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Summary

EMR or ESD? Let's go for one or the other

Jérémie Jacques

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This debate compared endoscopic submucosal dissection (ESD) and endoscopic mucosal resection (EMR) for large colorectal polyps, with speakers agreeing that the rectum favours ESD, training and centralisation are critical for both techniques, and patient selection using optical diagnosis and SMSA scoring should guide approach rather than universal application of either method.

KEY POINTS

- Three randomised trials show en bloc resection superiority over TAMIS for rectal lesions in R0 rates, cost, and adverse events, with the speakers agreeing that ESD is the preferred approach in the rectum.
- For colonic lesions, the speakers reported that EMR procedure time averaged 40.5 minutes versus 47 minutes for ESD, though the French group stated their experts now achieve 60 square millimetres per minute, meaning a 4×4 cm lesion can be resected in 21 minutes.
- ESD had a perforation rate of 9 per 100 procedures with 1 in 210 requiring surgery, while 96.8% of perforations were managed conservatively; EMR had lower perforation rates but the speakers noted both techniques require expert training to achieve optimal safety profiles.
- A French training programme of 2000 ESDs by 34 trainees achieved 93% en bloc resection, 86% R0 resection, and 0.9% delayed perforation requiring surgery, demonstrating that structured training following the ESG curriculum can produce competent practitioners.
- Expert EMR centres reported recurrence rates of 1.4% using meticulous technique with large-piece resection, defect inspection, margin ablation, and thermal treatment, though multiple studies showed 13% recurrence rates in less-experienced hands.
- The speakers agreed that optical diagnosis with a three-pronged approach can achieve 96% negative predictive value for any cancer and that SMSA-4 lesions should be centralised, while simpler lesions may be managed locally with high-quality EMR including underwater techniques for 20-30mm polyps.

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