required ileocecal resection. Relevant haemorrhage was not observed. 30-days mortality rate was 0 %.

In summary this study confirms that application of the FTRD System makes endoscopic resection of neoplasms with difficult localisation and extensive fibrosis possible. Technical problems arise from stenosis distal to the target lesion. The authors warn against using the device in cases with native appendix.

Endoskopische Vollwandresektion mit dem FTRD System: Effektivität der Methode bei 27 Patienten mit kolorektalen Neoplasien, die einer Mukosaresektion nicht zugänglich waren. *Von Helden A, Sido B, Hildenbrand R, Dumoulin FL, Bonn.*

FTRD application in adenomas with non-lifting sign, submucosal localisation or progressed histology: analysis from 3 hospitals

H. Albrecht and colleagues presented an analysis of data from patients from 3 hospitals, who had been admitted for EFTR due to adenomas in the lower gastrointestinal tract. The respective adenomas showed non-lifting sign, submucosal localisation or suspected (pre-) malign histology. Aim of the study was to describe the histological findings of the resected lesions, the resulting proceeding and the effects on the clinical course of the patient.

Between 11/2014 and 02/2017, a total of 55 patients were admitted to the three centers for FTRD application due to above-mentioned indication. Two of the adenomas initially deemed suitable for FTRD therapy presented endoscopically too big and were subsequently treated by primary surgery. Four lesions could not be resected because of inaccessible localisation or lacking retrieval. The other 49 lesions were diagnosed as relapse adenoma or adenoma with non-lifting sign (n=21), high-grade intra-epithelial neoplasm and/or intra-mucosal adenocarcinoma (n=21), submucosal lesion / NET (n=6) and metastasis of malign melanoma (n=1). The resected specimen had a median size of 2.5 ± 2 cm. R0-resection was achieved in 38/49 (77.6 %), 11 lesions were incompletely resected (R1 or R2). In 8 cases (8/49 = 16.3 %), surgical revision was necessary. In three cases (3/49 = 6.1 %) the full-thickness specimen showed early infiltration of lymphatic vessels, these patients also underwent surgery. The following complications occurred (n=4): one Hb-relevant haemorrhage, which could be managed endoscopically, one perforation, which could be managed without surgery by OTSC application, in one case not enough tissue could be drawn into the cap, and in one case resection was incomplete because of snare dislocation during resection.

In summary these data show that surgery could be avoided by FTRD application in more than two thirds of the patients. The authors recommend, however, that the indication for EFTR for big lesions (>4 cm) and in case of evidence of mucosal carcinoma in biopsies should be rather strict.

Endoskopische transmurale Vollwandresektion (EFTR) am unteren Gastrointestinaltrakt (GIT): Welche Patienten profitieren? *Albrecht H, Neumarkt i.d.OPf., Raithel M, Nagel A und Braun A, Erlangen, Stegmaier A, Schwabach, und Schaefer C, Neumarkt i.d.OPf.*

Successful eFTR at the appendiceal basis with the FTRD System

C. Schaefer and colleagues reported on a 66-year old female patient, who was admitted for EMR attempt of a coecal polyp at the appendiceal basis. Colonoscopy showed the aforesaid adenomatous polyp located at the appendiceal cavity of the coecum. Histological examination yielded the diagnosis of a tubular adenoma without evidence of dysplasia. Submucosal injection and following resection by EMR was not successful due to the location of the polyp. A second attempt of resection by eFTR with the FTRD System was performed and succeeded. The resected specimen was sized 3x1x1 cm. Histological examination showed a partial appendix, at the appendiceal basis a 9 x 8 mm sized polyp with R0 resection status. The patient received peri-interventional antibiotic prophylaxis with Cefuroxim and Metronidazol. The post-interventional clinical course was uneventful, step-wise return to normal diet was tolerated without problems and the patient could be discharged after two days.

Erfolgreiche endoskopische Appendektomie mittels EFTR. *Schaefer C, Michalek M, Albrecht H, Hemmel M, Reitinger S, Neumarkt i.d.OPf., und Evert M, Universität Regensburg.*

OTSC System

100 % hemostasis with OTSC reported for first-line emergency treatment of acute hemorrhage

A. Braun and S. Peter, SRO Langenthal, Switzerland, presented personal data on OTSC application for emergency treatment of acute hemorrhage.

Between 2011 and 2017, 48 patients (29 female, median age 75.5 years (61-92)) each received one OTSC clip for first-line treatment of acute gastrointestinal hemorrhage. Bleeding was located in the upper GI tract in 34 cases (14 Forrest Ia, 15 Forrest Ib, and 5 Forrest IIa) and in the lower GI tract in 14 cases (4 Forrest Ia, 7 Forrest Ib and 3 Forrest IIa). Patients with upper GI bleeding received peri-interventional PPI medication (80mg i.v. bolus, 320 mg i.v. / 24 h).

OTSC application and primary hemostasis were successful in all cases. Maximal procedure time was 20 minutes. No relapse hemorrhage occurred. 26 patients (15 F Ia, 9 F Ib) received follow-up endoscopy on day 1 to 4, which showed the clip in situ and no bleeding stigmata. The other 22 patients received no follow-up examination. The clinical course was uneventful in all cases.

The authors concluded that OTSC application for emergency endoscopic treatment of acute hemorrhage is safe and very effective, and related to short procedural time.

Endoskopische Behandlung von akuten Blutungen mit einem over-the-scope clip (OTSC). *Braun A, Peter S, Langenthal, Schweiz.*

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