

Webinar

Resection techniques in endoluminal surgery



Q&A: FTRD® in T1 tumors: Expanding the horizons for early colonic cancer presented by Dr. Barbara Bastiaansen, UMC Amsterdam, Netherlands.

Question from Prof. Neuhaus: The selection of patients with early cancers is important to mention. Most of patients with early cancers have larger lesions, e.g. lateral spreading tumor with a nodule within an area of a lateral spreading non granular tumor. The risk of cancer here is about 14 %. How to apply FTRD in such a case?

According to Dr. Bastiaansen the main limitation for EFTR might be the size limitation for malignant cases of about 2 cm. She and her T1 working group in the Netherlands looked at the size of T1 cancers and they found that indeed about half of the tumors are smaller than 2 cm and the other half are invasive parts in laterally spreading lesions. In her personal experience she never encountered a demarcated invasive area that was still T1 and larger than 2 cm. Usually it is a laterally spreading benign lesion with very often a clearly demarcated area that is malignant and the whole area around it is benign. That malignant area still being T1 is very rarely more than 2 cm.

Question from the audience: There is a leak rate after conventional surgery. Is the perforation not a reflection of a similar process and how will stool softeners help that?

Dr. Bastiaansen replies that, with regard to the stool softeners there is not really any evidence, it is rather a personal feeling. When performing a full thickness resection, you basically perform a wedge resection in the left sided colon, so per definition there will be a relative stenosis at the level of the clip. Naturally, pressures and stools are higher in the left sided colon, thus Dr. Bastiaansen believes these high pressures can indeed contribute to tissue rupture at the level of the clip. Stool softeners would contribute to a decrease in pressure on the clip site in that area.

Question from Prof. Neuhaus: You re-emphasized that if submucosal invasion of more than 1000 microns is the only risk factor, then it is probably safe enough to avoid surgery in advanced cancer. However, this does not meet current guidelines, at least not in Germany, and it is very important that detailed information on tumor budding is acquainted which is not provided by most of the pathologists. How is the situation in the Netherlands?

Dr. Bastiaansen first stresses, that there is no long-term safety data on the endoscopic resection of deep submucosal cancers. Treatment options cannot be decided in a multidisciplinary meeting only, but rather the risks and benefits should be evaluated together with the patient. According to the evidence at the moment though, it seems that indeed deep submucosal invasion is not a strong risk factor for lymph node metastasis and thus a safe excisional biopsy is the first step to make. She emphasizes that however, you still have to be careful to conclude now that deep submucosal invasive cancers can be safely removed, the patient is cured and that you never have to perform any surveillance or surgery. The point of tumor budding is also not included in the guidelines in the Netherlands yet. The adoption of including tumor budding, and also the assessment of tumor budding is still difficult to do for the pathologists.

Further questions that were asked but not addressed in the webinar:

Is full thickness for eFTR classified as including serosa or just to level of muscular propria, as you do not always seem to get serosa?

Full thickness resection is usually classified as a complete transmural resection, including all the layers of the wall. If it is not possible to include the serosa into the resection you would rather speak of a deep wall resection which may more likely occur in the rectum or in the stomach. In some cases (e.g. benign lesions) it may be sufficient to achieve a deep wall resection reaching or including the muscular layer.

Do you ever use knife-assisted FTRD in order to make the larger lesions more mobile to be pulled into the cap?

There are users who use a knife or a snare to dissect the mucosa in order to better access the lesion and to be able to mobilize it better (e.g. with GIST in the stomach).

Can we use OTSC to perform FTR for a small gastric fundal GIST?

This technique has been applied in some cases, however it is usually more difficult to resect the lesion safely above the clip since you are lacking the safety distance between the snare and the clip which is given in the FTRD System. Thus, Ovesco has developed a dedicated device (gastroduodenal FTRD) for full-thickness resection in the upper GI.