Foreword

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Dear colleagues and friends,

In this issue, we publish 12 original papers, 1 case report and 3 editorials.

Writing and publishing guidelines is one of the main tasks of an active nonprofit scientific organization. ASGE and ESGE are very active in producing guidelines. Nevertheless, we should never forget that a guideline is most useful if it can be easily applied. At least, we should as frequently as possible assess if the practice is in accordance with the guidelines and identify the factors associated with compliance to the guidelines. In this issue, we have the results of two US surveys on guideline application, with two excellent attached editorials, one from Cesare Hassan and one from Doug Rex. The first survey concerns the management of patients on anti-platelet therapy. Response rate was quite high (60%). This survey shows that a fourth of endoscopists discontinue antiplatelet therapy for all procedures and half discontinue NSAIDs prior to high-risk techniques. A high rate of patients are thus exposed to unnecessary risk of thrombosis because of this low guideline uptake. A second survey tried to determine if endoscopists are willing to adopt and apply an ESGE statement on incorporating an imaging-guided surveillance protocol to replace the Seattle protocol for Barrett's esophagus surveillance. The study had several limitations (survey and not auditing, low numbers, low response rate) but produced very interesting data: the operators of course asked to be trained in new imaging technology, but more interestingly 40% stated that they would not implement the statement due to the lack of financial incentives and also because of legal issues. The message is "clear" and logical and the discussion which attempts to explain this attitude is precise and very informative for non American readers.

A study from Kansas City reports the long-term results of the mucosal ablation of Barrett's esophagus. This study is a part of a randomized controlled trial comparing argon plasma coagulation to multipolar electrocoagulation for the ablation of non-dysplastic and low grade dysplastic Barrett's esophagus. The patients were followed up with annual surveillance endoscopies (mean F-U: 6.4 years). Recurrence, defined as the finding of intestinal metaplasia after initial complete eradication, was observed in 50% of cases. This study has several limitations (among them, radiofrequency treatment is now the gold standard for ablation) but it raises several questions: How long should these patients be followed after eradication? Does ablation reduce the need for follow-up and is ablation finally clinically relevant (except for high grade dysplastic areas) if patients still need follow-up? Could proton pump inhibitors change the recurrence?

Achalasia type III characterized by spastic contractions of the whole esophagus has a low prevalence. Peroral myotomy (POEM) has a major theoretical advantage on Heller myotomy in case of achalasia type III: Myotomy itself can be longer and can extend towards the proximal esophagus. Despite this the multicenter study suffers from several limitations (retrospective, non randomized, …), it underlines the advantage of POEM in comparison to Heller's: POEM is more clinically effective with less side-effects than Heller's. An attached editorial of Sabine Roman explains why the management of achalasia type III is so challenging.

Several studies have recently suggested that contrast-enhanced harmonic endoscopic ultrasonography (CH-EUS) can improve the characterization of solid pancreatic lesions and can overcome some limitations of EUS-FNA. Evaluation of the inter-observer agreement was missing. Colleagues from Portugal, Spain and Sweden conducted a multicenter study involving 11 endoscopists with different levels of expertise in EUS and CH-EUS. They observed that long experience in EUS and CH-EUS resulted in higher accuracy of CH-EUS, but that inter-observer agreement was fair even for non experienced endoscopists.

A large multicenter study has been conducted in USA on EUS-guided liver biopsies. 110 patients have been included in 8 centers. This study demonstrates that this technique 1.) provides adequate tissue (median aggregate length of 38 mm with median of 14 complete portal triads) and 2.) is safe (only one complication in a coagulopathic and thrombocytopenic patient). This paper helps to understand the different advantages of EUS-guided liver biopsy (safe track avoiding vessels and other structures, possible biopsies in both lobes, reduced diameter of the needle, …).

A large study from Taiwan confirmed the role of double balloon enteroscopy for the endoscopic management of biliary disorders in case of surgically altered pancreatico-biliary anatomy. This series only report the results of DBE in case of Billroth II (87% of success, 75% of bile duct stone clearance at the first attempt). Of course, in this case, the papilla can be approached with a duodenoscope or a forward-viewing regular endoscope. But this approach is challenging and we now know that DBE should be considered in case of failure.

Two papers were on detection of lesions (autofluorescence, cap) and two on characterization. Autofluorescence imaging is frequently considered as a recent technology but in fact is not recent. It has been developed since years without finally any clinical application in digestive endoscopy. It is based on the spectroscopic detection of fluorescence emitted by endogenous molecules called fluorophores. Some fluorophores are cancer-specific or the light emitted by the fluorophores located in the submucosa is hindered by mucosal neoplasms. This results in a difference of fluorescence between neoplastic and non neoplastic tissues. The limitation of autofluorescence is the lack of specificity. It is thus not surprising that a metanalysis (from 6 studies including 1199 patients) did not observe an effect of autofluorescence on ADR. In parallel, other technologies such as chromoendoscopy are continuously improving and it is not sure that once, autofluorescence will reach the bar to become the red flag technology.

Poor visualization behind the colonic folds could partly explain that we can miss 20% of colonic adenomas. Two types of technology can help us to overcome this problem: large-viewing endoscopy or cap attached to the distal tip of the endoscope ("to defold the folds"). Many studies are ongoing and no one can predict which will become the gold standard: cap or large-viewing endoscope. Maybe it will be a combination of both. A Swiss team from St Gallen conducted a pilot study with the Endocuff cap on 104 patients. This study demonstrates at least the feasibility and efficacy of this technique (cecal intubation rate 99%, adenoma detection rate of 47%) and no severe side effects were reported. Characterization of colorectal polyps produced recently a much interest because of the discard policy. The large majority of studies have been conducted with NBI and we have only few studies with other technologies of chromoendoscopy, such as FICE. This prospective double blind trial from Brazil confirms that FICE is highly accurate (95% accuracy) for the diagnosis of colorectal adenoma with a good to excellent interobserver agreement. Assessment of high confidence levels is missing.

Japanese authors from Kobe conducted a very interesting study. Chromoendoscopy using indigo-carmine has been found helpful to better detect colonic sessile serrated lesions/adenomas (SSL/A). Our Japanese colleagues systematically performed a spray dying with indigo carmine of the whole colon in 343 patients. They then measured the proportion of SSL/A among the total number of hyperplastic lesions which have been detected and/or resected. 792 hyperplastic polyps were resected. The proportion of SSL/A was quite low (2.7%) but was higher in the proximal colon (10,9%). The role of the lesion size is odd: the rate of SSL/A was 0.7% in case of lesion <5 mm, 29% for lesions 6–9 mm and 70% for the lesions larger than 10 mm. It is too simple to say that the size is predictor of SSL/A histology. Practically, this is the case but why should a SSL/A be not small? There are several possibilities: 1.) when small, SSL/A cannot be differentiated from classical HPs (more probably) 2.) Some HPs become SSL/A when they grow 3.) SSL/A has a higher potential to grow and evolve than classical HPs, …

And finally, we have two papers on the endoscopic resection of colorectal lesions. Another team from Kobe has described a very particular feature during colorectal ESD: the muscle retracting sign. This sign is more frequently observed in case of sessile lesion (41%) than in case of lateral spreading lesion (0–9%) and is associated to a very high risk of incomplete resection (36%). The authors show very demonstrative and convincing pictures of the muscle retracting sign. This sign can be due to the fibrosis generated at the level of the submucosa by the repeated mobilizations of the lesion during peristalsis. Very often we observe an unhealthy lateral margin after resection of a colorectal adenoma with a snare. Alternatively, this lateral margin cannot be interpreted because of electrocoagulation artefacts. The question is: does it matter if there is no carcinomatous component within the specimen? The only consequence is "recurrence" or more exactly persistence of adenomatous tissue at the level of the resection site. A study was performed in the National Cancer Center in Tokyo on 844 endoscopically resected colorectal intramucosal neoplasms with a size of ≥10 mm. When the lateral margin was healthy, no local recurrence was observed and this was not surprising. More interesting was the fact that in case of indefinite lateral margins, the recurrence rate was higher (15.2%) with piece-meal resection than with en-bloc (2.2%).

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