

ESD, EID, transmural resection: When, how and by whom?

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Presentation

Colorectal

Digestive Oncology

Endoscopy

Surgery

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The speaker presented Japanese approaches to ESD for high-risk T1 colorectal cancer, emphasizing that pit pattern diagnosis has limited sensitivity (50% for granular LSTs) and that submucosal invasion depth greater than 2000 microns remains the strongest predictor of lymph node metastasis in a published nomogram.

KEY POINTS

- The speaker reported that a nomogram based on more than 4000 cases (described as 'Taiwan' cases, possibly ASR error) identifies submucosal invasion depth exceeding 2000 microns as the highest odds ratio for lymph node metastasis, and this factor alone may warrant surgery or adjuvant therapy in rectal lesions according to the speaker.
- Pit pattern shows the highest diagnostic accuracy among morphologic features but sensitivity remains only 50% for LST granular type and over 70% for nongranular type, limiting detection of so-called covert cancers.
- The speaker presented case examples including a 20 cm LST with curative ESD, and non-curative cases with invasion depths of 2000 and 4500 microns where estimated lymph node metastasis risks were 23% and 34% respectively.
- Japanese practice includes intramucosal cancer in ESD indications because differentiating it from SM1 cancer is challenging even with advanced imaging, a distinction the speaker noted is difficult for Western pathologists due to differing criteria.
- In discussion, the speaker stated that Japanese guidelines currently do not differentiate rectum from colon but acknowledged that recurrence rates and post-surgical quality of life differ, and future guidelines may separate the two sites.

- European colleagues noted that validation of risk models across countries is hampered by heterogeneous pathology interpretation, particularly for lymphovascular invasion, and suggested future research should focus on distant metastasis and biomarkers like ctDNA rather than lymph node metastasis alone.

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