

Appropriatezza dell'Endoscopia nel Ca Gastrico



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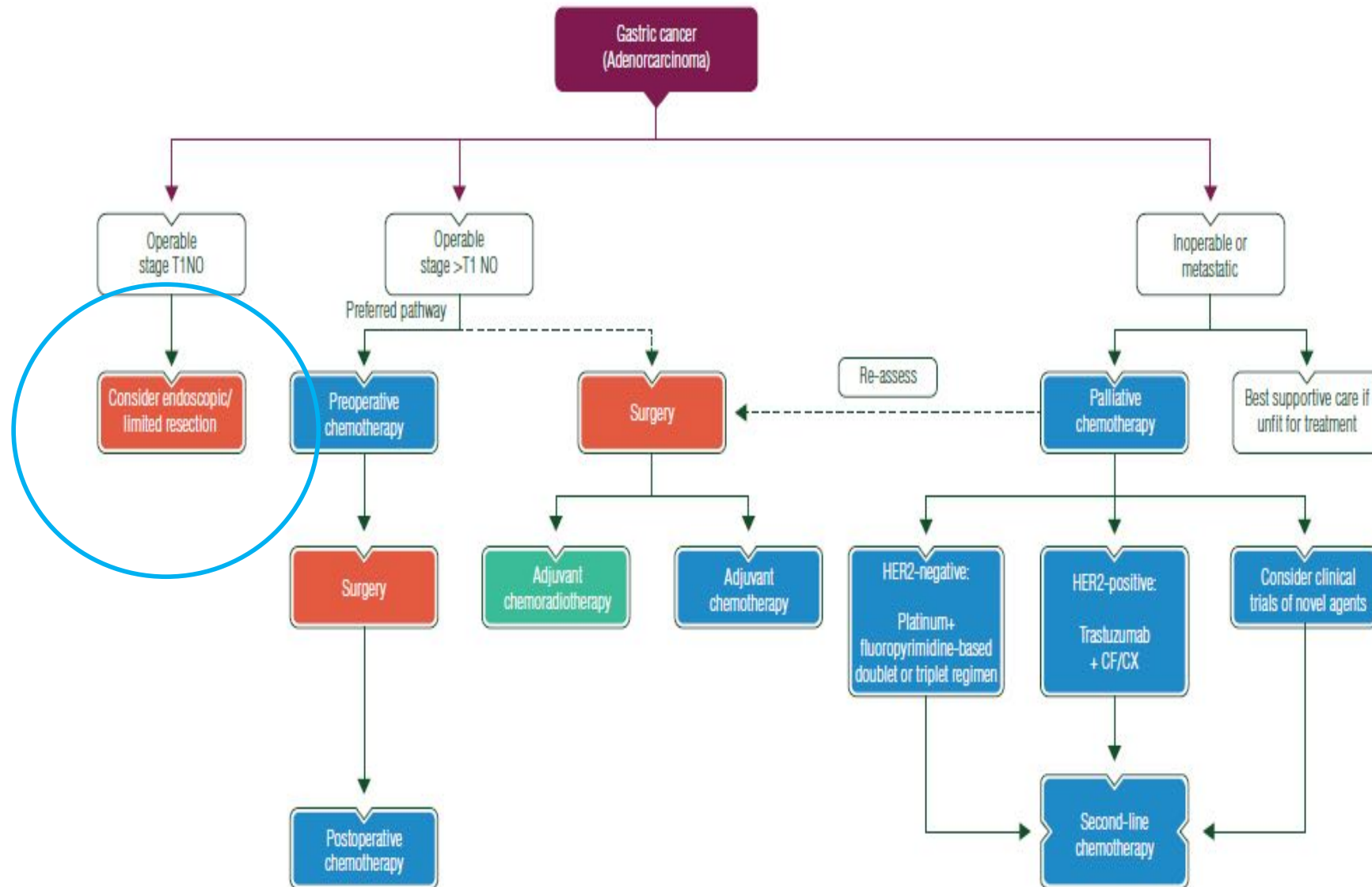
Resp. UOSD Gastroenterologia ed
Endoscopia Digestiva, Ospedale
SS. Annunziata, Chieti

Overview of presentation

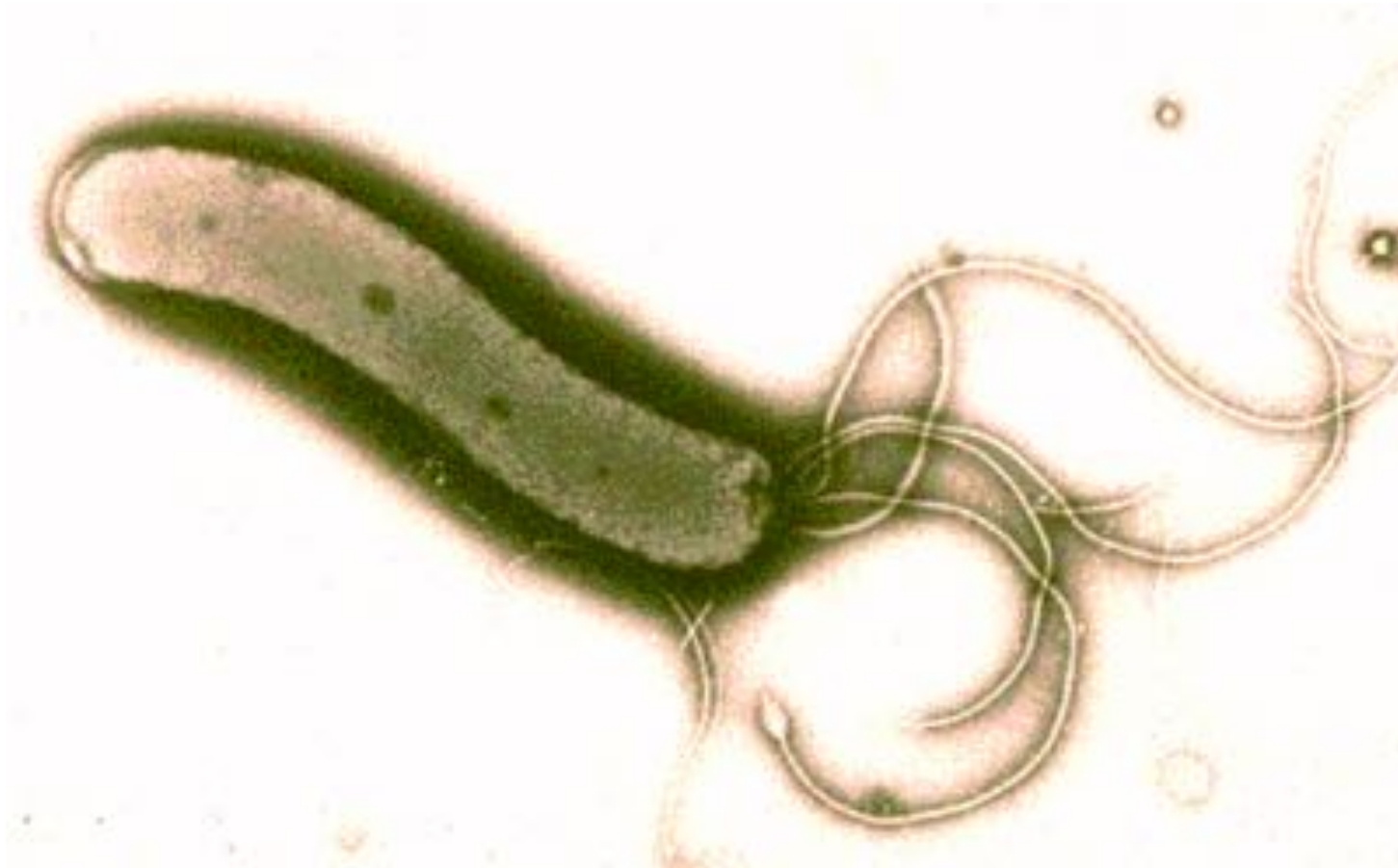
What should we do:

- Before Cancer
 - Endoscopy in precancerous condition (atrophic gastritis and metaplasia/dysplasia)
- At Endoscopy
 - superficial neoplastic lesions of the stomach:
Diagnosis, Treatment, Follow-up
- After Gastric Surgery
 - Follow-up

Gastric cancer: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up



The principal cause of Gastric Cancer is *H. Pylori*



The OLGA/OLGIM score



ATROPHY SCORE		CORPUS			
		No atrophy (score 0)	Mild atrophy (score 1)	Moderate atrophy (score 2)	Severe atrophy (score 3)
ANTRUM	No atrophy (score 0) (including <i>incisura angularis</i>)	STAGE 0	STAGE I	STAGE II	STAGE II
	Mild atrophy (score 1) (including <i>incisura angularis</i>)	STAGE I	STAGE I	STAGE II	STAGE III
	Moderate atrophy (score 2) (including <i>incisura angularis</i>)	STAGE II	STAGE II	STAGE III	STAGE IV
	Severe atrophy (score 3) (including <i>incisura angularis</i>)	STAGE III	STAGE III	STAGE IV	STAGE IV

Score 0: no atrophic glands
 Score 1: 1–30% of atrophic glands
 Score 2: 31–60% of atrophic glands
 Score 3: >60% of atrophic glands

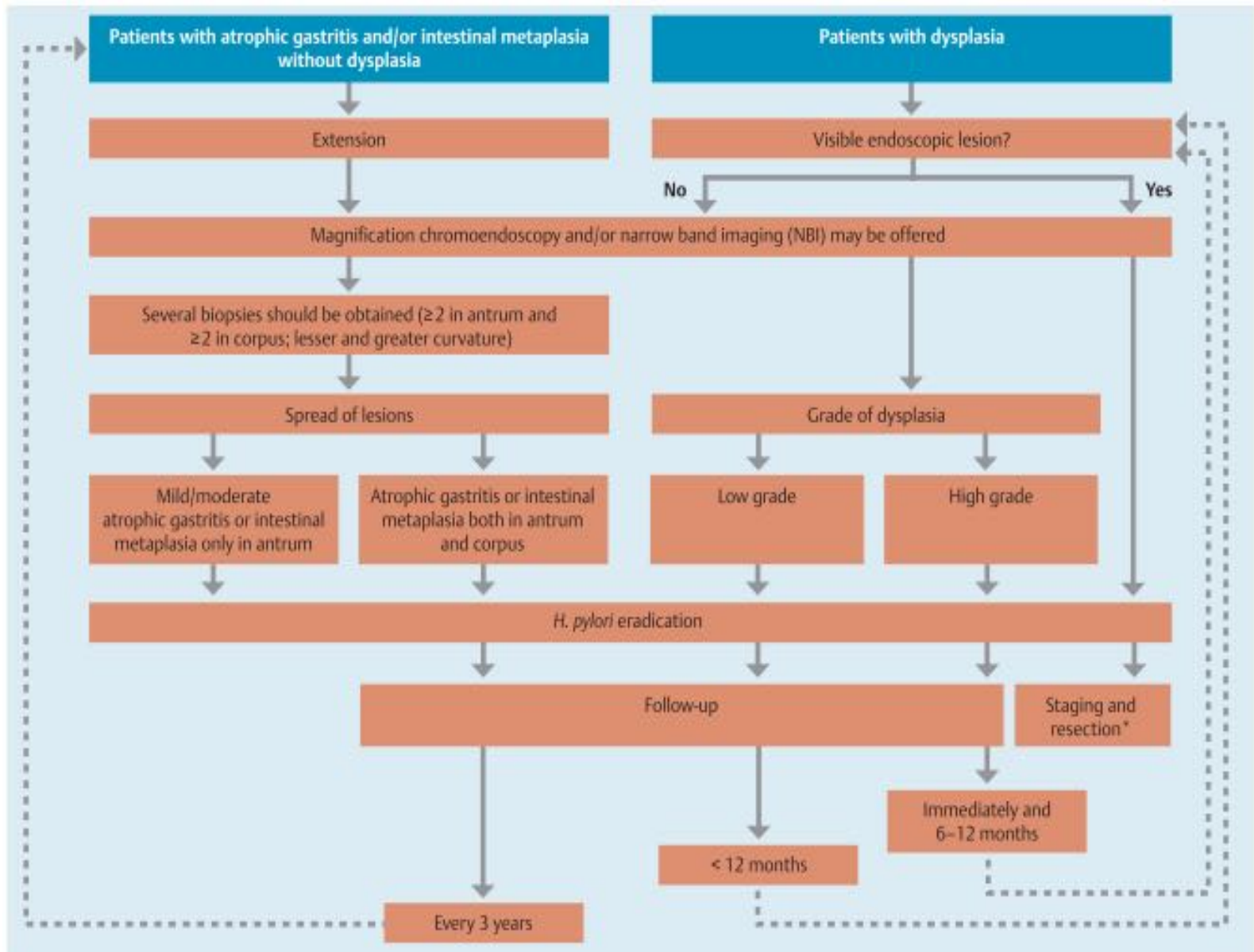
ANTRUM

No atrophy (score 0)
(including *incisura angularis*)
 Mild atrophy (score 1)
(including *incisura angularis*)
 Moderate atrophy (score 2)
(including *incisura angularis*)
 Severe atrophy (score 3)
(including *incisura angularis*)

No atrophy (score 0) Mild atrophy (score 1) Moderate atrophy (score 2) Severe atrophy (score 3)

STAGE 0 STAGE I STAGE II STAGE II
 STAGE I STAGE I STAGE II STAGE III
 STAGE II STAGE II STAGE III STAGE IV
 STAGE III STAGE III STAGE IV STAGE IV

Management of precancerous conditions in the stomach

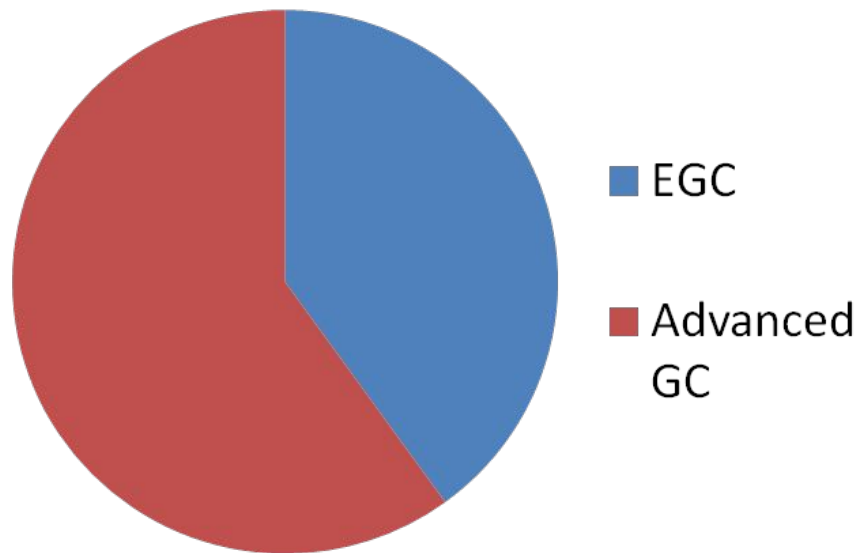


How to do it

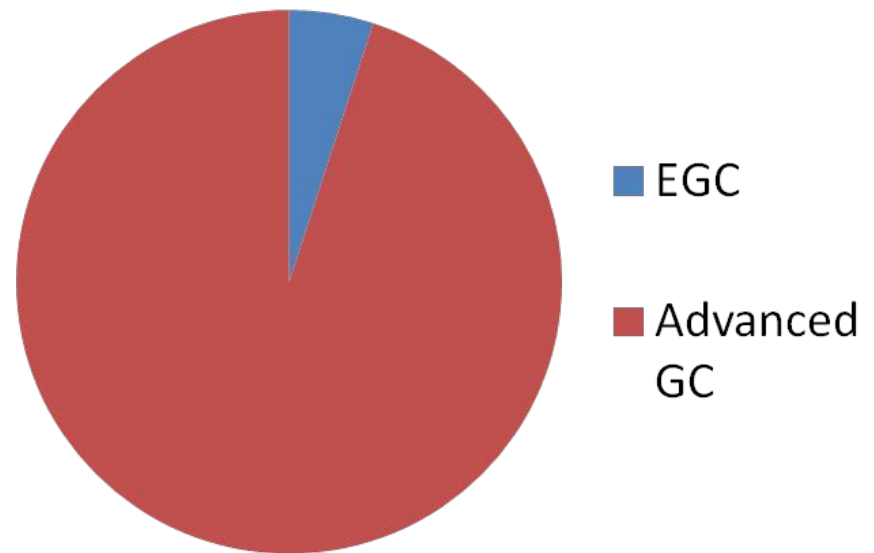


Gastric Cancer detection rates

EASTERN GC detection rates



WESTERN GC detection rates



Metodologia di esplorazione del tratto digestivo alto: SSS





Performance measures for upper gastrointestinal endoscopy: A European Society of Gastrointestinal Endoscopy quality improvement initiative

United European Gastroenterology Journal
2016, Vol. 4(5) 629-656

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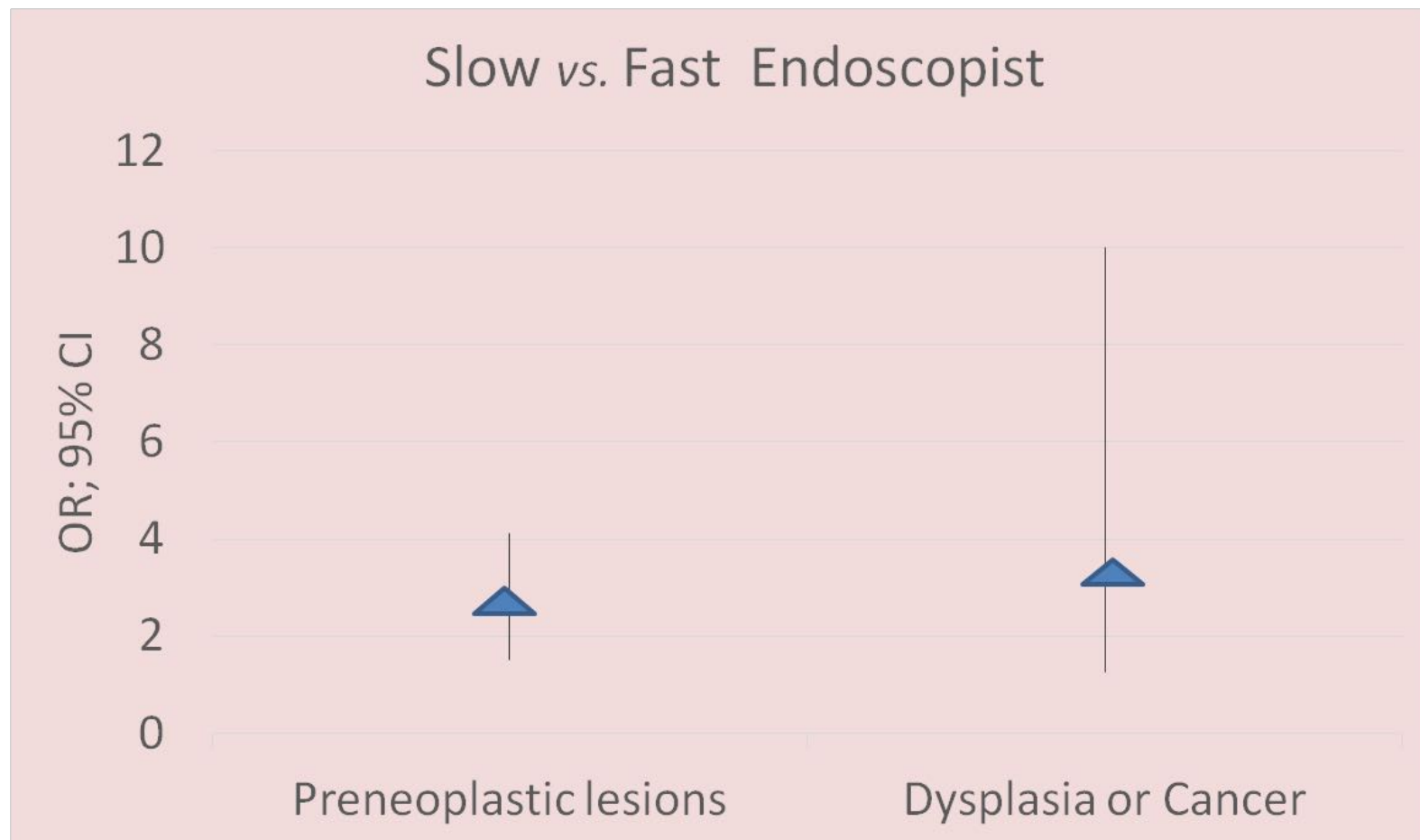
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Domain: completeness of procedure

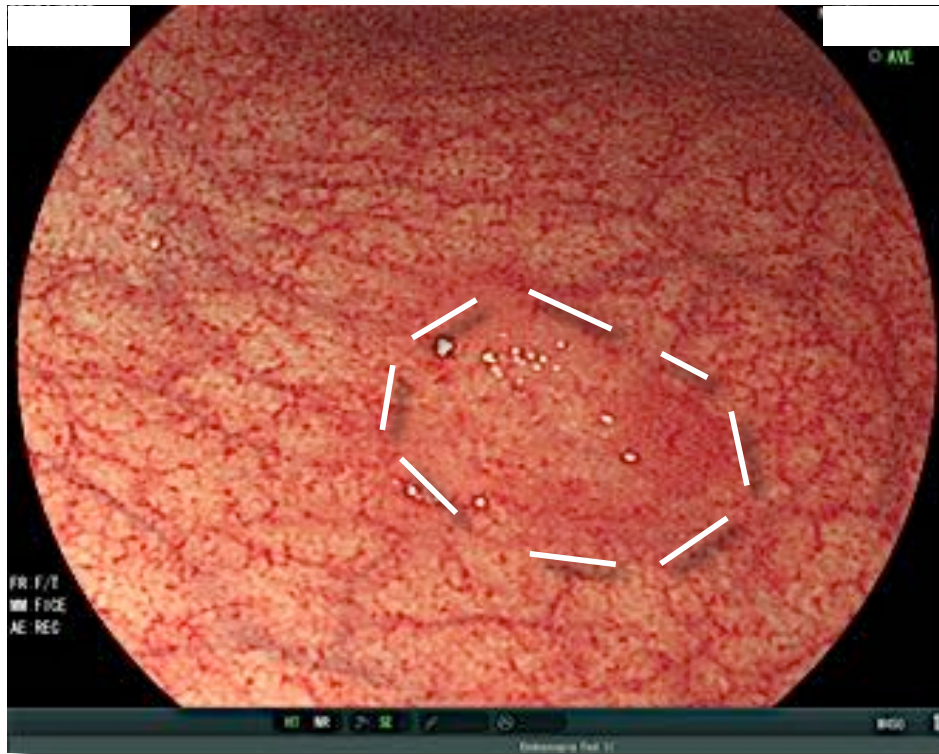
- **A UGI endoscopy** in a patient who has not undergone a previous gastroscopy within the last three years should include inspection of the esophagus, stomach, and duodenum, and should last for **at least seven minutes** from intubation to extubation.

(N2.2) Agreement: 80%.

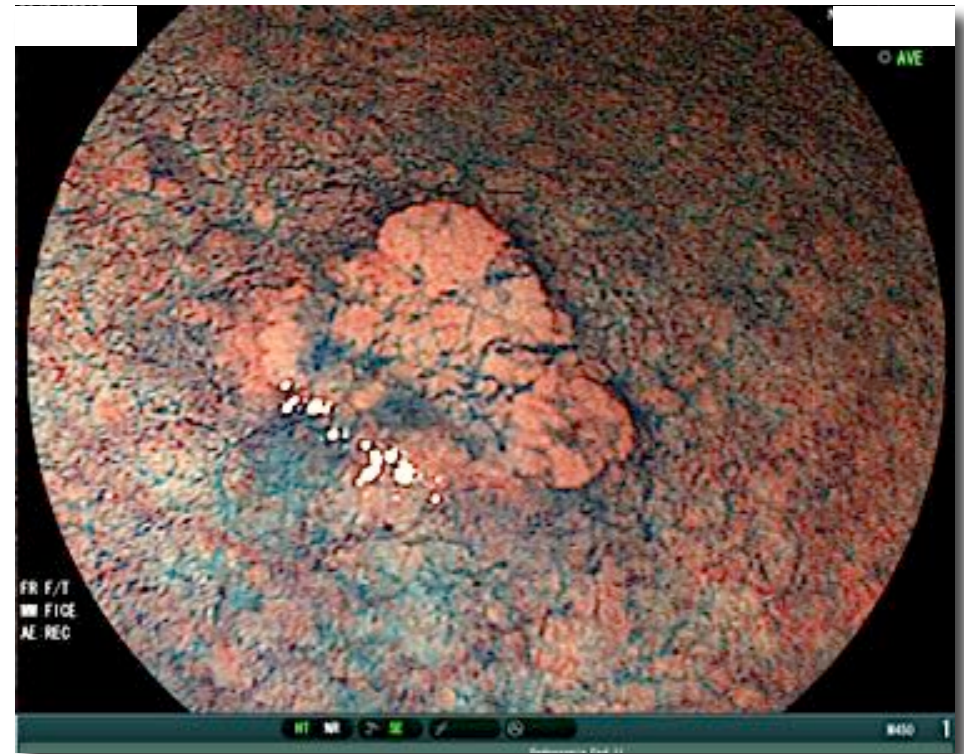
Longer Examination Time Improves Detection of Gastric Cancer During Diagnostic Upper GI Endoscopy



How to improve visualization: Chromoendoscopy with indigo carmine



GRANULARITY AND VASCULAR TRIMMING

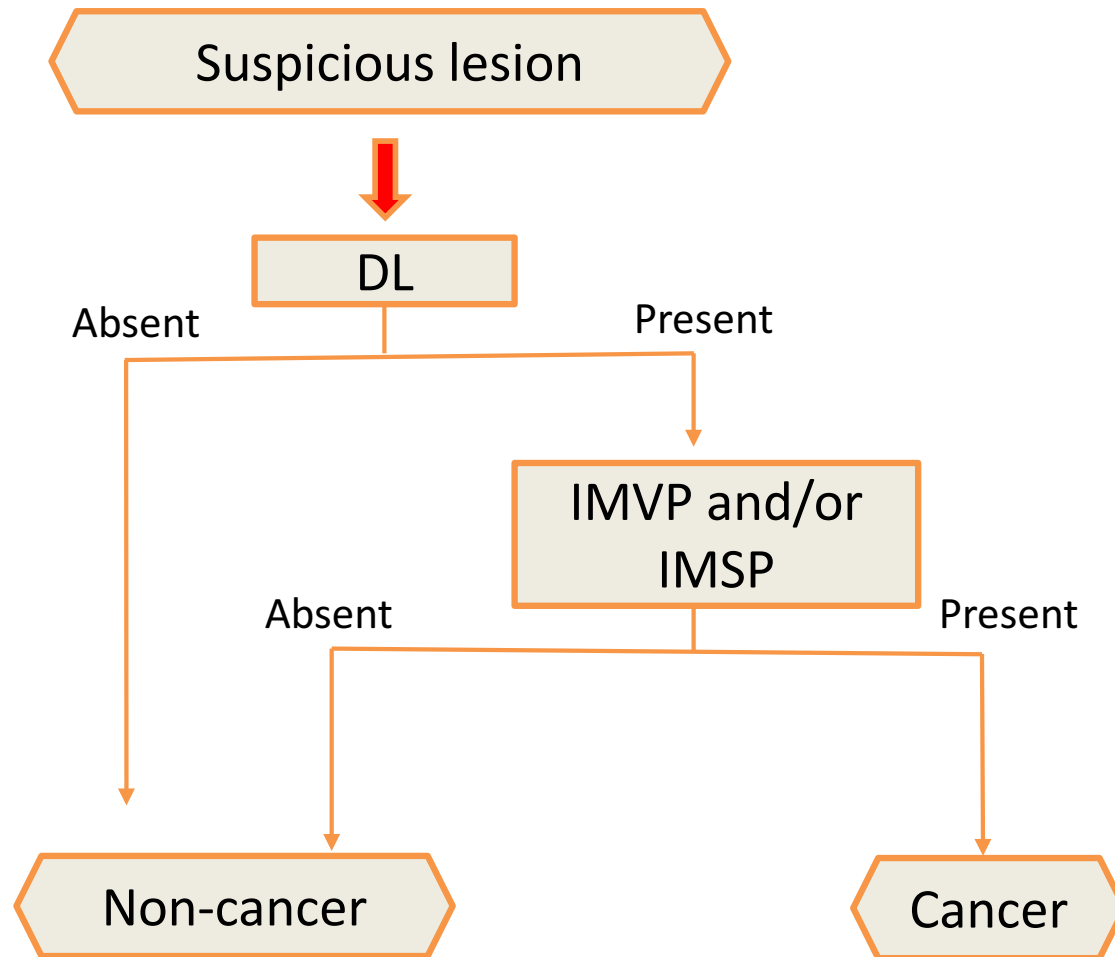


II a LESION

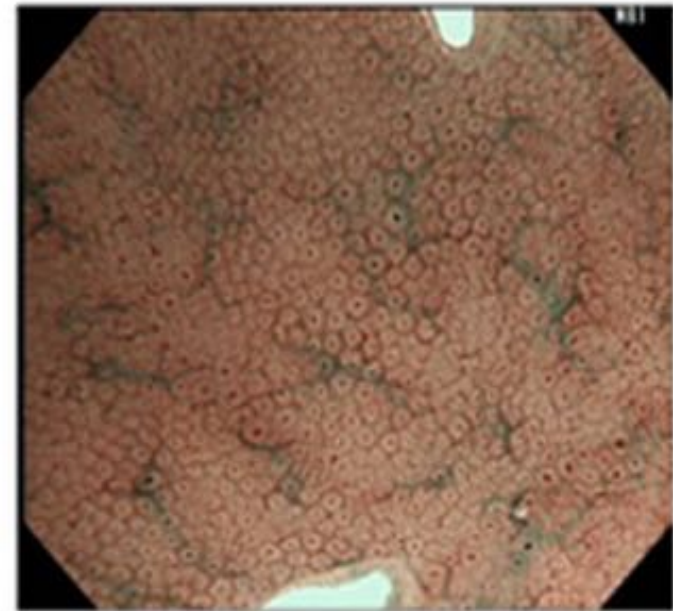
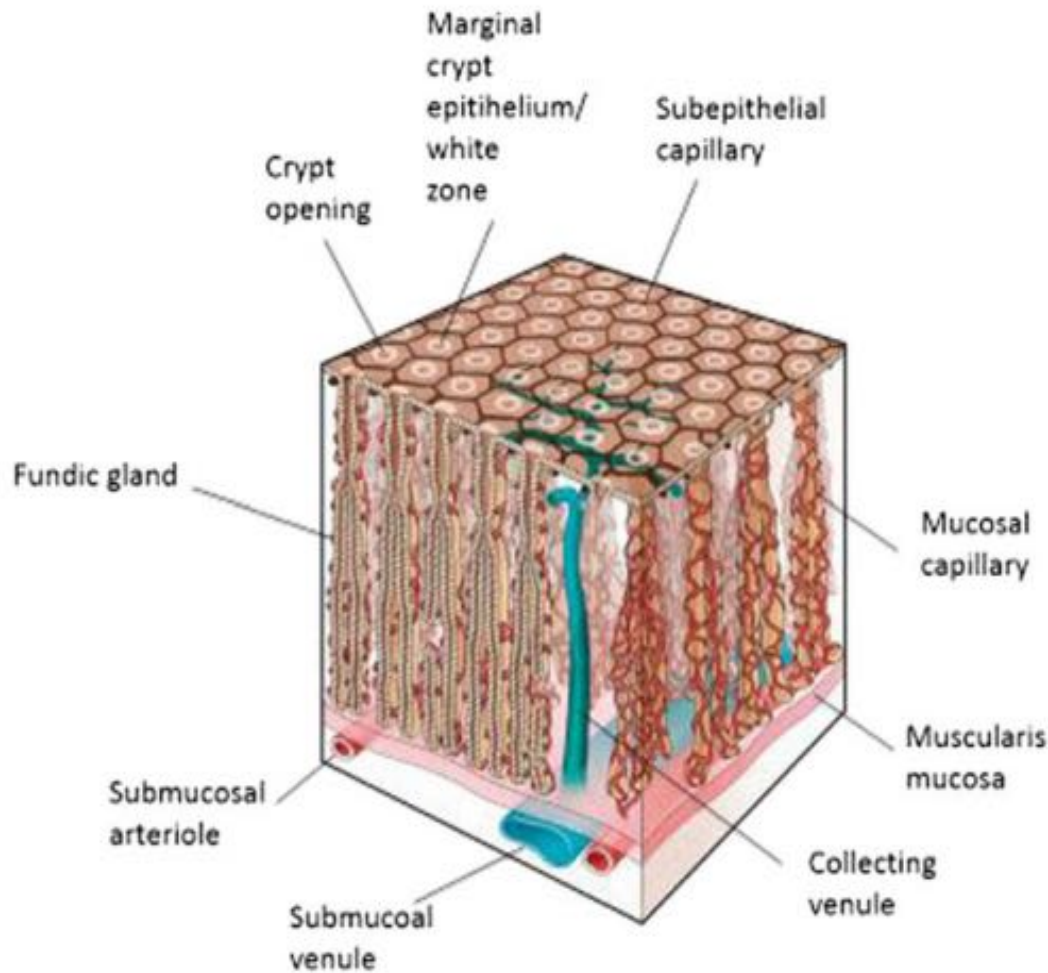
Technology is important!



Magnifying Endoscopy Simple Diagnostic Algorithm for Gastric Cancer (MESDA-G)

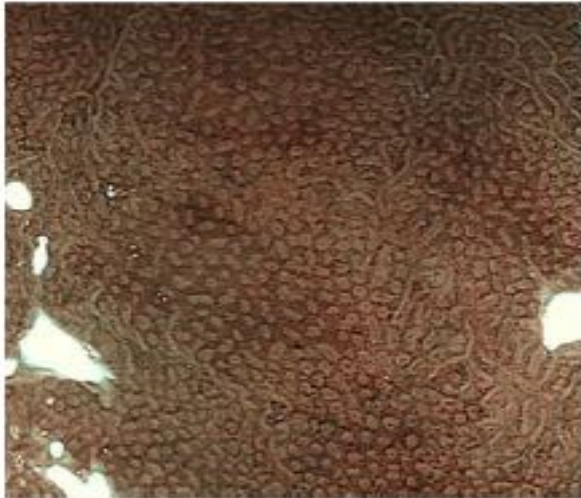


Microvascular architecture and microsurface structure at ME and NBI



Microvascular architecture and microsurface structure at ME and NBI

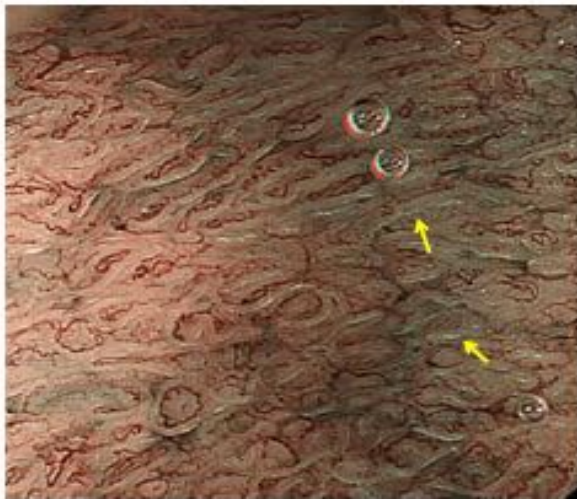
Inflammation



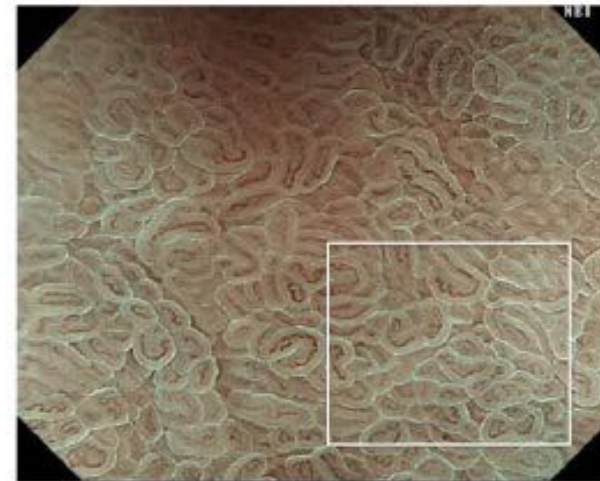
Advanced inflammation



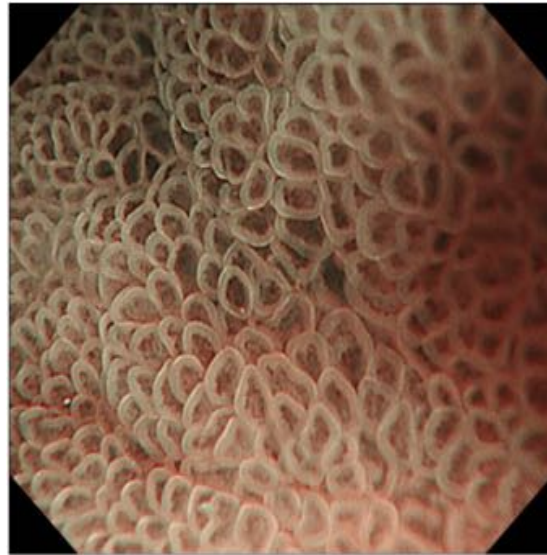
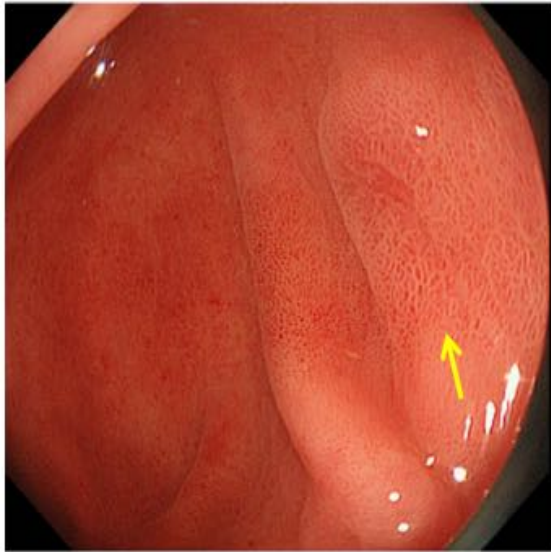
Atrophy



Metaplasia



Microvascular architecture and microsurface structure at ME and NBI

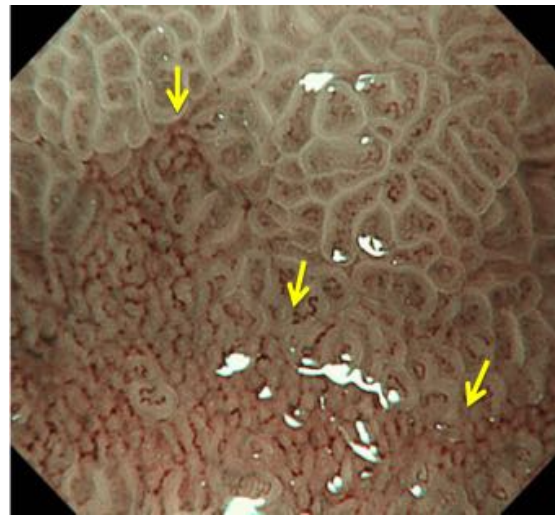
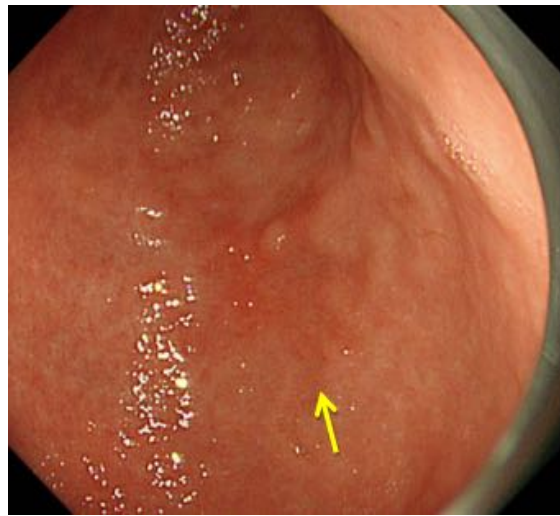


there is no
demarcation line



NO Cancer

Microvascular architecture and microsurface structure at ME and NBI

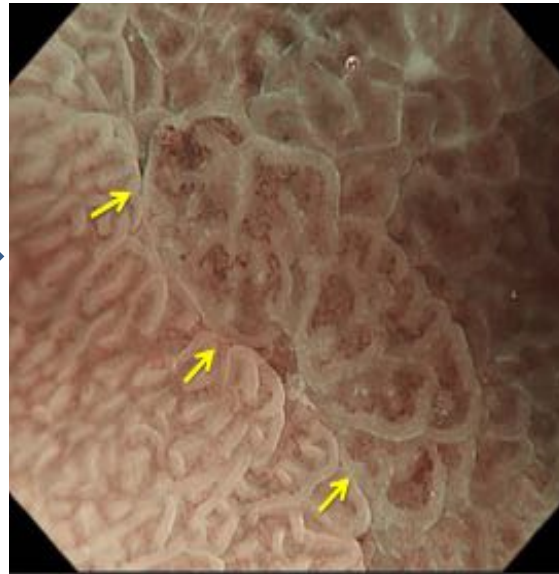
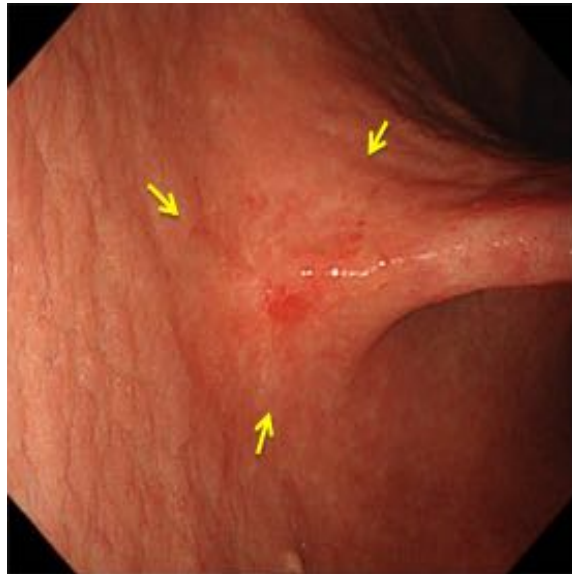


Inside the
demarcation line :
regular microvascular,
regular microsurface
patterns



NO Cancer

Microvascular architecture and microsurface structure at ME and NBI

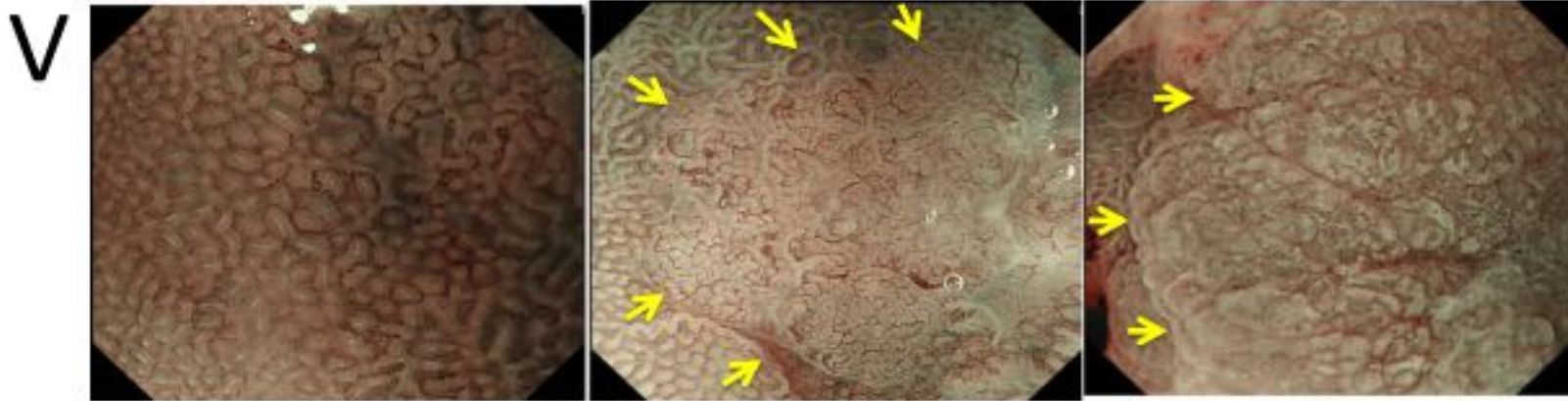


irregular microsurface and
irregular microvascular
patterns
are present within the
demarcation
line



Cancer

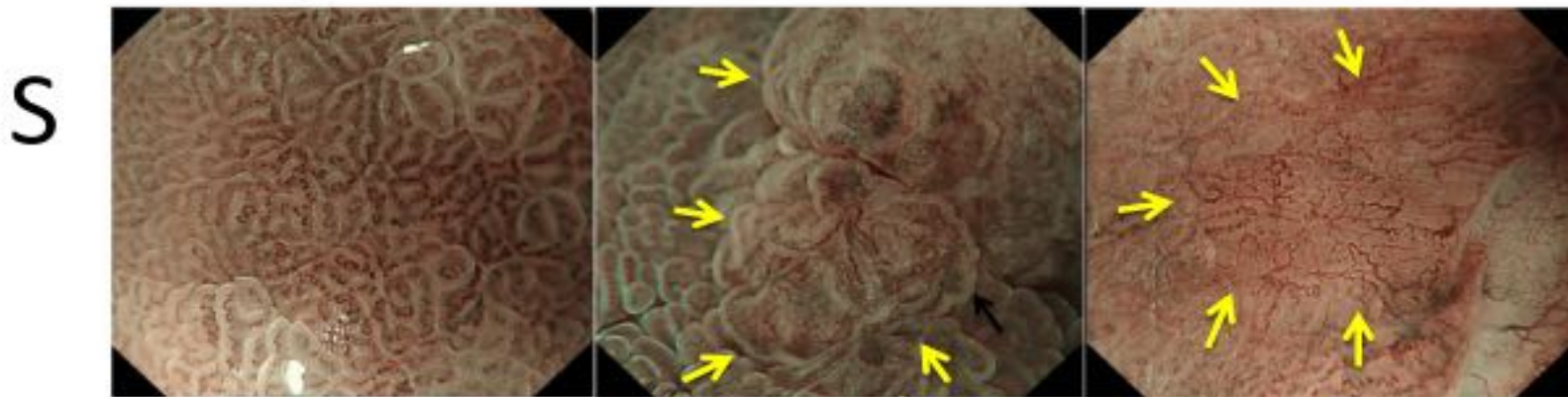
Vessels plus Surface (VS) classification system



Regular

Irregular

Absent



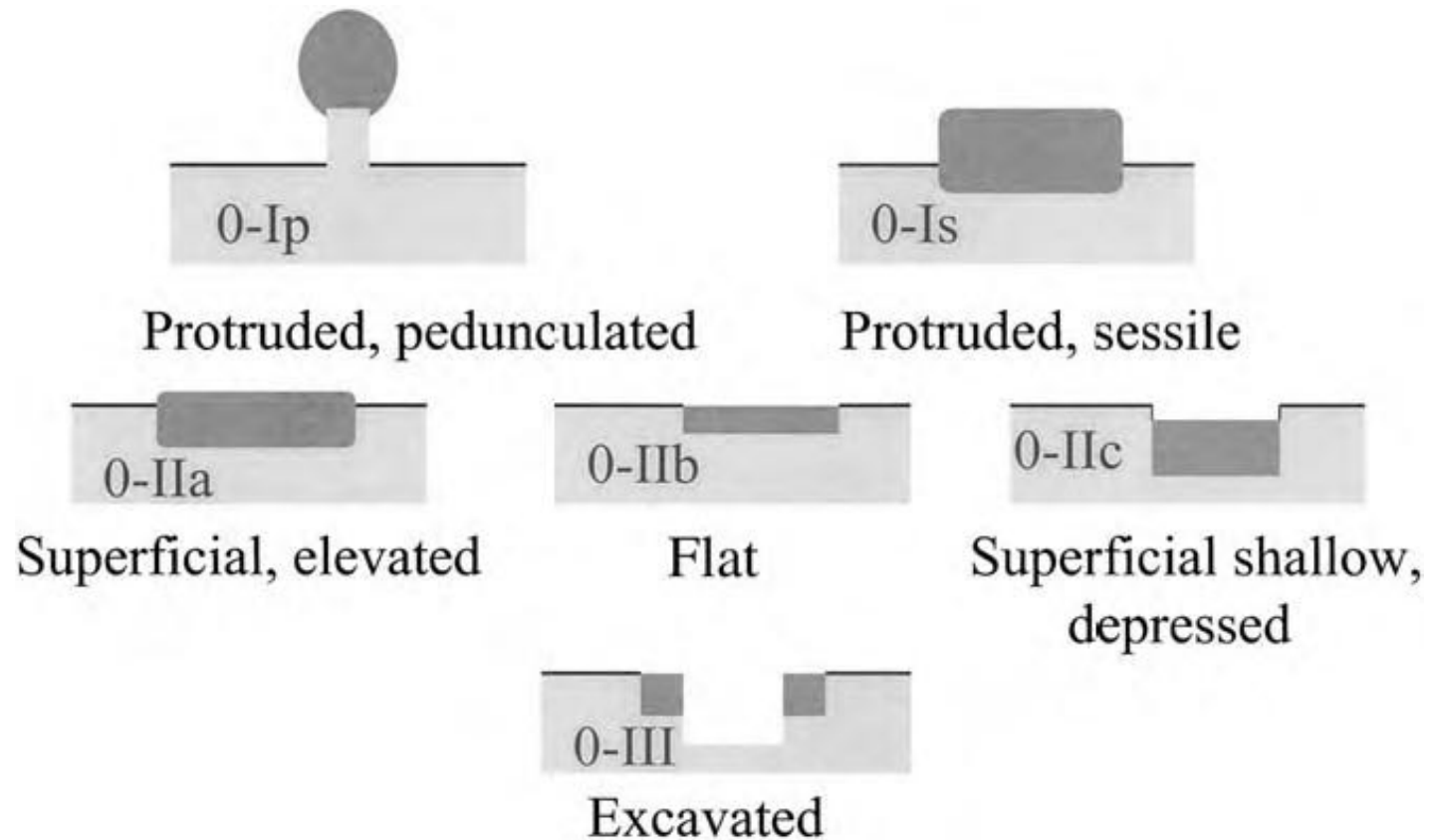
Regular

Irregular

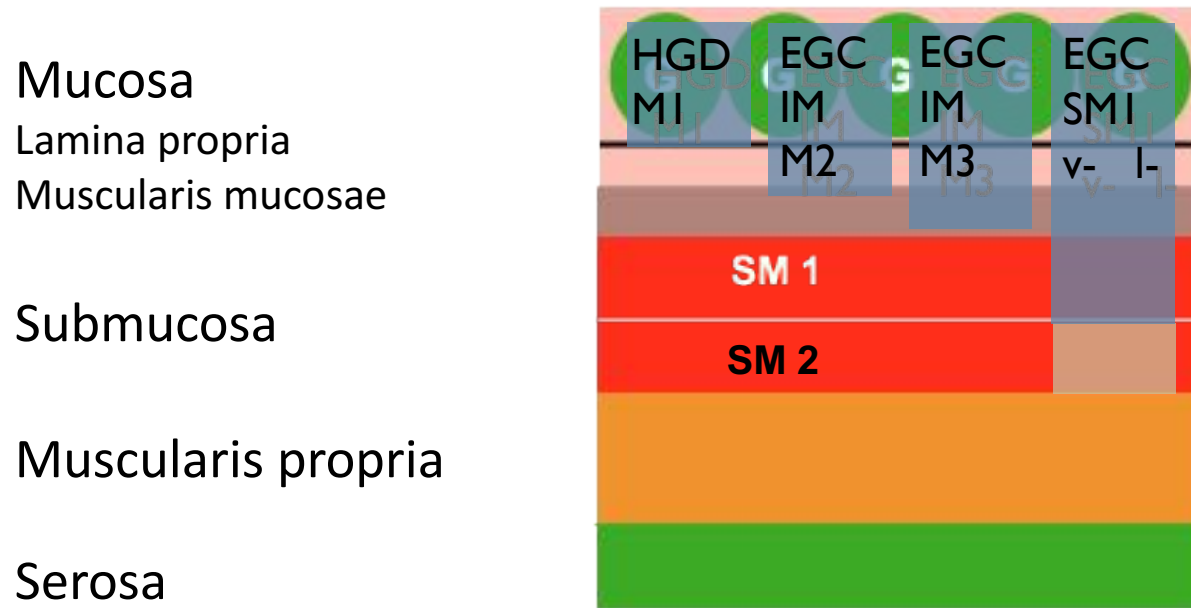
Absent

← : Demarcation line

Paris classification: Stomach EGC and Nodal invasion



Depth of infiltration and invasion



pT Stage	N+ %
M1	0
M2	0-1
M3	2
SM1	2-3
SM2	25-27

Paris classification: Stomach EGC and Nodal invasion

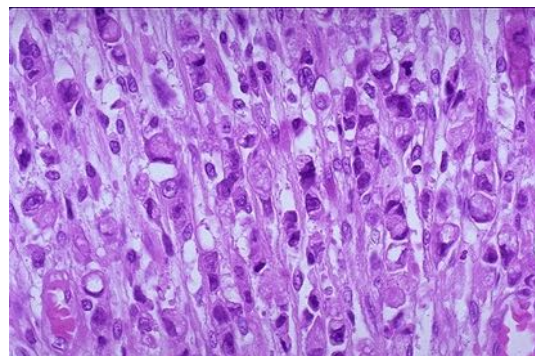
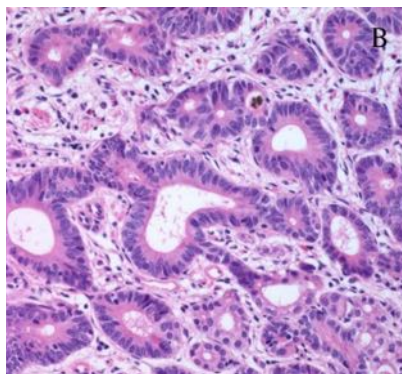
Size & Submucosal invasion

Ulcer +/-

Size in mm	<500 μ n/N (%)	>500 μ n/N (%)
<10	1/31 (3)	5/39 (13)
10-20	4/71 (6)	28/195 (14)
21-30	4/71 (6)	52/273 (19)
>30	6/92 (7)	86/319 (27)
Total	15/265 (6)	171/826 (21)



Histology



Superficial neoplastic lesions of the stomach

ESGE recommends endoscopic resection for the treatment of gastric superficial neoplastic lesions that possess a very low risk of lymph node metastasis (strong recommendation, high quality evidence)

EMR is an acceptable option for lesions smaller than 10–15mm with a very low probability of advanced histology (Paris 0-IIa)

Indication to endoscopic resection according to the risk of lymph node metastasis

Depth of invasion	Ulceration	Differentiated		Undifferentiated	
		≤ 2cm	> 2cm	≤ 2cm	> 2cm
T1a (M)	UI -				
		≤ 3cm	> 3cm		
	UI +				
T1b (SM)		sm1, ≤500µm			
Dysplasia					



Absolute indication



Expanded indication

Staging

ESD/EMR
feasible

Protrusion or depression of a smooth
surface

Slight marginal elevation

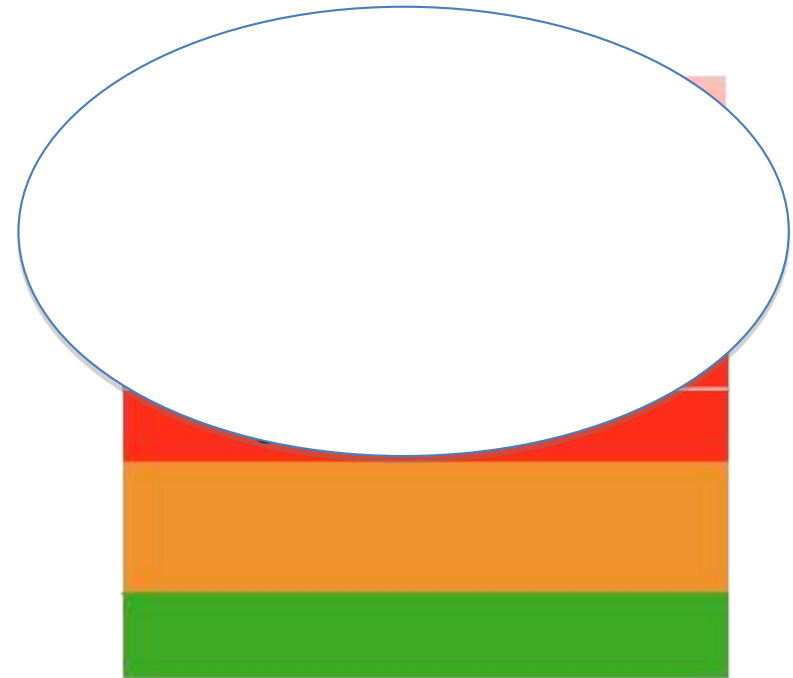
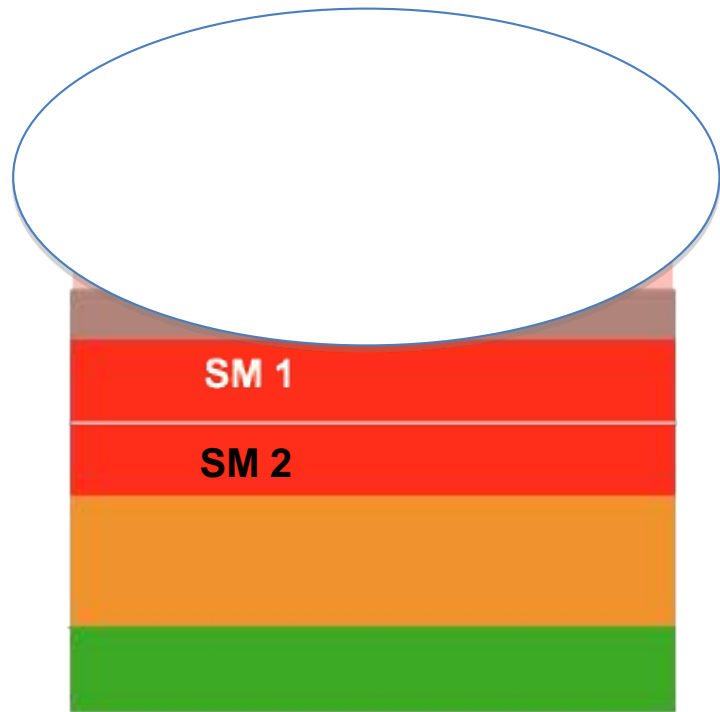
Smooth tapering of converging folds

ESD/EMR
unfeasible

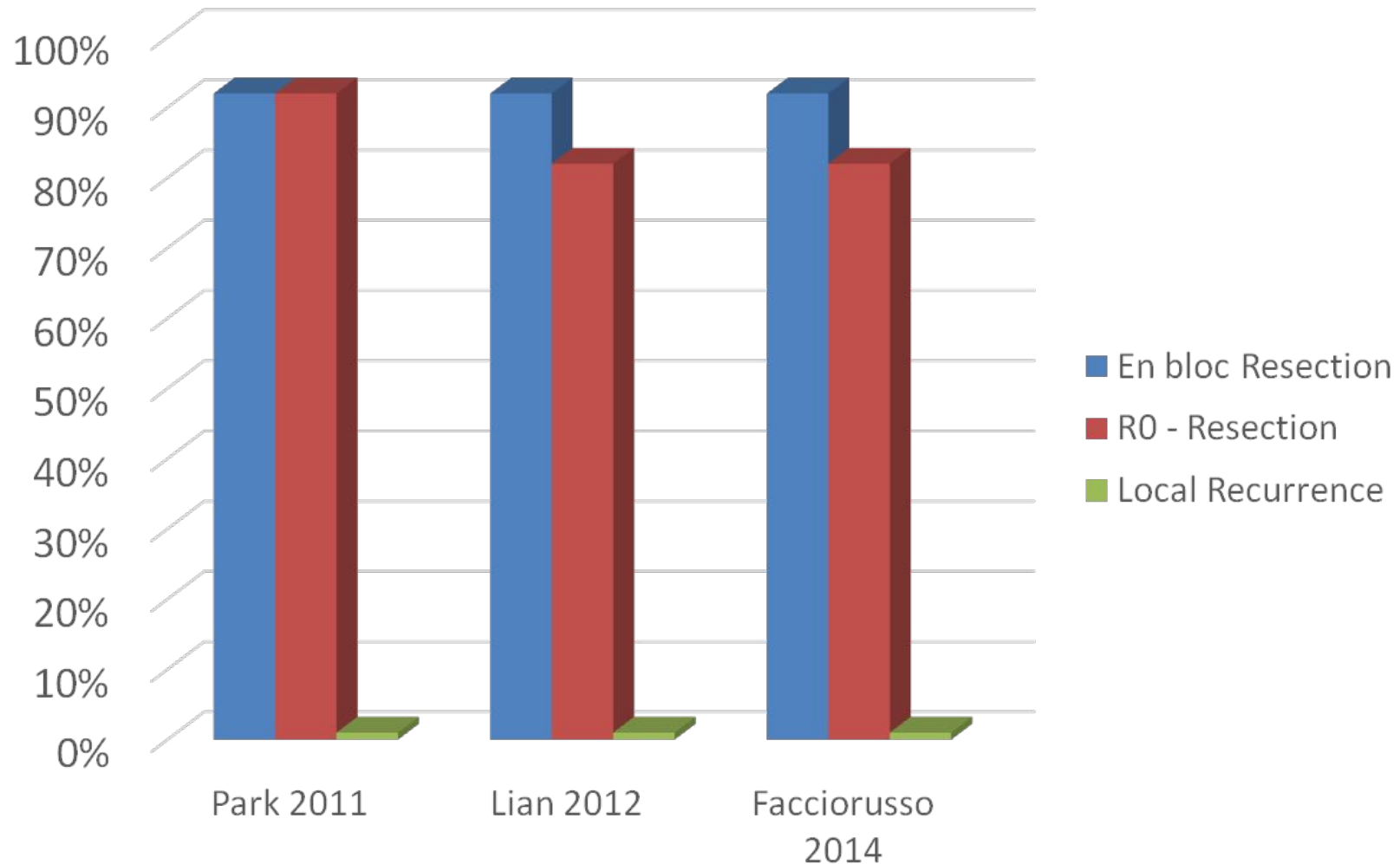
Irregular surface, marked marginal
elevation,

abrupt cutting or fusion of converging
folds.

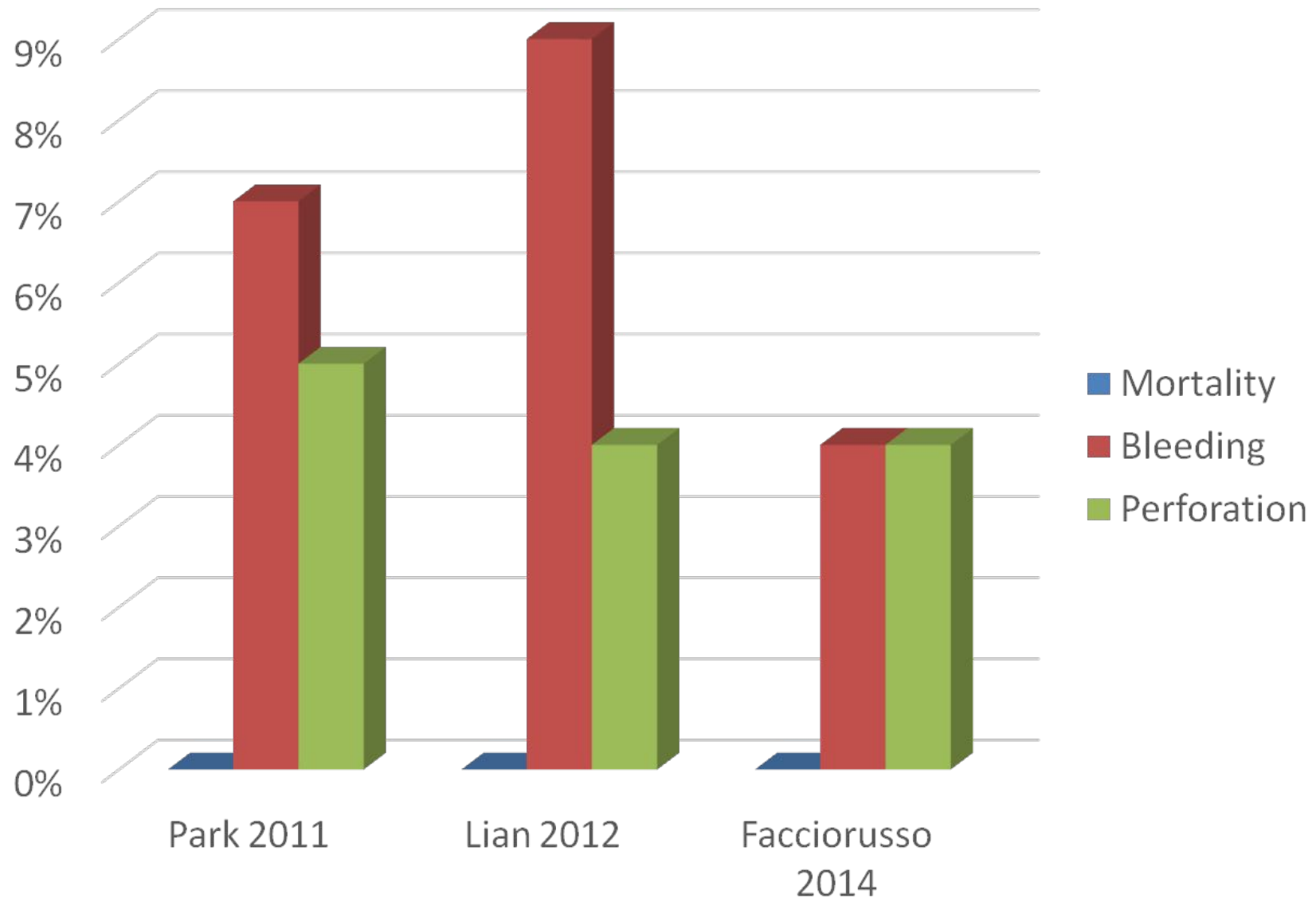
Endoscopic Mucosal Resection v. Submucosal Dissection



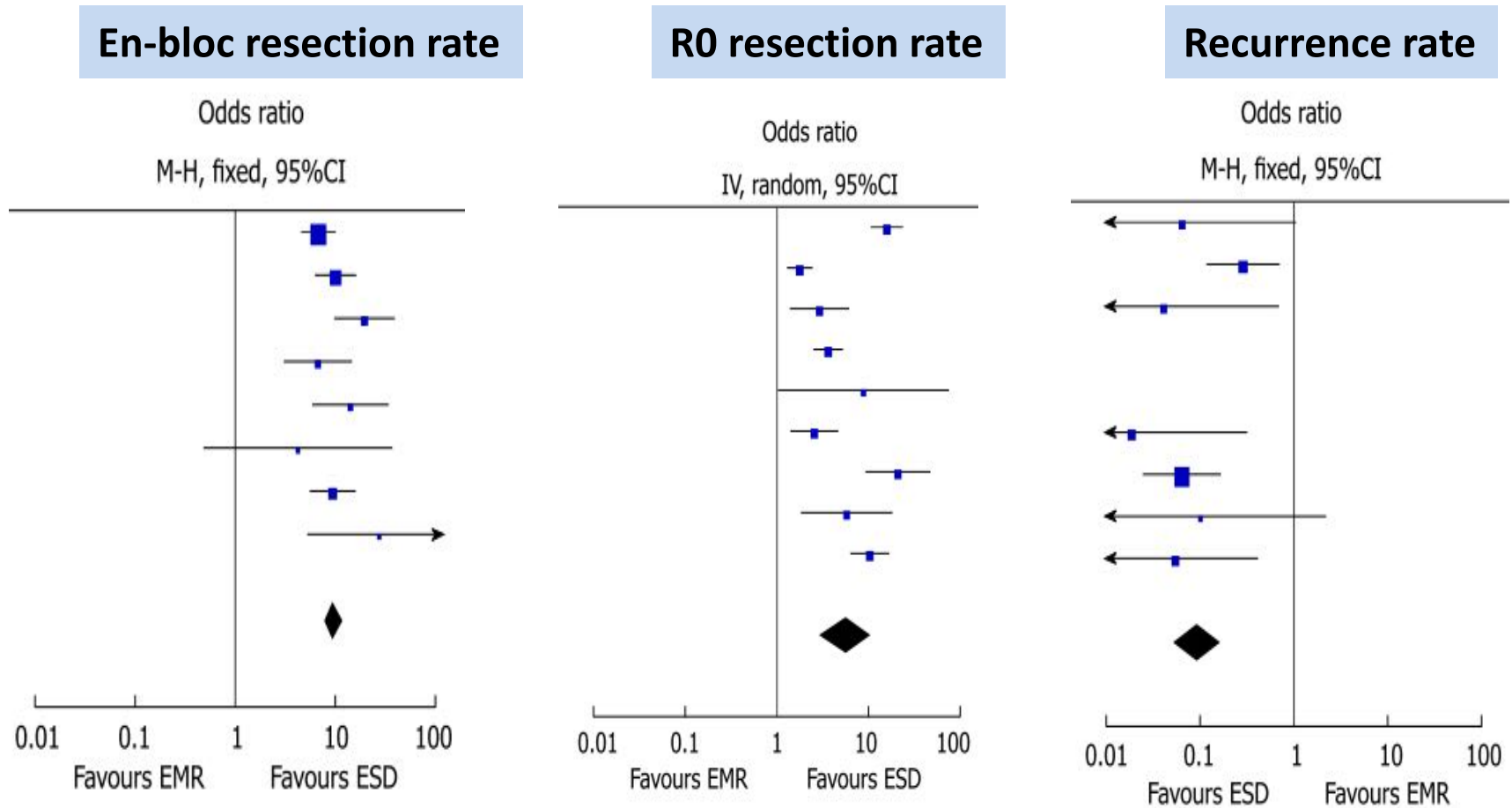
Outcomes of endoscopic submucosal dissection (ESD) for gastric superficial lesions



Outcomes of endoscopic submucosal dissection (ESD) for gastric superficial lesions

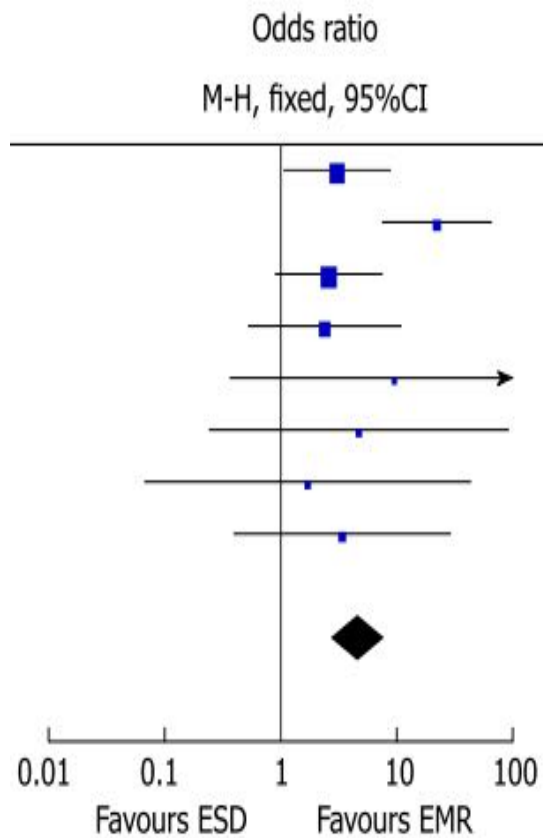


Outcomes of endoscopic submucosal dissection (ESD) vs mucosa resection (EMR)

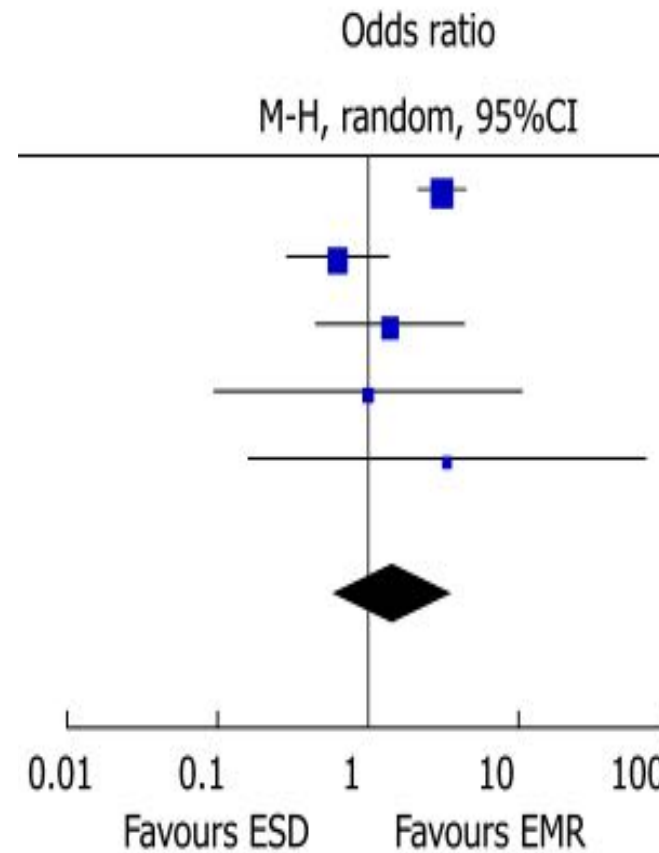


Outcomes of endoscopic submucosal dissection (ESD) vs mucosa resection (EMR)

Perforation rate



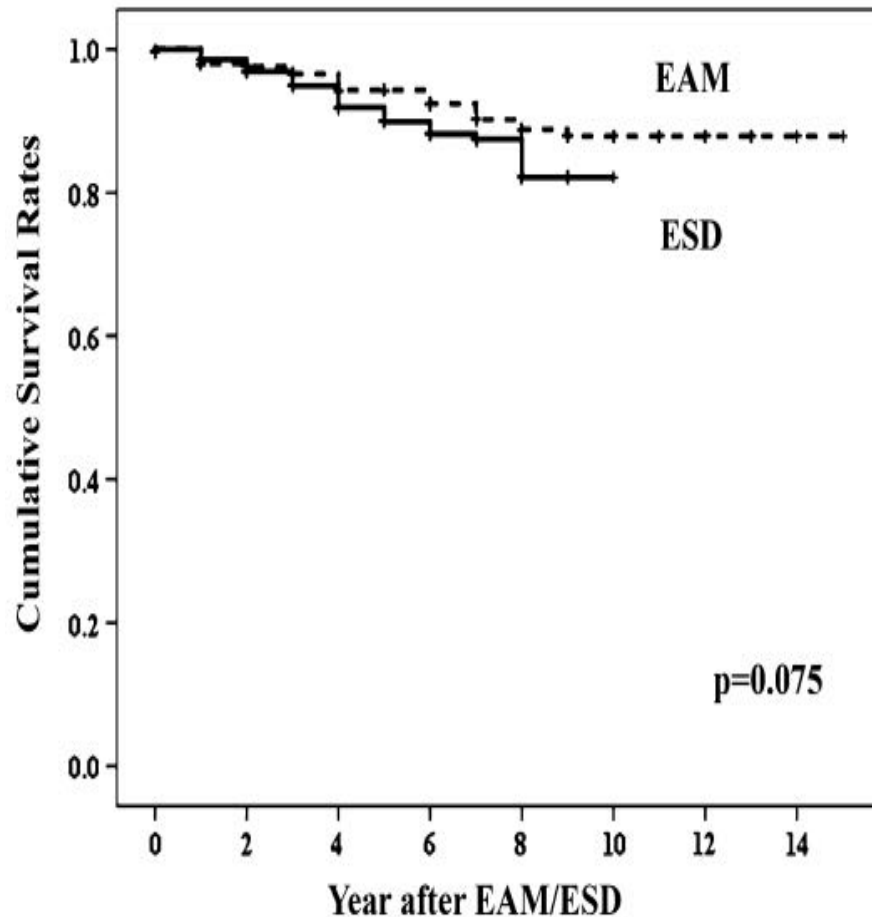
Bleeding rate



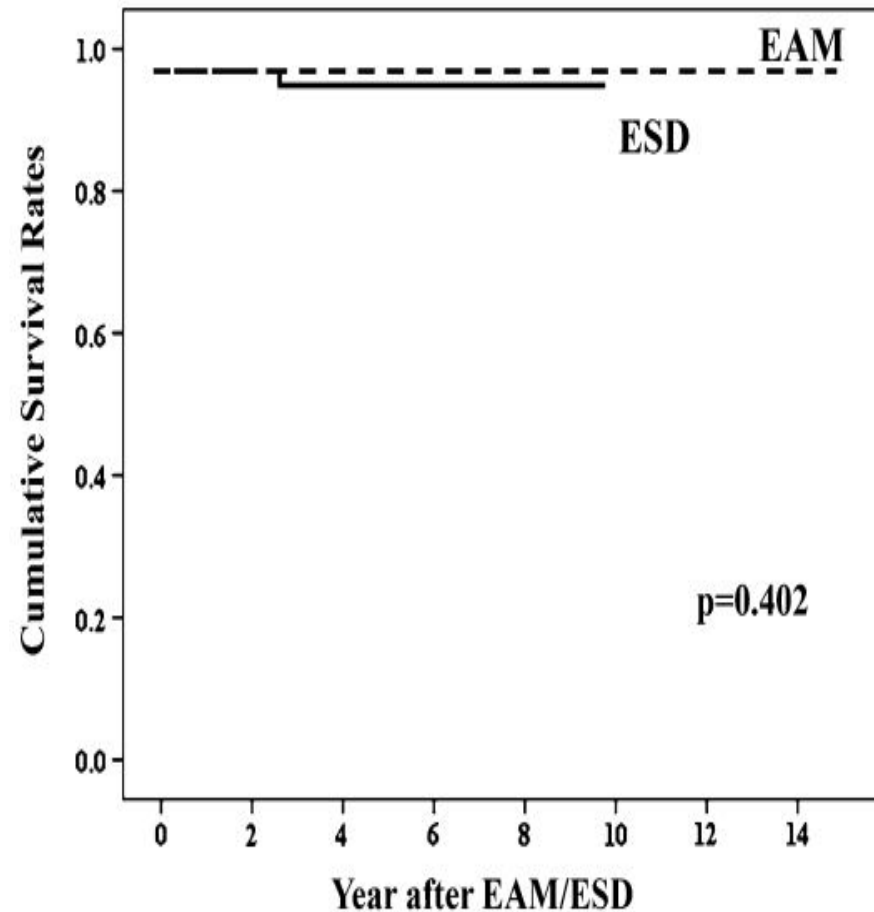
Outcomes of ESD vs. EMR

Survival rate

Cumulative overall survival



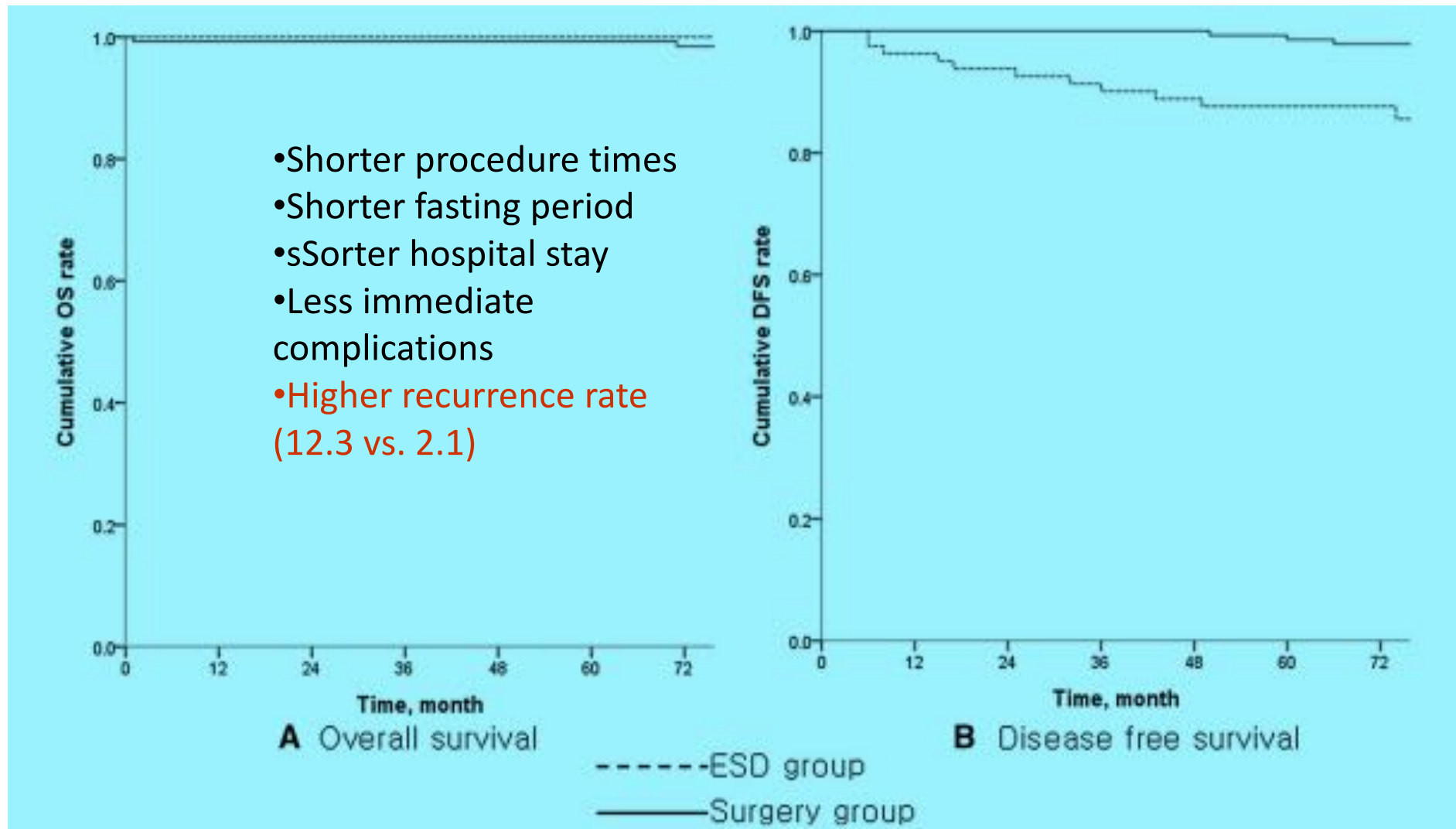
Cumulative overall survival after exclusion of deaths unrelated to GC



Critical issues

- *H.pylori* infection
- Survival rate >5aa
- Age of patients
- Metachronous lesions (vs. surgery)
- Expanded indication
- Cancer histology
- Long Follow-up (number of EGDS?)

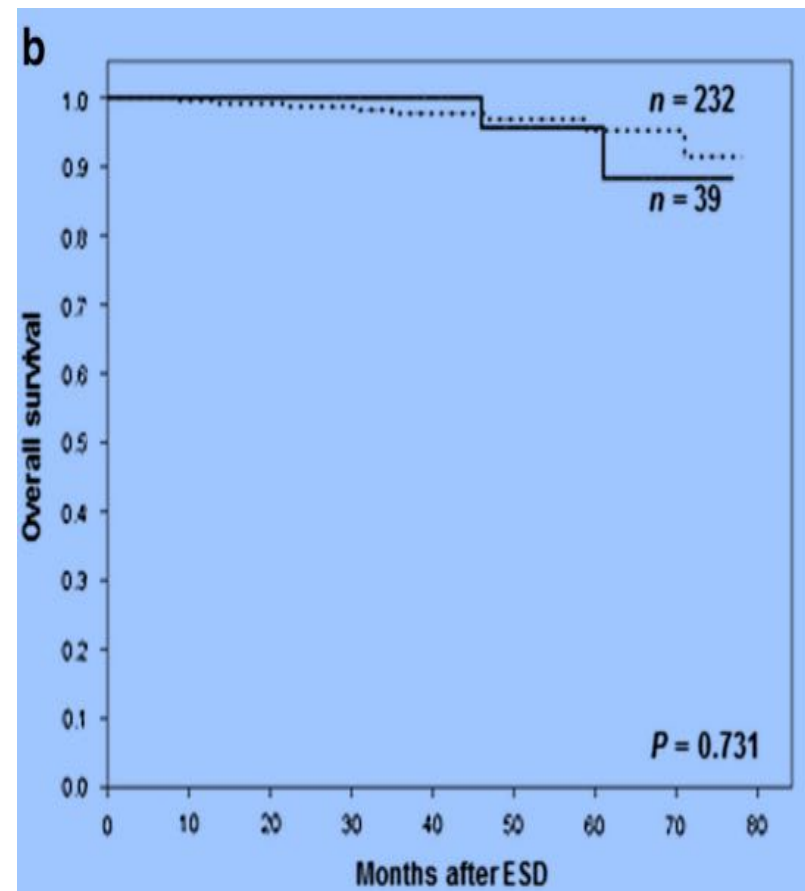
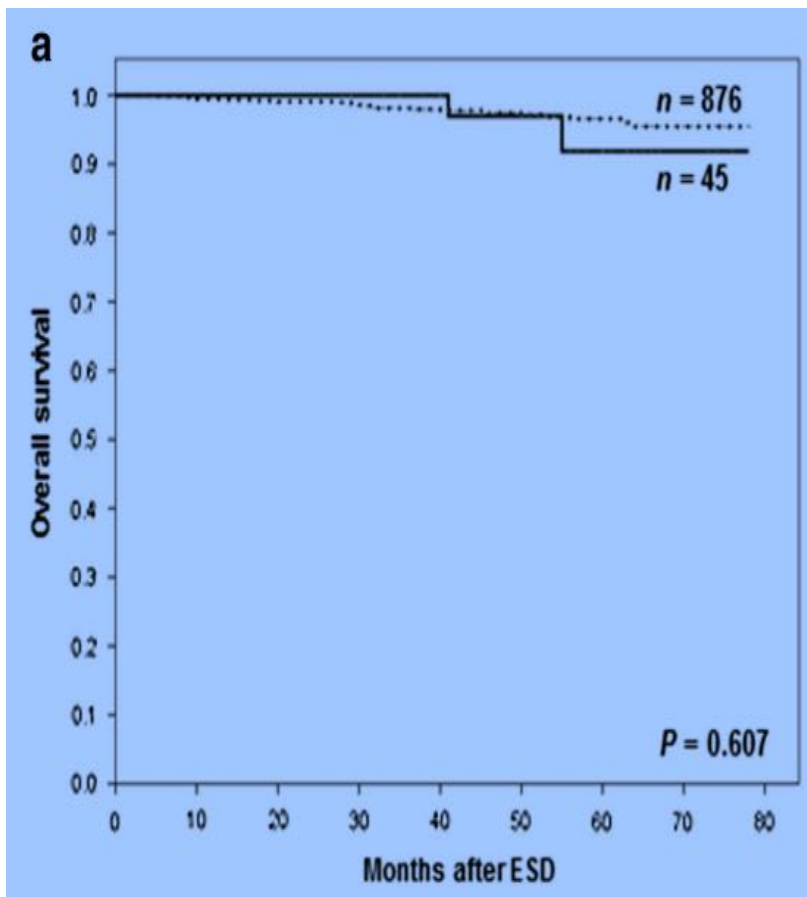
ESD versus surgical resection for EGC



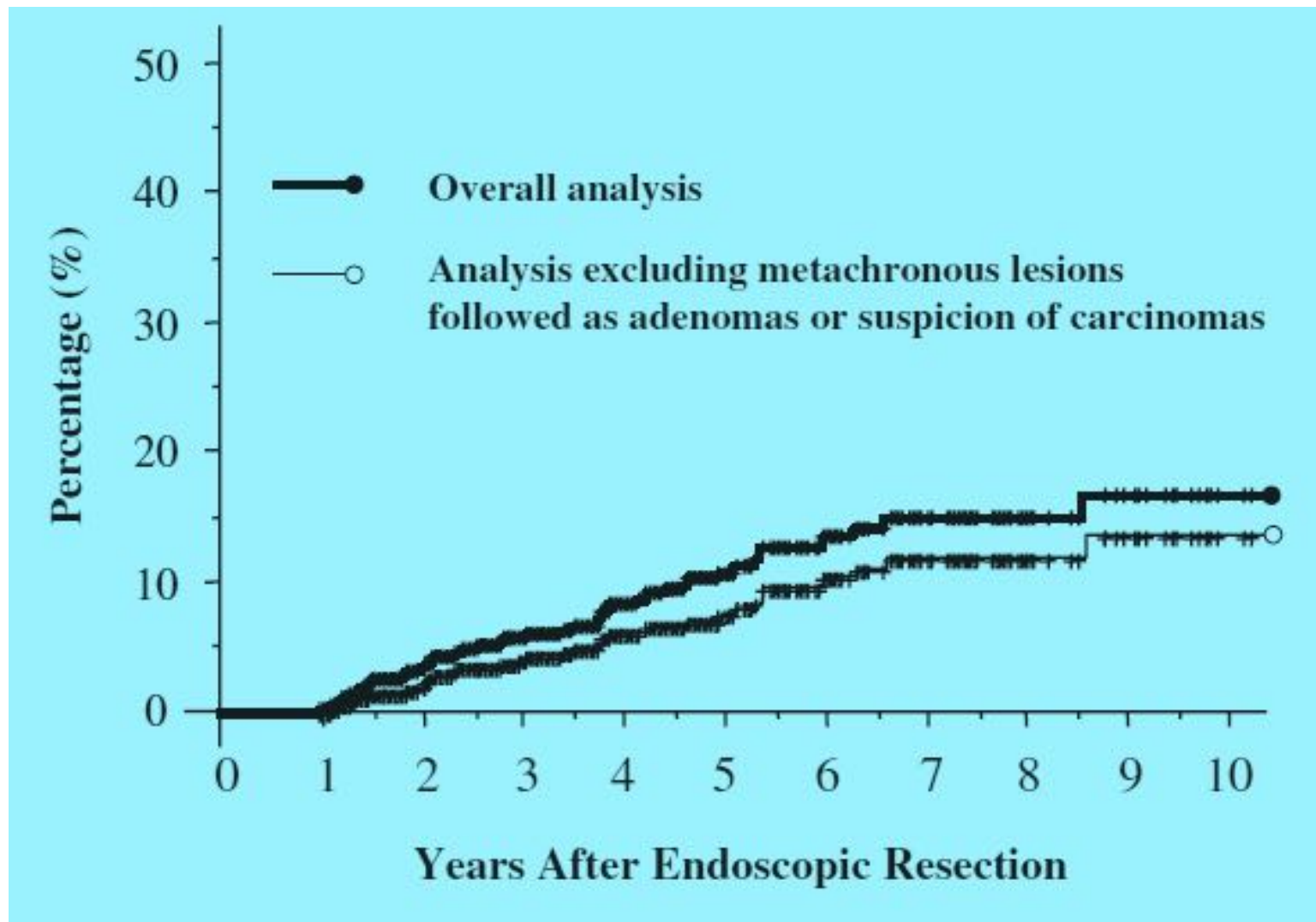
Outcomes of ESD for differentiated-type early gastric cancer with histological heterogeneity

Absolute indications

Expandend indications



ESD and Follow-up: 6 vs 12 months



Gastric cancer: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up[†]

E. C. Smyth¹, M. Verheij², W. Allum³, D. Cunningham⁴, A. Cervantes⁵ & D. Arnold⁶ on behalf of the ESMO Guidelines Committee*

Follow-up, long-term implications and survivorship

- A regular follow-up may allow investigation and treatment of symptoms, psychological support and early detection of recurrence, though there is no evidence that it improves survival outcomes [III, B]
- Follow-up should be tailored to the individual patient and the stage of the disease [V, B]
- Dietary support is recommended for patients on either a radical or a palliative pathway, with reference to vitamin and mineral deficiencies [V, B]
- In the advanced disease setting, identification of patients for second-line chemotherapy and clinical trials requires regular follow-up to detect symptoms of disease progression before significant clinical deterioration [IV, B]
- If relapse/disease progression is suspected, then a clinical history, physical examination and directed blood tests should be carried out. Radiological investigations should be carried out in patients who are candidates for further chemotherapy or RT [IV, B]



Management clinico-endoscopico dell' EGC

