Introduction

Endoscopic submucosal dissection (ESD) for early gastric cancer (EGC) in remnant stomach or gastric tube is a technically difficult procedure because of the limited working space as well as the presence of staples and severe fibrosis under the suture line. We evaluated technical results to determine the feasibility of ESD for such EGC.

Patients and methods 1 (remnant stomach)

We investigated patients undergoing ESD for EGC in remnant stomach from 1997 to 2011.

Results 1 (remnant stomach)

A total of 128 consecutive patients with 139 lesions underwent ESD in the study periods who had previously undergone 87 distal (68%), 25 proximal (19.5%) and 16 pylorus preserving gastrectomies (12.5%). The median period from the original gastrectomy to ESD for EGC in the remnant stomach was 5.7 years (range, 0.6-51); the median tumor size was 13mm (1-60); and the median procedure time was 60 minutes (15-310). There were 131 en-bloc resections (94%) and 109 curative resections (78%); 22 lesions (16%) resulted in non-curative resections with possible risk of lymph node metastasis such as submucosal invasion or lymphovascular invasion; and eight lesions (6%) were diagnosed as non-curative resections with only horizontal margin positive or inconclusive. Complications included two delayed bleeding (1.4%) and two perforations (1.4%) with one patient requiring emergency surgery.

Patients and methods 2 (gastric tube)

We investigated patients undergoing ESD for EGC in gastric tube from 1998 to 2011.
Results 2 (gastric tube)

A total of 51 consecutive patients with 79 lesions underwent ESD in the study periods who had previously undergone esophagectomy. Median period from esophagectomy to ESD for GTC was 5.2 years (range, 0.3-17.0). Median procedure time was 90 minutes (15-360) including 73 en-bloc (92%) and with 51 lesions (65%) involving curative resections and 28 (35%) non-curative resections. Histologically, median tumor size was 15mm (1-57) with 61 differentiated, 15 undifferentiated and three mixed type adenocarcinomas. Complications included three perforations (3.8%) during ESD and two delayed perforations (2.5%) without any emergency surgery and three delayed bleeding (3.8%).

Conclusions

ESD rustled in favorable technical outcomes for EGC in remnant stomach or gastric tube. In the lecture, I will present the technical tips of ESD for such EGC.

References