A 63-year-old man was investigated because of long-standing pathological gastroesophageal reflux. Diagnostic endoscopy showed long-segment Barrett’s esophagus associated with a flat lesion compatible with a granular laterally spreading tumor (LST-G), and endoscopic submucosal dissection was decided upon [1]. A Fujinon EG-590-ZW diagnostic endoscope was used for the procedure. A Fujinon transparent conical cup and Fujifilm 1.5-mm FlushKnife BT were used as the dissecting instruments. The endoscope was advanced to the distal esophagus, where long-segment Barrett’s esophagus (6 cm in length) was confirmed. In addition, a homogeneous flat lesion compatible with a LST-G of 4 cm maximum diameter was shown (Fig. 1). Flexible spectral imaging color enhancement (FICE) and magnification were used for exhaustive assessment of the surface and margins of the lesion, which presented a granular flat segment on its edges. The edges of the lesion were marked with a safety margin of 5 mm (Fig. 2). The lesion was then raised by submucosal injection with a solution made up of 500 mL Voluven, 2.5 mL methylene blue, and 1 mg epinephrine. A complete perimeter mucotomy, external to the marking, was performed (Fig. 3). Careful hemostasis was carried out, followed by endoscopic dissection of the submucosal layer adjacent to the muscularis propria (Fig. 4) [2]. The entire submucosal layer of the lesion in the dissected specimen was included. The surgical bed was undamaged, with no signs of perforation and correct hemostasis (Fig. 5; Video 1).

At 6-month post-procedure follow-up the wound had healed. Re-epithelialization with squamous mucosa without evidence of esophageal stenosis was demonstrated. On this occasion, the remaining Barrett’s esophagus was ablated using radiofrequency.

The pathological report was of well-differentiated, intramucosal adenocarcinoma without compromise of lateral or deep margins. Carrying out ESD for incipient neoplastic lesions in Barrett’s esophagus is feasible and safe [3] and achieves good oncological results. It should be followed by radiofrequency ablation of the remaining Barrett’s esophagus [4, 5].
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