

## EUS-guided fine-needle biopsy for gastric submucosal tumors: Does one size fit all?

Dear Editor,

We read with interest the article by Kamata *et al.*<sup>[1]</sup> on the usefulness of a 20G needle with a core trap for EUS-guided fine-needle biopsy (FNB) for gastric submucosal tumors (SMTs). This was a multicentre prospective study on (I) technical success rate, (II) adequacy for histologic evaluation, (III) rate of complications, (IV) accuracy for histological diagnosis of gastric SMTs, and (V) concordance between gastrointestinal stromal tumors (GISTs) mitotic index determined by EUS-FNB and after tumor resection. The results were good to excellent: (I) 100%, (II) 90.4%, (III) 0%, (IV) 81.6%, and (V) 89.7%.

The authors concluded that EUS-FNB using a 20G needle with a core trap is technically feasible and provides histological specimens of sufficient quality for the diagnosis of gastric SMTs.

Gastric SMTs detected by endoscopy can be either benign not requiring further interventions (leiomyomas, ectopic pancreas, schwannomas), or bear malignant potential (GISTs). While symptomatic GISTs should be resected, there is no consensus about asymptomatic ones. Based on the size and EUS features of the lesions, management includes either endoscopic/surgical resection or EUS surveillance to monitor for suspicious changes.<sup>[2]</sup>

Growth during follow-up and tumor ulceration is sufficient to refer the lesion to the surgeon without the need of a biopsy.<sup>[3]</sup> Heterogeneity of the internal echoes and/or irregular margins may be additional imaging features that suggest a malignant potential. According to the latest guidelines, in case of suspected GISTs that may need neoadjuvant therapy before surgery, histological diagnosis is always warranted.<sup>[3]</sup> Unfortunately, Kamata *et al.* did not mention whether

some patients underwent neoadjuvant therapy before surgical resection.

Moreover, the authors underlined the importance of performing EUS-FNB even for gastric SMTs <2 cm. It appears that EUS features were not taken into account to gauge the decision whether to perform EUS-FNB or not. While this strategy could be beneficial in detecting those benign SMTs not requiring further follow-up, on the other hand, internal growth is observed in <5% of GISTs,<sup>[4]</sup> suggesting a malignant behavior only in rare cases. Therefore, EUS-FNB for small GISTs, irrespective of imaging features or performed outside clinical studies, could be interpreted as overtreatment.

Another study published in this journal by the same authors enrolling a larger number of patients (157 vs. 52 in the present study) showed that contrast-enhanced harmonic EUS could help in defining the SMTs nature. The hyper-enhanced pattern of the SMTs predicted GISTs with an 82.2% diagnostic accuracy,<sup>[5]</sup> which is comparable to the accuracy obtained by the histological assessment with EUS-FNB in the present study (81.6%).

In our opinion, the management of patients with SMTs should be as less invasive as possible and based on a cost/benefit ratio. Since EUS-FNB is more invasive and expensive compared to EUS with CH-EUS, imaging follow-up is still a valid option for gastric SMTs with benign features. Instead, it should always be pursued in those gastric SMTs showing either indeterminate features or suspicion of GISTs requiring neoadjuvant therapy. The authors should be commended in demonstrating that a 20 G EUS-FNB core trap needle is a useful tool to select the optimal management on an individual basis.

*Financial support and sponsorship*

Nil.

*Conflicts of interest*

Pietro Fusaroli is a senior associate editor of the journal. The article was subject to the journal's standard procedures, with peer review handled independently of this editor and his research groups.

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**Received:** 2021-04-11; **Accepted:** 2021-07-13;

**Published online:** 2021-11-04

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<b>Quick Response Code:</b> 	<b>Website:</b> <a href="http://www.eusjournal.com">www.eusjournal.com</a>
	<b>DOI:</b> 10.4103/EUS-D-21-00095

**How to cite this article:** Cortellini F, Carrara S, Fusaroli P. EUS-guided fine-needle biopsy for gastric submucosal tumors: Does one size fit all? *Endosc Ultrasound* 2022;11:151-2.

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