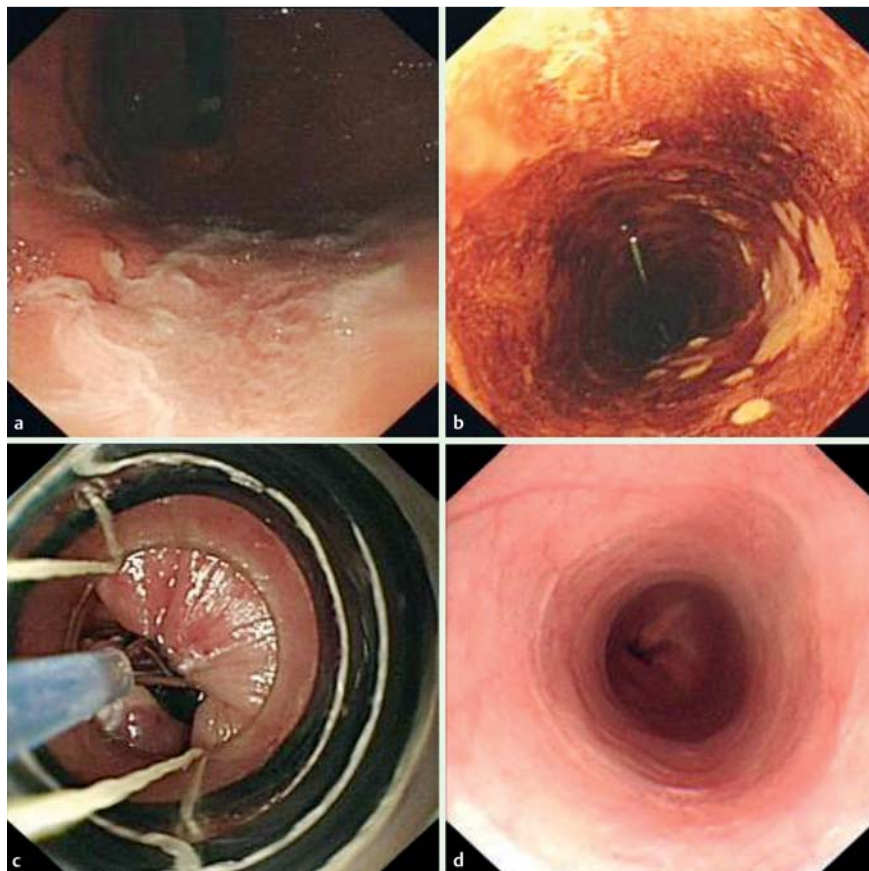


## Endoscopic resection for esophageal high grade dysplasia in a patient with cervical esophageal stricture via the transgastric approach



**Fig. 1** Endoscopic views in a 51-year-old man with previous history of both mouth and cervical esophageal cancer showing: **a** the cardia (the endoscope having been inserted through the gastrostomy fistula); **b** the lesion in the esophagus after spraying with Lugol's solution to mark the periphery of the lesion; **c** endoscopic resection being performed with the Duette multi-band mucosectomy kit; **d** the appearance at follow-up 1 year later showing a well-healed esophageal scar.

Patients with head and neck cancer often have synchronous or metachronous esophageal squamous cell carcinoma or its precursor [1–4]. Multimodal therapy may be necessary for patients with multiple cancers. In patients with metachronous double cancers, the prior treatment of the first primary carcinoma often affects the treatment of the second cancer [5].

We herein report on a 51-year-old man with a complicated medical history. In 2006, he underwent radical surgery for cancer in the left side of the floor of the mouth. He underwent radiotherapy for

cervical esophageal cancer 5 years later, which led to cervical esophageal stricture. In the same year, he underwent surgery for a left submandibular lymph node metastasis and again received radiotherapy. In 2013, while he was undergoing a surveillance endoscopy using Lugol's solution, the patient was diagnosed with esophageal high grade dysplasia, superficial type, 0-IIb.

Laparoscopy-assisted gastrostomy, followed by passage of the endoscope through the gastrostomy port (fistula), with subsequent retrograde access to the distal esophagus and then endoscopic

resection of the esophageal lesion was planned at a multidisciplinary team (MDT) meeting.

The procedure was performed in the following steps: examination with an endoscope (GIF-XP260N); placement of a guidewire into the stomach; laparoscopic gastrostomy (the diameter of the fistula being about 18 mm); insertion of an endoscope (GIF-IT240) through the fistula and cardia into the esophagus, using the guidewire to aid insertion (● Fig. 1 a); spraying with Lugol's solution and marking of the periphery of the lesion (● Fig. 1 b); endoscopic resection using the Duette multi-band mucosectomy kit (● Fig. 1 c); closure of the gastrostomy site; and insertion of a gastrostomy tube.

Pathological examination of the resected specimen confirmed esophageal squamous high grade dysplasia, the margins of the resected specimen being free from abnormality. The patient's postoperative course was uneventful and he was discharged 7 days later. Follow-up endoscopy after 1 year showed a well-healed scar (● Fig. 1 d), without any evidence of recurrence.

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**Competing interests:** None

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