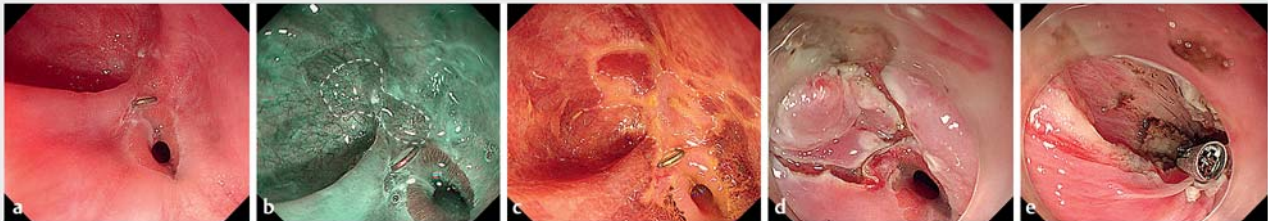
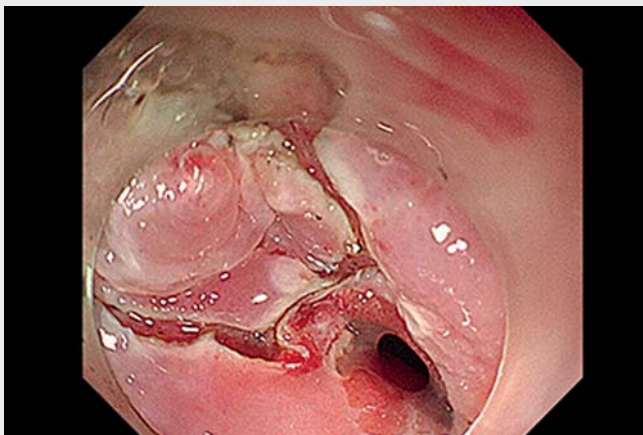


## Salvage endoscopic submucosal resection for residual esophageal superficial cancer involving a stenotic anastomosis: a challenging but desirable indication



► **Fig. 1** Endoscopic images showing: **a** the stenotic anastomosis; **b** on narrow-band imaging, a patch of abnormal mucosa with a clearly delineated margin in a pseudodiverticulum near the anastomosis; **c** the boundary clearly delineated on Lugol's iodine chromoendoscopy; **d** the appearance after endoscopic submucosal dissection had been performed; **e** the post-endoscopic submucosal dissection defect and a clip in place after a longitudinal incision of the anastomosis had been made.



► **Video 1** Salvage endoscopic submucosal resection is performed for residual esophageal superficial cancer involving a stenotic anastomosis after chemoradiotherapy and subtotal esophagectomy.



► **Fig. 2** Macroscopic appearance of the resected lesion.

A 48-year-old man with a history of neoadjuvant chemoradiotherapy followed by subtotal esophagectomy presented with symptoms of dysphagia over 2 months. Endoscopic examination showed an anastomotic stenosis at 20 cm from the incisors and the endoscope was unable to be passed through this (► **Fig. 1 a**). In addition, white-light endoscopy and narrow-band imaging revealed a patch of residual early esophageal cancer, with meandering vessels, in

a pseudodiverticulum near the anastomosis (► **Fig. 1 b**). A salvage endoscopic submucosal dissection (ESD) was scheduled to remove this lesion, with the aim of avoiding its further malignant progression and aggressive additional treatment (► **Video 1**). Nonstaining of the lesion with Lugol's iodine chromoendoscopy helped to delineate the margin (► **Fig. 1 c**). Intraoperatively, although submucosal lifting was not satisfactory because of the marked fibrosis, it was

still possible to complete en bloc dissection (► **Fig. 1 d**).

Furthermore, an endoscopic longitudinal incision was performed to relieve the anastomotic stenosis. After incision of the anastomosis, an endoscopic clip was used to bridge the opposing mucosa of both anastomotic edges (► **Fig. 1 e**), and the endoscope was able to pass through the narrowed segment smoothly after the procedure. The final pathology result revealed a high grade glandular intraepithelial neoplasm, with R0 resection (► **Fig. 2**). The patient was discharged on postoperative day 4, with no adverse events having occurred.

Locoregional recurrence or residue remains the major cause of failure, occurring in 50%–75% of patients treated with surgery and/or chemoradiotherapy for esophageal cancer [1, 2]. The scar tissue at the anastomotic site becomes rigid, resulting in poor lifting, so surgical reoperation of such lesions is technically more challenging and can cause complications [3]. ESD has been widely used for superficial esophageal cancer [4, 5]. Although ESD of a lesion involving a surgical anastomosis and pseudodiverticulum is challenging, this salvage treatment still offers significant clinical advantages in experienced hands.

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