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Summary

Incidental oesophageal squamous neoplasia at gastroscopy: How to proceed?

Stefan Seewald

UEG Week Barcelona 2026 | Presentation

Surgery | Stomach & H. Pylori | Oesophagus | Digestive Oncology

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The speaker presented techniques for characterising and delineating early oesophageal squamous cell cancer, emphasising the combination of magnification endoscopy with NBI and Lugol chromoendoscopy to predict depth of invasion and define resection margins.

KEY POINTS

- The speaker stated that intrapapillary capillary loop patterns using the Japanese Endoscopic Society classification can distinguish mucosal from deep submucosal cancer with approximately 90% diagnostic accuracy, with threefold enlarged IPCLs indicating mucosal cancer suitable for endoscopic resection and ninefold enlargement indicating deep submucosal cancer
- For lateral margin delineation before resection, the speaker recommended combining NBI with 1% Lugol solution followed by sodium thiosulphate neutralisation, stating that from practical experience this combination is necessary despite published literature favouring NBI specificity alone
- The speaker presented a case where NBI alone missed islands of high-grade dysplasia surrounding a polypoid lesion that were only revealed by Lugol staining and subsequent magnification endoscopy, requiring extended resection
- The speaker advised that patients with oesophageal squamous cell cancer require systematic head and neck examination with NBI and flexible endoscopy because of high rates of synchronous cancers in the oropharynx that conventional examination by other specialists will miss
- The speaker stated that circumferential ESD for lesions exceeding 6 centimetres in length will result in difficult strictures, and if submucosal invasion is suspected in surgery-unfit patients, primary chemoradiotherapy should be considered rather than resection because post-ESD strictures preclude subsequent chemoradiotherapy

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