

## Report on the 2023 DGE-BV Congress

52nd Congress of the German Society for Endoscopy and Imaging Techniques (DGE-BV) held in cooperation with the specialist associations CAES, DEGEA, DGD, CTAC, DEGUM, DGBMT, ÖGGH, bng, GPGE and SGG, as well as the host country Turkey

1–3 March 2023, Cologne, Germany

Chair: Prof. Dr. Andrea Tannapfel, Bochum  
Co-Chair: Prof. Dr. Arno J. Dormann MHM®, Cologne

### 2023 CAES Ovesco Award

#### **CAES presented Dr Stanislaus Reimer with the Ovesco Award in recognition of his outstanding work in the field of endoscopic vacuum therapy**

On 3 March 2023, the Surgical Working Group for Endoscopy and Sonography (CAES) of the German Society for General and Visceral Surgery (DGAV) presented Dr Stanislaus Reimer, University Hospital of Würzburg, Germany, with the Ovesco Award for his 10-year study on endoscopic vacuum therapy (EVT) as a primary versus secondary treatment option for gastric leaks after bariatric surgery. The award was presented by congress chairs Prof. Dr Tannapfel and Prof. Dr Dormann and was a highlight of the DGE-BV scientific programme.

Since Ovesco was founded, it has developed strong ties in the field of surgical endoscopy. We are therefore especially proud to be able to sponsor this CAES award and would like to congratulate Dr Reimer on this impressive achievement.

### FTRD® System

#### **Hybrid FTRD® in the upper and lower gastrointestinal tract: results of a large Swiss patient cohort**

In his lecture, Dr Heinrich, Clarunis – University Centre for Gastrointestinal and Liver Diseases, Basel, Switzerland, reported on the clinical use of the hybrid FTRD technique for various lesions in the gastrointestinal tract.

In a retrospective analysis, data from a total of 40 patients (13 female, 27 male) who had undergone hybrid EMR-FTRD to treat a variety of lesions over the period between 2017 and August 2022 was evaluated. The hybrid FTRD procedures included 13 conventional hybrid EMR-FTRDs, 3 ESD-FTRDs, 9 CAP O CLIP-FTRDs and 15 Clip over Loop (COL)-FTRDs. The lesions were located in the upper (n = 7), middle (n = 8) and lower (n = 25) gastrointestinal tract. The lesions treated included oesophageal submucosal cysts and gastric fibroid polyps (n = 2), submucosal lesions of the stomach and oesophagus (n = 5), duodenal adenomas and neuroendocrine tumours (NETs) of the duodenum (n = 8), NETs/lipomas/colonic polyps > 3 cm (n = 13), adenomas of the sigmoid (n = 3) and colonic polyps < 3 cm (n = 9). The average patient age was 61.3 years (27–91 years). The study parameters were technical success, histological confirmation of a margin-free resection (R0 resection) and any adverse events.

The results of the study by Heinrich et al. showed that macroscopic complete resection was achieved in 80% (32/40) of patients. In all cases, full-thickness resection was achieved. The histological examination of the full-thickness samples revealed free lateral margins in 37/40 patients (92.5% R0 resection rate) and positive margins in 3/40 patients. One of these patients received successful EMR treatment with negative histology on index endoscopy. In the hybrid EMR/ESD group, bleeding requiring hospitalisation occurred in 3/16 patients; one patient in this group required hospitalisation due to a periprocedurally closed perforation. In the CAP O CLIP- and COL-FTRD group, 4/24 patients were hospitalised due to comorbidities or old age.

Dr Heinrich concluded from the study that the hybrid FTRD techniques for lesions across the entire gastrointestinal tract are safe and effective, with an R0 resection rate similar to that of the conventional FTRD procedure.

#### **Hybrid FTRD in the upper and lower GI tract: results of a large Swiss patient cohort**

Heinrich H<sup>1</sup>, Gutknecht S<sup>2</sup>, Bauerfeind P<sup>3</sup>; <sup>1</sup>Clarunis Universitäres Bauchzentrum, Gastroenterologie, Basel, Switzerland, <sup>2</sup>Stadtspital Triemli, Viszeralchirurgie, Zürich, Switzerland, <sup>3</sup>St Anna, Gastroenterologie, Luzern, Switzerland

### **Retrospective multicentre analysis of the topographical efficacy and safety of endoscopic full-thickness resection in the segments of the colon – insights from clinical practice**

In his lecture, Dr Albrecht, Medizinisches Versorgungszentrum Internisten am Ring, Nuremberg, Germany, presented a retrospective multicentre analysis of the topographical efficacy and safety of endoscopic full-thickness resection (EFTR) in the segments of the colon.

According to Dr Albrecht, EFTR of the colon has been described as an effective, practicable method for resecting recurrent/advanced neoplastic lesions, but its performance and success may be difficult or different according to location of the lesion in the corresponding colonic segment. The aim of the study was therefore to investigate the segment-specific efficacy and safety of EFTR in the colon using the FTRD System based on real-world data. For this purpose, patient data from four participating centres obtained in the period from 2014 to 2020 was analysed. EFTR using the FTRD System was performed in patients who had undergone a previous colonoscopy that resulted in a diagnosis suitable for EFTR. The primary efficacy measure of EFTR was histologically complete resection (R0) of the lesion. Safety was investigated based on the frequency of adverse events (AEs) that occurred during or after EFTR.

A total of 105 patients (39 female, 66 male; median 70 years) were included in the analysis. EFTR using the FTRD was technically successful in 101/105 cases (96.2%), with a median lesion size of 20 x 19 mm. Histological R0 resection was achieved in 77.1% (81/105) of patients, with the following segment-specific R0 resection range: 90% (rectum), 70.6% (sigmoid), 78.6% (descending colon) and 62.5% (transverse colon). In the ascending colon and cecum, resection rates of 76.9% and 83.3% were achieved. Adverse events (AEs) were documented in 33/105 patients (31.4%), with only one perforation occurring (0.95%), which was located in the sigmoid. The other AEs were minor, such as abdominal postsurgical pain (18.1%), hematochezia (9.5%) and haemoglobin decline (7.6%). The topographical analysis revealed that most AEs occurred in the transverse colon (12.5%), while the rate of AEs in the other segments was ≤ 8.2% respectively. The segment with the lowest rate of AEs was the rectum (1.4%).

Dr Albrecht concluded from his study that EFTR is an effective method for the endoscopic treatment of colorectal lesions. The best results were obtained in the rectum (high R0 rate, low AE rate), followed by the cecum. The other segments appeared to be more difficult to completely resect and had a higher AE rate. The transverse colon had the lowest R0 resection rate and the highest AE rate. While only one major complication occurred, the rate of minor complications in all other segments was below 8.2% and these were short-lived.

### **Retrospective multicenter analysis of topographical efficacy and safety of endoscopic full thickness resection in the segments of the colon – insights from clinical practice**

Albrecht H<sup>1</sup>, Schäfer C<sup>2</sup>, Stegmeier A<sup>3</sup>, Raithel M<sup>4</sup>; <sup>1</sup>Medizinisches Versorgungszentrum, Internisten am Ring, Nuremberg, Germany, <sup>2</sup>Klinikum Neumarkt, Medizinische Klinik II, Neumarkt, Germany, <sup>3</sup>Kreisklinik Roth, Gastroenterologie, Roth, Germany, <sup>4</sup>Malteser Waldkrankenhaus Erlangen, Medizinische Klinik II, Erlangen, Germany

## **Further lectures involving Ovesco products**

### **Bleeding in endoscopy**

In his lecture on “Bleeding in endoscopy”, Dr Wedi, Sana Klinikum Offenbach, Offenbach, Germany, discussed in detail the use of the OTSC® System as an appropriate first-line treatment for high-risk patients and described the HemoPill acute as a key future triage tool for cases of suspected acute upper gastrointestinal and duodenal bleeding.

Dr Wedi first presented the main points of the current guidelines for the treatment of gastrointestinal (GI) bleeding (Addendum of December 2021 to the S2k Guideline “Gastrointestinal Bleeding” of the DGVS and the ESGE Guideline “Endoscopic diagnosis and management of NVUGIH” – Update 2021), mentioning the location of GI bleeding (80% of cases in the upper, 5% in the middle and 15% in the lower GI tract) and the aetiology of NVUGIB. He then described the various procedures for haemostasis: injection (with sodium chloride, adrenaline and fibrin glue), thermal therapy (APC, heater probe and laser), mechanical therapy (haemoclip and OTSC) and other haemostatic procedures (hemospray and gel).

On the basis of the FLETRock and STING-2 study data, Dr Wedi highlighted that OTSC is superior to standard first-line treatment for high-risk bleeding. He also presented the results of a multicentre international randomised

controlled trial by Chan et al., which investigated the use of OTSC versus standard therapy for the prevention of rebleeding in large peptic ulcers ( $\geq 1.5$  cm). Dr Wedi then went on to discuss the data obtained by Hollenbach et al. on the comparison between the traumatic (-t) and atraumatic (-a) type of OTSC design, recommending the use of the OTSC-a for the closure of duodenal ulcer bleeding to reduce the risk of rebleeding.

Following on from this, Dr Wedi gave an insight into the data from his current study entitled "Prophylactic clipping using the OTSC System after complex ESD and EMR of large ( $\geq 20$  mm) superficial colorectal lesions" (Blasberg, Wedi et al.). Due to the increasing focus on outpatient over inpatient care in Germany, he said that he sees a greater need to close wounds prophylactically using the OTSC System after complex resections. The study is primarily investigating the number of OTSC clips used per lesion site after ESD and EMR. To date, 59 patients (19 female, 40 male; median 64.5 years) with the following comorbidities have been included in the study: renal diseases (1%), diabetes mellitus (19%), lung diseases (22%), oncological diseases (22%) and cardiovascular diseases. The median lesion diameter was  $63 \pm 29.5$  mm. The lesions were located in the right hemicolon (39%), rectum (34%) and left hemicolon (7%); in 29% of cases, no information was provided. The results of the study currently show the following distribution of resection procedures and number of clips per lesion: EMR (n = 21, 1–5 clips), ESD (n = 38, 1–3 clips).

At the end of the lecture, Dr Wedi presented the HemoPill® acute, a swallowable sensor capsule that represents an important pre-endoscopic diagnostic tool and, as such, should be used for better triage in cases of suspected acute upper GI and duodenal bleeding.

*Wedi E, Sana Klinikum Offenbach, Offenbach, Germany*

### **Perforations in the GI tract**

In his lecture, Dr Meining, University Hospital of Würzburg, presented various methods and products for managing perforations in the upper and lower GI tract. He still considers the OTSC System to be a safe and important product for perforation management. The lecture was followed by individual questions on selecting the right clip size and clip type. The speaker answered these by pointing out that each perforation is unique, rather than recommending a special clip type or clip size as a model solution for certain situations.

*Meining A, Uniklinikum Würzburg, Würzburg, Germany*

### **Stent complications in endoscopy**

Prof. Dr Kahl, University Centre for Gastrointestinal and Liver Diseases, Basel, gave a lecture on common complications during and after the use of GI stents. He presented stentfix OTSC® as a good solution to stent migration and a safe and easy option for stent fixation. The data given in Prof. Dr Kahl's lecture was based on his own personal experience.

*Kahl S, Clarunis – Universitäres Bauchzentrum Basel, Basel, Switzerland*

*Contact us with any questions or for more information:*

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