Webinar

Resection techniques in endoluminal surgery




Q&A: Hybrid-EFTR-EMR - Full-thickness resection as advanced resection technique for gastrointestinal neoplasia presented by Prof. Dr. Karel Caca, Klinikum Ludwigsburg, Germany.

Question from Prof. Neuhaus: How do you select patients for EMR, ESD and FTRD? For example, if you have a patient with a 2 cm non-granular type of lateral spreading tumor or a mixed type (10-15 % of cancer). What would you suggest?

In the rectum Prof. Caca would perform an ESD because you can easily do it with a knife and a resection mode and you usually do not see any bleeding. In the colon however, he would not perform ESD because it is too risky and time-consuming. Instead he would choose to perform EMR. If the lesions are located in a flexible part of the colon and appear to be able to be grasped and pulled into the FTRD cap, he would choose FTRD. But those lesions that have the higher malignant potential, are very rarely on the right side of the colon. There are much more often in the rectosigmoid.

Question from Prof. Meining: Hybrid-FTRD in the rectum can sometimes be a little bit difficult due to scarring. Are there any tipps or solutions how to overcome problems of grasping the tissue in the rectum?

It usually depends on where the lesion is located in the rectum. If you are above the peritoneal line the tissue is usually flexible and easy to grasp. The further down it is located the more it is tied to the pelvic floor and you may not be able to pull everything inside the cap resulting in a deep submucosal resection. Prof. Caca recommends to not perform an FTRD in the deep rectum up to 5 cm. As an alternative, the use of the OTSC Anchor could be considered for the mobilization of the tissue. However, one needs to bear in mind that the risk of ripping off the tissue is more likely in that case.

Follow-up question from Prof. Meining: Would you do an ESD then or would you do something like underwater EMR? Would you generally do ESD then or cold snare resection? We are talking about lateral spreading tumors granular type.

Prof. Caca himself is not familiar with underwater EMR thus cannot provide any insights in this regard. Cold snare resection for lesions up to 1 cm appears to be standard. For lesions larger than 1 cm it is becoming more popular, but it is not something that he would pursue. For such lesions he would choose ESD because it usually takes only about half an hour.

Question from the audience: We have performed some hybrid EMR + eFTR in the left colon without complications. However, we experienced 2 delayed perforations (within 24 hours after the procedure) in the ascending colon. Maybe the thin muscle layer in the ascending colon can easily tear after placement of the OVESCO clip when the mucosal layer is removed by the EMR procedure. Is this coincidence or have others experienced the same?

Perforations can always happen since there is a possibility with every resection technique. Prof. Caca in his experience never encountered any perforations although he was concerned in the beginning as well. Prof. Neuhaus adds that it might make a difference if you can fully pull the lesion plus the EMR-resected area into the cap and apply the clip at least partly to the mucosa rather than having a wide resection in the cecum and applying the clip just on the thin wall. At least this difference should be taken into consideration.

Question from the audience: Would you always perform Hybrid-EMR-FTRD in one session, or would it not be better to perform the procedure in two separate sessions?

The main disadvantage of performing the Hybrid technique in two sessions is the scar formation. Scarring makes it more difficult to pull the remaining lesion into the FTRD cap in a second session.

Question from the audience: In case of an accidental non-lifting part in a case that was scheduled for EMR, EFTR can be applied to salvage the case. Would it make sense to get consent of patients right away for possibly needed EFTR when scheduling the case?

If the patients are referred for advanced resection techniques, they should ideally always be informed about all three different techniques (EMR, ESD, EFTR). Prof. Caca explains to the patient which technique he is aiming to use but if he is not 100 % sure and if there is the need, then he might switch to one of the other techniques.