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.

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power fields (HPF). Abdominal double-contrast radiography and computed tomography (CT) scan ruled out metastasis \((\text{Fig. 1})\). 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 \((\text{Fig. 2})\). Because of the patient’s co-morbidities, an endoscopic resection with laparoscopic support was then performed \((\text{Fig. 3})\). Briefly, the laparoscopic surgeon released the upper part of the lesser and greater curvature of the stomach for better mobilization \((\text{Fig. 4})\). 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 \((\text{Video 1})\). After resection, seroserosal stitches were applied by the laparoscopic surgeon to reinforce the resected area \((\text{Fig. 5})\). 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.

Endoscopy_UCTN_Code_TTT_1AO_2AG

Competing interests: None
References

Bibliography
DOI http://dx.doi.org/10.1055/s-0042-104191
Endoscopy 2016; 48: E112–E114
© Georg Thieme Verlag KG
Stuttgart · New York
ISSN 0013-726X

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