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Summary

Panel discussion: Multidisciplinary tumour board session: Managing upper GI neoplasia

UEG Week Barcelona 2026 | Presentation

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

October 19, 2026

This panel discussion addressed practical questions on managing Barrett's oesophagus dysplasia, early oesophageal and gastric cancers, emphasizing the challenges of pathological interpretation, endoscopic resection techniques, and post-procedure stenosis prevention.

KEY POINTS

- The speaker stated that crypt dysplasia in Barrett's oesophagus is a real entity that can be diagnosed when pathologists are confident after examining multiple levels, particularly when p53 abnormality is present.
- For squamous cell oesophageal cancer, even small lesions, the speaker recommends always performing ESD rather than EMR because submucosal glands in squamous epithelium create recurrence risk if cut through.
- Measuring depth of submucosal invasion is very difficult in Barrett's resections due to muscularis mucosae reduplication and specimen fragmentation, which is critical since assessment errors can lead to esophagectomy recommendations.
- The speaker reported that after extensive oesophageal ESD, despite injecting cortisone, giving oral budesonide, and systemic steroids, strictures still occur and no definitive prevention solution exists; radiochemotherapy cannot be performed after extensive resection.
- For diffuse gastric cancer, the speaker performs endoscopic resection with mapping biopsies only for lesions around one centimeter, but not for lesions two centimeters or larger, noting that Eastern and Western data do not correspond and lateral spread is unpredictable in poorly cohesive types.

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