ANNUAL

Advances and Innovations in Endoscopic Oncology and Multidisciplinary Gastrointestinal Cancer Care

Endoscopist as Surgeon: Expanding Boundaries of Interventional Endoscopy

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Disclosures

- Consultant for Boston Scientific, Medtronic, Olympus

The presentation and/or comments will be free of any bias toward or promotion of the above referenced companies or their product(s) and/or other business interests.

This presentation and/or comments will provide a balanced, non-promotional, and evidence-based approach to all diagnostic, therapeutic and/or research related content.

This presentation has been peer-reviewed and no conflicts were noted.

Cultural Linguistic Competency (CLC) & Implicit Bias (IB)

STATE LAW:

The California legislature has passed Assembly Bill (AB) 1195, which states that as of July 1, 2006, all Category 1 CME activities that relate to patient care must include a cultural diversity/linguistics component. It has also passed AB 241, which states that as of January 1, 2022, all continuing education courses for a physician and surgeon **must** contain curriculum that includes specified instruction in the understanding of implicit bias in medical treatment.

The cultural and linguistic competency (CLC) and implicit bias (IB) definitions reiterate how patients' diverse backgrounds may impact their access to care.

EXEMPTION:

Business and Professions Code 2190.1 exempts activities which are dedicated solely to research or other issues that do not contain a direct patient care component.

The following CLC & IB components will be addressed in this presentation:

- Asian vs Western Approach to stage 1 cancers
- Subspecialty bias towards particular treatment approach

Objective

An endoscopist is not a surgeon

Endoscopy itself can be a means to carry out the same objectives as a surgeon

Understanding how organ preserving surgical endoscopy can work in the multidisciplinary approach to GI carcinomas allows us to provide the best options when there is cross-specialty awareness and the appropriate patients are selected.

Objective

For a physician surgery implies a technical skill set facilitated through performing a procedure which alters anatomy through external incision.

The lines between “procedure” and surgery are becoming blurred

For the patient – procedure and surgery are the same: when requiring anesthesia, altering anatomy, and carrying potential risks

ESD

ESD – Patient Selection

Esophagus:

- **Barrett's Esophagus:**
  - **Large or bulky area of nodularity**
  - **Lesions with a high likelihood of superficial submucosal invasion**
  - **Recurrent dysplasia after EMR**
  - **Endoscopic mucosal resection specimen showing invasive carcinoma with positive margins**
  - **Equivocal preprocedural histology**
  - **Intramucosal carcinoma.**

- **SCC without submucosal invasion**

- **T1a Adenocarcinoma of Esophagus**

High risk or Dysplastic patients clinically appropriate for treatment

No nodularity:

→ Ablative therapy

Focal Nodularity <1 – 1.2 cm

→ Band EMR followed by Ablation to flat areas

Focal Nodularity <1-3cm

→ EMR vs ESD – limited data shows no difference for neoplasia

Multifocal nodularity, unclear degree of nodularity, ulcerated lesions, or biopsy proven T1 carcinoma >3cm

→ ESD

ESD – Patient Selection

Stomach:

- Lesions <2cm.
- Moderately and well-differentiated superficial cancers that are >2 cm
- Lesions ≤3 cm with ulceration or that contain early submucosal invasion
- Poorly differentiated superficial cancers ≤2 cm in size

Duodenum:

- Avoid unless you have extensive experience, and then proceed with caution

Colon:

- Large Colorectal Adenomatous lesions without Submucosal invasion but suspicion of HGD or multiple prior manipulations

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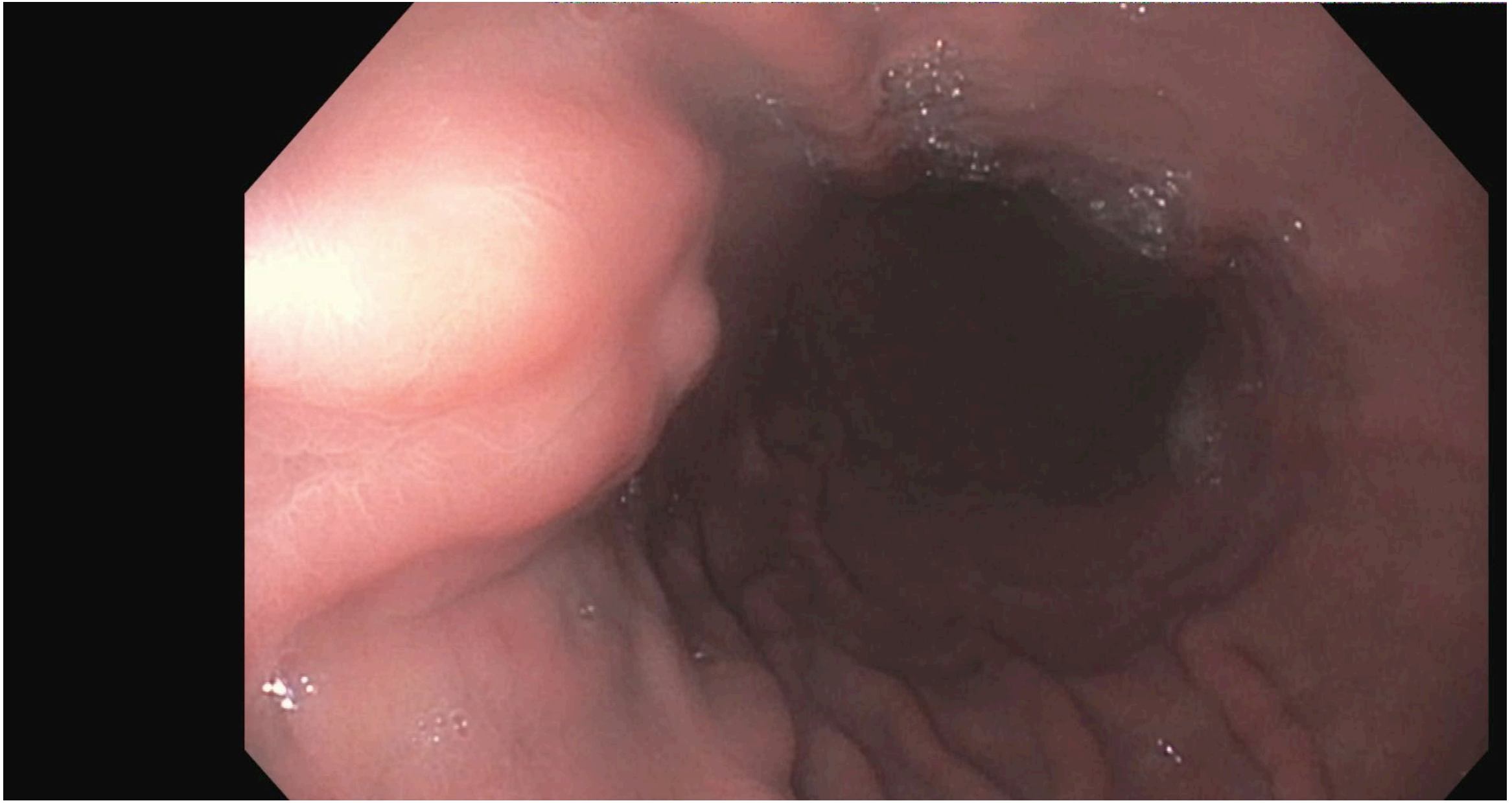
STER



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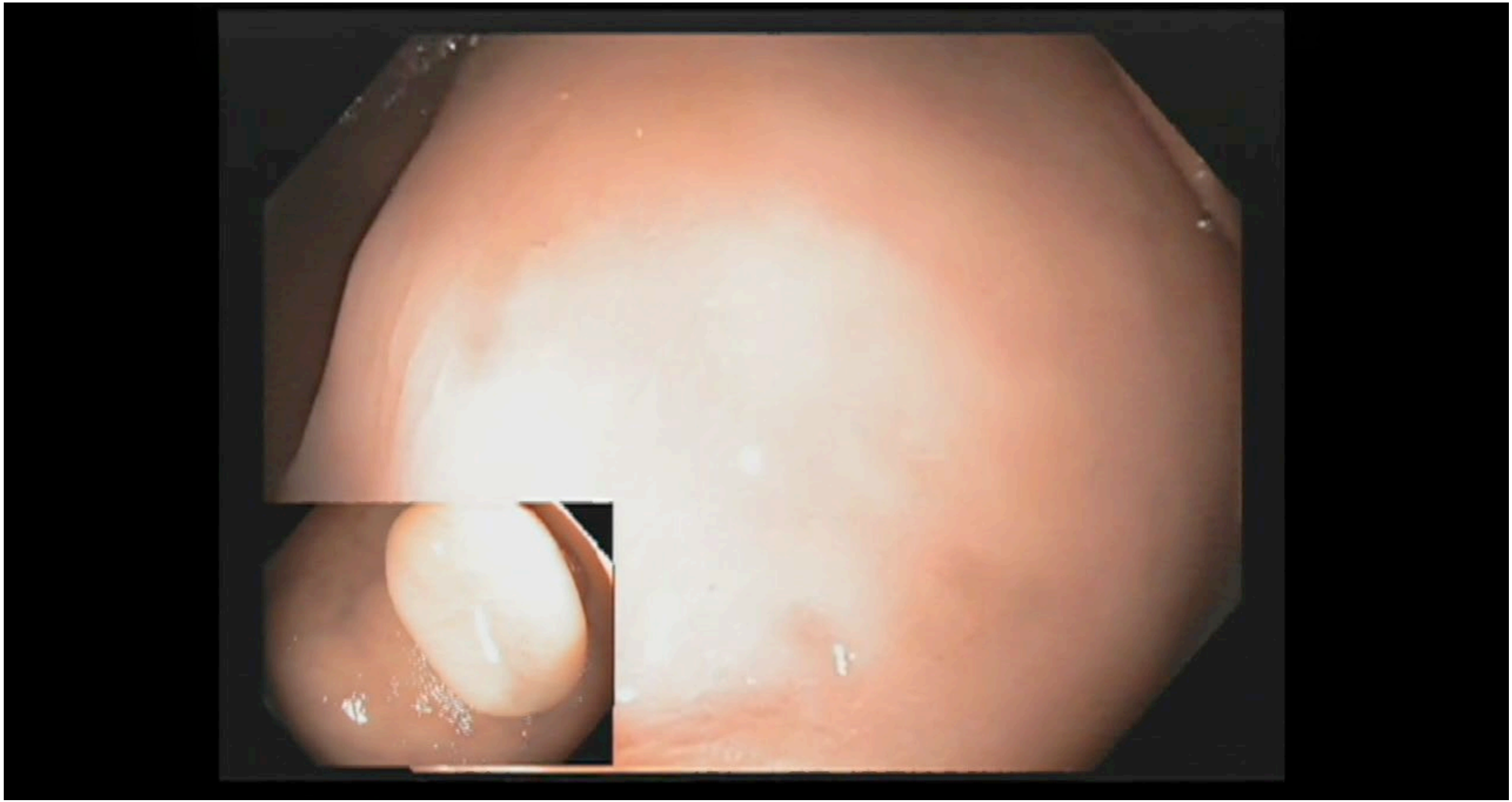

TAKE HOME MESSAGES

Take home messages

- **Minimally invasive resection is the optimal option in terms of cost and morbidity for patients**

- **Open surgery → Laparoscopic → Robotic → Transcatheter & Endoscopic**

- **Some Early cancers can be resected endoscopically**
  - **Must follow sound surgical oncology principles**

Take home messages

- **Minimally invasive resection is the optimal option in terms of cost and morbidity for patients**

- **When patients are found to have localized lesions we must ask the following:**

    1. **Is this cancer or is there a high potential for Early Cancer?**
        - **Consider ESD**
            - **Know ESD criteria**
            - **Work with multi-disciplinary tumor board!!**

    2. **How can we achieve complete removal of the lesion in the safest & least morbid manner for the patient?**
        - **Location, Lesion classification: ESD/STER/FTRD vs Robotic/Laparoscopic vs Open**

    3. **How can I ensure the lowest risk of recurrence?**
        - **Technique matters**
        - **Patient selection**
        - **Preoperative thorough staging & Multidisciplinary review prior to treatment initiation**

Thank you!