

Congress report Viszeralmedizin 2022

Joint Annual Meeting of the German Society for Gastroenterology, Digestive and Metabolic Diseases with Endoscopy section (DGVS) together with the German Society of General Surgery and Visceral Surgery (DGAV)

Hamburg, 12–17 September 2022

Congress presidents:

Prof. Dr med. Thomas Frieling, Krefeld, Germany

Prof. Dr med. Jens Werner, Munich, Germany

Prof. Dr med. Ulrike Denzer, Marburg, Germany

OTSC® System

Investigating the rebleeding rate after ESD and EMR of large colorectal lesions and prophylactic wound closure using the OTSC® System

T. Blasberg (Offenbach, Germany) presented a multicentre, retrospective analysis of the efficacy of prophylactic wound closure using the OTSC System after resection of large colorectal lesions in reducing the risk of post-polypectomy bleeding (PPB). Blasberg stated that PPB is the most common complication after large endoscopic resection in the colon. Several RCTs have shown that prophylactic closure of the wound surface using endoclips can significantly reduce the risk of rebleeding, thereby lowering follow-up costs.

As the OTSC seems to be superior to endoclips for haemostasis and perforation prophylaxis, the objective of the study was to evaluate the efficacy and safety of prophylactic wound closure using OTSC after ESD and EMR of large (≥ 20 mm) colorectal polyps. Patients were enrolled between February 2009 and October 2021. The primary study outcome was the rate of PPB and secondary perforations.

The study included data from 50 patients (67%) who underwent ESD and 25 patients who underwent EMR (mean age 64.5 ± 11.2 years; male 67% (50/75)). The mean lesion size was $63 \text{ mm} \pm 30.1 \text{ mm}$ (range 22–144 mm). Intraoperative bleeding occurred in 5.3% (ESD 2% vs EMR 12%; $p = 0.105$) and intraoperative perforation in 6.7% (ESD 8% vs EMR 4%; $p = 0.659$) of the cases. All cases of intraoperative bleeding were treated endoscopically; two cases of intraoperative perforation had to be treated surgically. A total of 73 patients thus underwent prophylactic wound closure using the OTSC. An average of two OTSC clips (1–5) were used.

After wound closure using OTSC, the rate of PPB was 1.4% (ESD 0% vs EMR 4.2%; $p = 0.329$). No secondary perforations or adverse events occurred, leading Blasberg to conclude that prophylactic wound closure using OTSC clips after large resection in the colon seems to be a promising technique to reduce the risk of PPB and secondary perforation.

KA417 Prophylaktischer Wundflächenverschluss mit Over-the-scope-clips (OTSC®) nach ESD und EMR von großen (≥ 20 mm) kolorektalen Läsionen (Prophylactic wound closure using the Over-the-Scope Clip (OTSC®) system after ESD and EMR of large (≥ 20 mm) colorectal lesions).

Blasberg T, Jung C, Leifeld L, Seif A, Weber M, Hochberger J, Wedi E

FTRD® System

Interim results of the DUO-RESECT study show that eFTR has a comparable efficacy and lower complication rate compared to EMR

B. Meier presented the interim results of the randomised, multicentre DUO-RESECT study, which started in 2018. At the beginning, Meier explained that the initial study hypothesis (planned $n = 100$ patients; 50 per arm) was amended in 2021. (“eFTR of non-ampullary duodenal adenomas (up to 25 mm) with the gdFTRD has a 20% lower overall complication rate compared to EMR, with the same level of efficacy”). The new hypothesis states that eFTR is not inferior (resection success, efficacy), with a lower complication rate. The number of cases was also amended to $n = 30$ (15 per arm). Patients with non-ampullary duodenal adenomas measuring 10–25 mm (treatment-naïve or not pretreated) are included in the study. The exclusion criteria include adenomas with a

short distance to the papilla, malignancy or suspected malignancy (macroscopic findings), and conditions/previous operations that prevent the passage of the gdFTRD.

The study's primary endpoint is complication rate (composite endpoint of procedure-related bleeding and perforation); the secondary endpoints are technical success (macroscopic complete resection), R0 resection, en bloc resection/piecemeal resection, procedure time, duration of hospitalisation, need of secondary angiographic or surgical intervention, local recurrence or residual findings at follow-up. A follow-up endoscopy, including biopsies of the resection site and clip removal, if necessary, takes place after 3, 12 and 24 months.

To date, both arms have enrolled n = 8 patients respectively. In terms of procedure characteristics, the results of the EMR arm compared to the eFTR arm are as follows (% (n)): technical success 87.5% (7) vs 100% (8), macroscopic complete resection 100% (8) vs 75% (6), en bloc resection 37.5% (3) vs 100% (8), intraoperative difficulties 0% vs 12.5% (1 – balloon dilatation before passage through the pylorus required), procedure time 42 mins (30–50) vs 44.7 mins (30–85) and duration of hospitalisation 4.7 days (2–10) vs 3.6 days (2–6). The histology results showed an Rx situation in 100% (8) of the cases in the EMR arm compared to 50% (4) in the eFTR arm. The other results of EMR vs eFTR showed R0 in 0% vs 37.5% (3), R1 in 0% vs 12.5% (1, after 3 months re-eFTR with evidence of early carcinoma (low-risk, curative)) and evidence of HGIEN in 50% (4) vs 25% (2) of the cases. The overall complication rate was 37.5% (3) in the EMR arm vs 12.5% (1) in the eFTR arm. All complications were successfully treated endoscopically. Delayed rebleeding occurred after EMR in 25% (2) and after eFTR in 12.5% (1) of the cases. Secondary perforation occurred after EMR in 12.5% (1) of the cases; there were no cases of secondary perforation after eFTR. In the 3-month follow-up, there were no cases of macroscopic recurrence or histologically confirmed recurrence in both arms.

Meier concluded from the interim results that the efficacy of eFTR for the resection of non-ampullary duodenal adenomas is comparable to that of EMR. The data suggests that the complication rate of eFTR in the duodenum is lower than that of EMR. Study recruitment is ongoing, which is why no final results and findings can be concluded from the study at present.

EMR vs. endoskopische Vollwandresektion zur Resektion von nicht- ampullären Duodenaladenomen – Zwischenauswertung der DUORESECT-Studie (EMR vs endoscopic full-thickness resection for the resection of non-ampullary duodenal adenomas – interim analysis of the DUO-RESECT study).

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