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Summary

The role of endoscopy vs resection for T1a and T1b disease

Jérémie Jacques

UEG Week Vienna 2024 | Presentation

Colorectal | Digestive Oncology | Endoscopy | Histopathology

October 13, 2024

Endoscopic resection should be the primary approach for T1 colorectal cancer because lymph node metastasis occurs in only 10% of cases and recent data show adjuvant surgery after local excision does not improve recurrence-free or overall survival.

KEY POINTS

- The speaker stated that two large recent studies, one Japanese study with 2000 patients and one French emulated trial with 200 patients, showed adjuvant surgery after endoscopic resection protects only against local recurrence but does not reduce distant recurrence or improve overall survival.
- En-bloc R0 resection via endoscopic submucosal dissection is the recommended technique for suspicious T1 lesions, with R0 rates of 70-85% reported; intramuscular dissection can achieve 90% R0 rates for rectal lesions up to 20mm.
- Second pathological reading by an expert pathologist is key because reproducibility of lymphovascular invasion assessment is poor and surgical specimens analyzed every 5mm may miss findings visible in endoscopic specimens analyzed every 2mm.
- The speaker stated that conflicting data exist on depth of submucosal invasion as a risk factor, with some studies reporting 2.6% lymph node risk and others reporting 9-13%, and lymphovascular invasion remains the strongest predictor at approximately 30% lymph node risk.
- The speaker recommends surveillance alone for T1a without prognostic factors, adjuvant surgery for T1b colon cancers in fit patients, and discussion of surveillance or radiochemotherapy for rectal T1b or unfit patients, with shared decision-making emphasized throughout.

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