Salvage endoscopic submucosal dissection for recurrent invasive Barrett neoplasia after endoscopic resection and radiofrequency ablation

Endoscopic resection is indicated for visible lesions in Barrett’s esophagus (BE) for either curative treatment or optimal histopathological staging [1]. Endoscopic submucosal dissection (ESD) should be considered only for lesions larger than 15 mm [2]. Even in larger lesions, it still offers a moderate rate of cure [3]. We report the case of an 82-year-old man with a 40 × 30-mm visible lesion in an area of BE (C8M8), which was removed R0 by ESD, with the histological diagnosis being high grade dysplasia (▶ Fig.1). Subsequent high definition endoscopy found no suspicious visible lesions. Radiofrequency ablation (RFA) was scheduled for the remaining BE. However, on the second session of RFA, two suspicious lesions were detected and biopsies confirmed the presence of an adenocarcinoma component within high grade dysplasia. It was decided to perform salvage endoscopic resection to manage these recurrent lesions.

We performed ESD with the “tunnel + clip” strategy [4] (▶ Fig.2). In spite of severe fibrosis, we were able to remove the lesions endoscopically en bloc, without any adverse events, in 1 hour (▶ Video 1). Two specimens measuring 55 × 40 mm and 12 × 10 mm were submitted for pathological analysis, which confirmed an R0 resection of moderately differentiated adenocarcinoma with budding and submucosal invasion less than 200 μm (pT1b) (Lesion #1) and an intramucosal adenocarcinoma (Lesion #2) (▶ Fig.3). A shared discussion of the choice between salvage surgery and endoscopic surveillance took place with the patient.

This is the first case reported so far of recurrent invasive BE neoplasia within a period of only 7 months from the initial curative endoscopic resection. Regardless of severe fibrosis following the previous resection and RFA, complete resection by endoscopy remained feasible and safe with the “tunnel + clip” strategy.
Although the recurrence rate after curative resection is reported to be low [5], we should not overlook visible lesions during follow-up. ESD is still a preferable and effective management in this situation.

Endoscopy_UCTN_Code_CPL_1AH_2AJ

Competing interests

The authors declare that they have no conflict of interest.

The authors

Borathchakra Oung1,2, Julien Faller3, Florence Juget Pietu4, Marco Petronio5, Mathieu Pioche3
1 Faculty of Medicine, University of Health Sciences, Phnom Penh, Cambodia
2 Cambodian Association of Gastrointestinal Endoscopy (CAGE), Cambodia
3 Department of Endoscopy and Gastroenterology, Pavillon L – Edouard Herriot Hospital, Lyon, France
4 Clinique générale Anney, Annecy, France

References


Corresponding author

Mathieu Pioche, MD
Endoscopy unit – Digestive Disease department, Pavillon L – Edouard Herriot Hospital, 69437 Lyon, France
mathieu.pioche@chu-lyon.fr

DOI https://doi.org/10.1055/a-1167-8069
Published online: 2020
Endoscopy © Georg Thieme Verlag KG Stuttgart · New York ISSN 0013-726X

ENDOSCOPY E-VIDEOS
https://eref.thieme.de/e-videos

Endoscopy E-Videos is a free access online section, reporting on interesting cases and new techniques in gastroenterological endoscopy. All papers include a high quality video and all contributions are freely accessible online.

This section has its own submission website at https://mc.manuscriptcentral.com/e-videos

Fig. 2 Views of the two recurrent lesions found after the initial resection and radiofrequency ablation showing: a a protruded lesion on the anterior wall of esophagus; b another small visible lesion; c endoscopic submucosal dissection being performed with line traction assistance; d endoscopic submucosal tunnel dissection being performed.

Fig. 3 Macroscopic appearance of the two resected lesions, measuring 55 × 40 mm and 12 × 10 mm, stretched on cork boards.