Endoscopic full-thickness resection of esophagogastric junction gastrointestinal stromal tumor assisted by laparoscopy after neoadjuvant therapy

Gastrointestinal stromal tumors (GISTs) are the most common mesenchymal neoplasms of the digestive tract [1]. Surgery is the only potentially curative therapy. However, some tumors are locally advanced, and therefore R0 resection cannot be guaranteed. In this situation, imatinib can allow organ-preserving surgery and optimal oncological outcome [2–5]. GISTs located at the esophagogastric junction (EGJ) are challenging because wedge resection is difficult to achieve, and gastrectomy and/or esophagectomy are associated with morbidity and mortality. Consequently, endoscopic resection could be an ideal alternative to surgery, with comparable oncological outcomes.

We present the case of an 82-year-old woman with a 1-month history of progressive dysphagia. An upper endoscopy showed a 6-cm pedunculated polypoid lesion at the EGJ, with a short and wide pedicle that protruded into the gastric fundus. The biopsy demonstrated a high-risk GIST with 20 mitoses per 50 high-

Fig. 1 Gastrointestinal stromal tumor at the esophagogastric junction. a Double-contrast radiography. b Computed tomography.

Fig. 2 Computed tomography with perfusion. a Before neoadjuvant therapy with imatinib. b 1 week after treatment with imatinib. c 2 months after treatment. d 4 months after treatment. The size of the lesion decreased progressively.
power fields (HPF). Abdominal double-contrast radiography and computed tomography (CT) scan ruled out metastasis (Fig. 1). It was decided to treat the tumor with imatinib to decrease its size. A 6-month course of therapy was started. CT scans performed at 1 week, and at 2 and 4 months showed optimal response to treatment, with a decrease in size from 6.5 cm to 2.7 cm (Fig. 2). Because of the patient’s co-morbidities, an endoscopic resection with laparoscopic support was then performed (Fig. 3). Briefly, the laparoscopic surgeon released the upper part of the lesser and greater curvature of the stomach for better mobilization (Fig. 4). The endoscopist completed the en bloc resection using a diathermic snare with the support of the laparoscopic surgeon, who pushed the lesion inside the snare, avoiding perforation (Video 1). After resection, seroserosal stitches were applied by the laparoscopic surgeon to reinforce the resected area (Fig. 5). The final histology showed a GIST of 3.8 cm with 1 mitosis per 50 HPF (low-risk lesion). After 6 months of follow-up, there was no recurrence.

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Andrés Navarrete1,2,3, Dulce Momblan1, Gloria Fernandez-Esparrach4, Salvadora Delgado1, Marta Jimenez1, Amelia Hessheimer1, Antonio M. Lacy1
1 Gastrointestinal Surgery Department, Hospital Clinic, Barcelona, Spain
2 Surgery Department, Faculty of Medicine Clínica Alemana Universidad del Desarrollo, Santiago, Chile
3 Digestive Surgery Department, Hospital Militar, Santiago, Chile
4 Endoscopy Department, Hospital Clinic, Barcelona, Spain
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Corresponding author

Andrés Navarrete, MD
Gastrointestinal Surgery Department
Hospital Clinic
Aribau 159 3-1
Barcelona 08036
Spain
Fax: +34-93-2275400
andres_navarre38@hotmail.com