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Many Options to Manage Laterally Spreading Tumors

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See “Endoscopic Mucosal Resection with Circumferential Incision for the Treatment of Large Sessile Polyps and Laterally Spreading Tumors of the Colorectum” by Young Mi Hong, Hyung Wook Kim, Su Bum Park, et al., on page 52-58

Laterally spreading tumors (LSTs) are found frequently in the colon but not in other sections of the gastrointestinal tract. These tumors are usually less invasive than protruding or depressed tumors of the same size; thus, we have much freedom in selecting treatment modalities for LSTs. However, a pitfall lurks in the technical difficulties.

It is preferable to resect every single tumor in one piece if possible, since *en bloc* resection is advantageous for curability and histological evaluation. The flat and wide appearance of LSTs makes it difficult to cleanly and completely remove them.

Three steps are useful in selecting the way to treat polyps.¹ The first is to decide whether the polyp is a premalignant lesion. Tumors with no potential to progress to malignancy do not need to be treated. Secondly, any cancer cells in the polyp confined to the mucosa or invaded beyond it should be assessed. Based on this consideration, we can decide if piecemeal resection is an acceptable option. Different from early gastric cancers, colonic mucosal cancers, the so-called stage 0 cancers, have a superbly excellent prognosis even when broken into pieces. Like with benign adenomas, piecemeal resection for colonic mucosal cancers is second best but is still an effective treatment option. Finally, we should decide if the polyps are curable by endoscopic treatment. Massively invasive tumors deep in the submucosa or even deeper have a chance to migrate to the regional lymph nodes and possibly

to the distant organs, so they should be treated surgically.

In this issue, Hong et al.² present their article titled, “Endoscopic mucosal resection with circumferential incision for the treatment of large sessile polyps and laterally spreading tumors of the colorectum.” Their *en bloc* resection rate and histologic complete resection rate were 66.3% and 45.0%, respectively, by endoscopic mucosal resection with circumferential incision (EMR-CI) for the is tumors, and the LSTs ranged from 20 to 50 mm in size. When confined to tumors smaller than 30 mm, the *en bloc* resection rate was 77.4%. Importantly, they did not observe any recurrence during the median follow-up period of 23 months. They added an explanation that the hot biopsy ablation for all cases of piecemeal resection might have prevented local recurrence. Ultimately, zero recurrence dispels any concerns about the low *en bloc* resection rate. They concluded that EMR-CI is an effective treatment method for 20 to 30-mm sized colorectal tumors and may be considered as a second line therapeutic option for patients when endoscopic submucosal dissection (ESD) is difficult.

In this article, we need to focus on the histology distribution of their enrolled tumors. Although half of their cases had advanced pathology such as high-grade dysplasia (25%) and mucosal cancer (22.5%), only two cases (2.5%) were submucosally invasive cancers, and one of those two was additionally treated by surgery because of the massive submucosal involvement.

Taking into account the three steps in the treatment of polyps, most benign tumors and mucosal colorectal cancers can be treated curably even by piecemeal resection. Therefore, conventional EMR, EMR-CI as the authors had performed, or piecemeal EMR may all yield favorable outcomes for this category of tumors.

What matters may lie in the adequacy of histologic margin

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evaluation and the complication rate. Piecemeal resection has a fundamental disadvantage in evaluating the resection margin. EMR-CI also showed a relatively low *en bloc* resection rate, but when performed in tumors smaller than 30 mm, it raised acceptability considerably. A perforation rate of 6.3% with EMR-CI seems somewhat high but comparable to that with ESD, and fortunately, all of the perforated cases were treated by endoscopic closure with hemoclips and antibiotics. For large tumors, snaring may not be as safe as mucosal incision or submucosal dissection, as 80% of perforations occurred during snaring. ESD with snaring, in which the submucosal layer is dissected as much as possible in view of time efficiency and safety, can minimize the area of snaring and may be a good alternative.

Treatment option selection depends on the endoscopist's

personal experience and preference. Any of the aforementioned methods can be reasonably adopted, but all endoscopists should consider curability and safety regardless of their choices.

Conflicts of Interest

The author has no financial conflicts of interest.

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