7è RÉUNION ANNUELLE DE PATHOLOGIE DIGESTIVE
Hôpital Cochin- Hôtel Dieu

CANCER SUPERFICIEL DURECTUM : Place du traitement endoscopique

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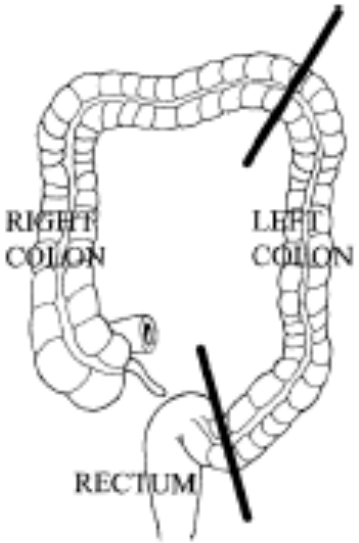
CAS CLINIQUE DE Mr X

- Film
- Examen anatomo-pathologique : ADK envahissant la sous muqueuse (T1sm)

DISTRIBUTION DES CANCERS T1 DU COLON ET DU RECTUM ET RISQUE DE METASTASES GG

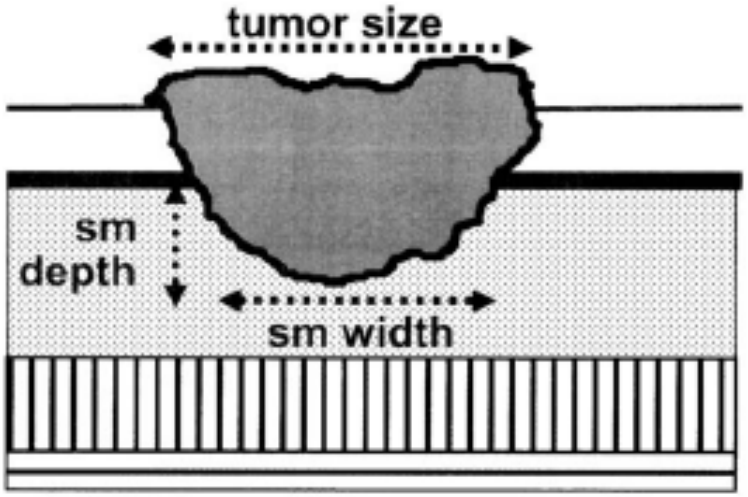


Location	TOKYO	NEW YORK	All Cases	
Right Colon	1 /35 2.9%	2 /57 3.5%	3/92	3.0%*
Left Colon	3 /85 3.8%	10 /75 13%	13/160	8.0%**
Rectum	13/73 19%	14/103 14%	27/176	15%
Total	17/193 8.8%	26/235 11%	43/428	10%

* P = .003 right colon versus rectum
** P = .04 left colon versus rectum

Okabe et al. J Gastrointestinal Surg 2004; 8 ; 1032-1040.

CARACTERISTIQUES DES CANCERS DU RECTUM T1



	median	range
tumor size (cm)	2.0	0.3 - 15
sm width (mm)	7.3	0.14 – 23.5
sm depth (mm)	3.0	.02 – 13.3

Okabe et al. J Gastrointestinal Surg 2004; 8 ; 1032-1040.

EXISTE T'IL UNE PLACE POUR LE TRAITEMENT ENDOSCOPIQUE ?

Comprehensive Review

Local Excision for Rectal Carcinoma

Edward Kim,[1] John M. Hwang,[1] Julio Garcia-Aguilar[2]

Clinical Colorectal Cancer, Vol. 7, No. 6, 376-385, 2008;

On peut en douter si on lit cette mise au point où il n'est même pas mentionné !!!!

PARAMETRES A CONSIDERER AVANT DE DECIDER DU GESTE

1. Taille
2. Siège
3. Aspects endoscopiques
4. Echoendoscopie

TAILLE

Size does not determine the grade of malignancy of early invasive colorectal cancer

Table 2 Incidence of LNM and clinicopathological characteristics based on tumor size *n* (%)

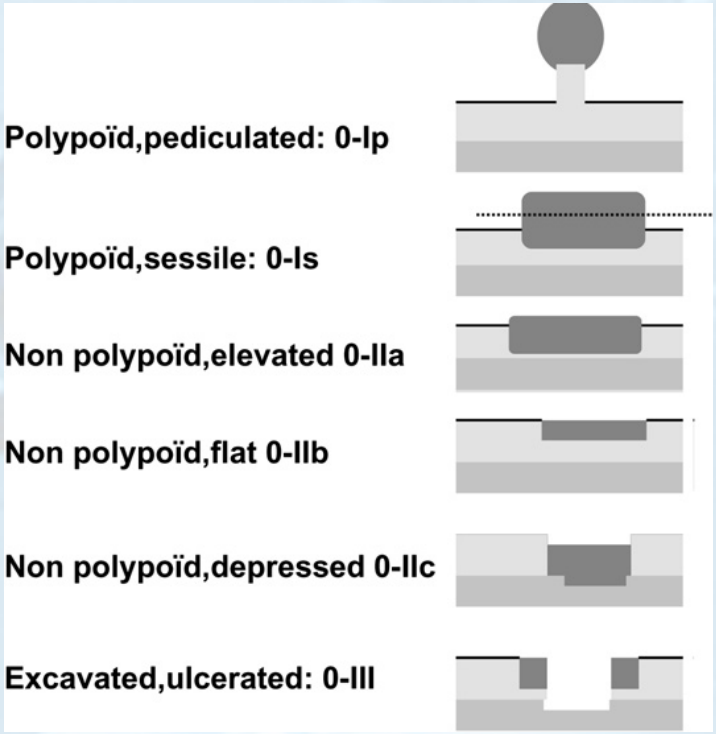
	Small (≤ 10 mm)	Large (> 10 mm)	*P* value
LNM	10/89 (11.2)	46/381 (12.1)	0.85
Depth of invasion			
sm-superficial (< 1000 μm)	30 (25)	83 (18)	0.08
sm-deep (≥ 1000 μm)	90 (75)	380 (82)	
LVI	26 (22)	125 (27)	0.23
PDA	12 (10)	79 (17)	0.06

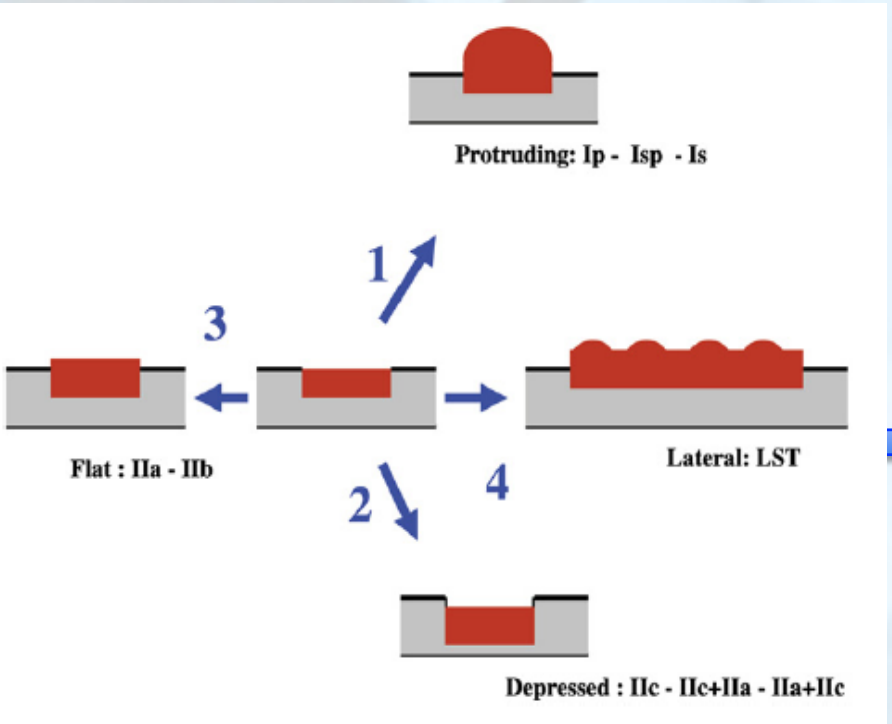
LVI: Lymphovascular invasion; PDA: Poorly differentiated adenocarcinoma; LNM: Lymph node metastasis.

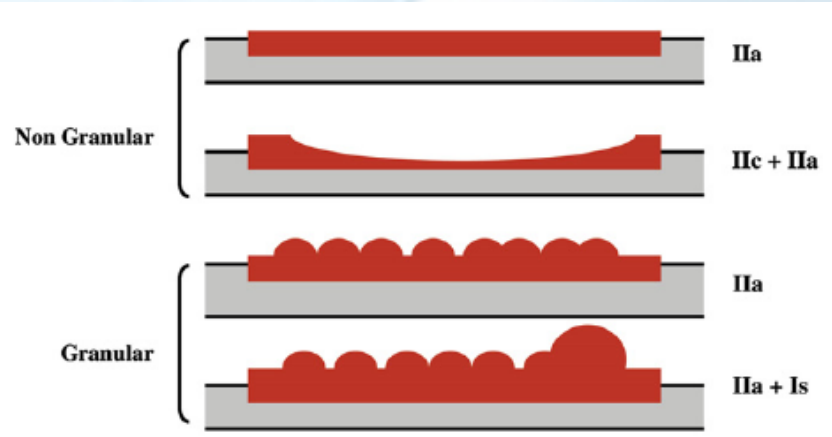
World J Gastroenterol 2009 June 14; 15(22): 2708-2713

ASPECTS ENDOSCOPIQUES

Volume 68, No. 4 : 2008 GASTROINTESTINAL ENDOSCOPY S3

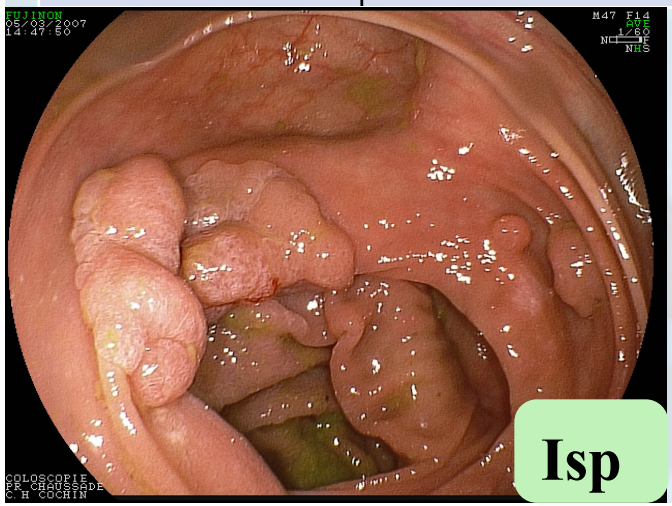


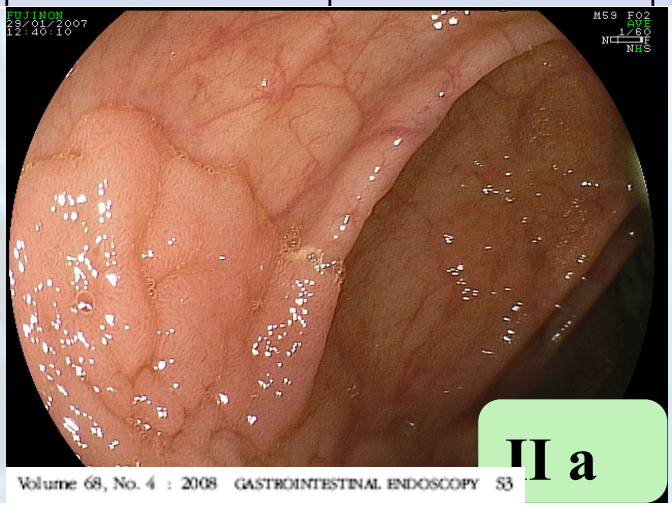


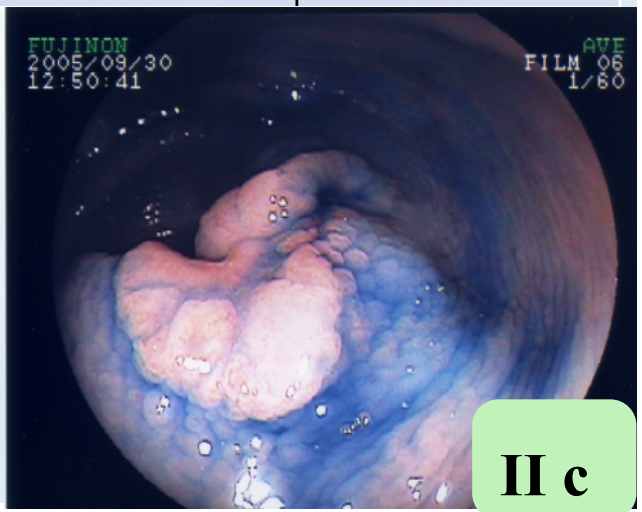


TAILLE, ASPECT ENDOSCOPIQUE ET RISQUE DE CANCER T1sm

	Total	< 5mm	6-10mm	11-19mm	> 20mm
Polypoide Is ou sp	14 814	0% (0/7046)	1.3% (72/5582)	10.3% (192/1863)	29.1% (94/323)
Plan IIa	10 363	0.03% (2/7583)	0.35% (5/1436)	5.3% (50/929)	19.5% (81/415)
Déprimé IIc	585	8.4% (22/263)	43.6% (75/172)	73.2% (93/127)	87% (20/23)







CLASSIFICATION DES TUMEURS VILLEUSES

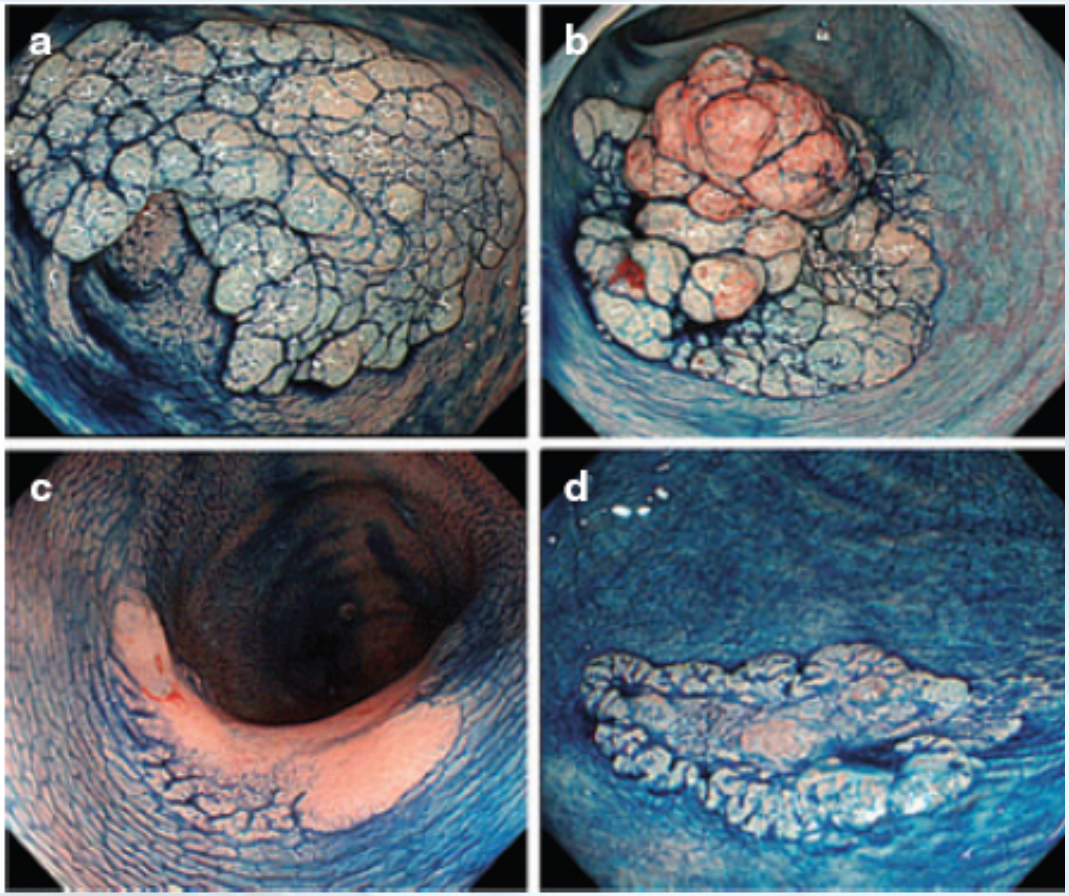


Fig. 1. Subclassification of laterally spreading tumors (LSTs). (a) LST-granular (G) homogenous type; (b) LST-G nodular mixed type; (c) LST-non granular (NG) flat elevated (FE) type; (d) LST-NG pesudodepressed (PD) type.

Digestive Endoscopy (2009) **21** (Suppl. 1), S43–S46

INVASION DE LA SOUS MUQUEUSE EN FONCTION DE L'ASPECT ENDOSCOPIQUE DES LST

Type	Size (mm) 10–19	20–29	30–	Total	
LST-G					
Homogenous	0%	0.9%	1.5%	0.9%	
	0/140	1/109	2/132	3/351	*
Nodular mixed	6.0%	13.9%	15.5%	13.3%	
	3/50	11/79	22/142	36/271	
LST-NG					
Flat elevated	5.1%	6.9%	10.5%	6.1%	
	21/414	16/232	6/57	43/703	*
Pseudodepressed	23.8%	57.1%	100%	42.1%	
	5/21	8/14	3/3	16/38	

*$P < 0.01$ Jan. 1990–Sep. 2008, Department of Endoscopy, Hiroshima University Hospital.

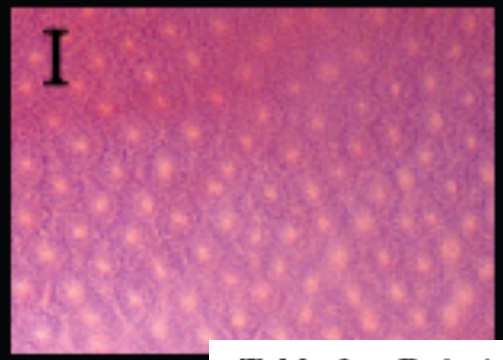
Digestive Endoscopy (2009) **21** (Suppl. 1), S43–S46

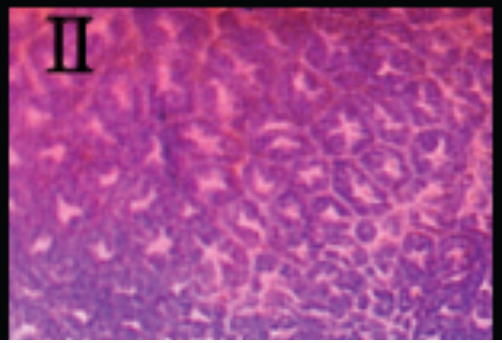
Pit Pattern Classification

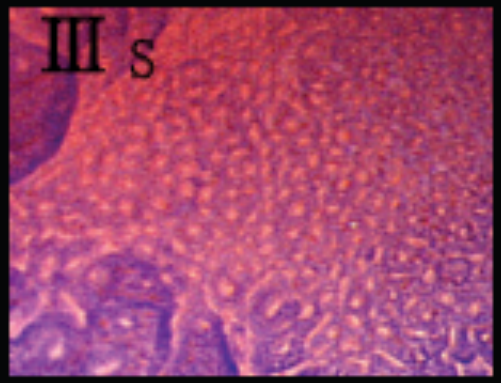
non-neoplastic

adenomatous

cancerous







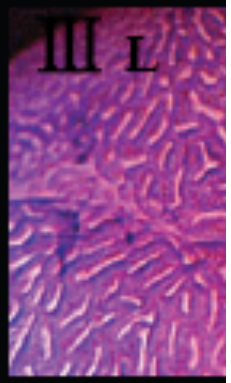
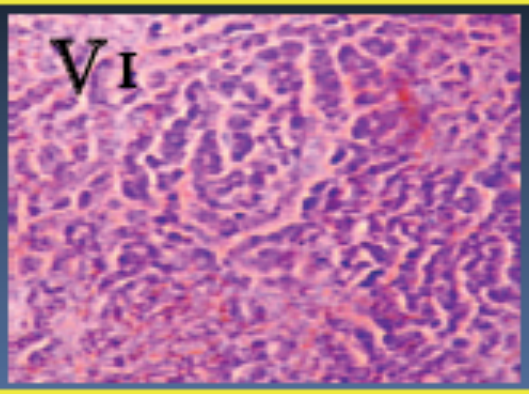
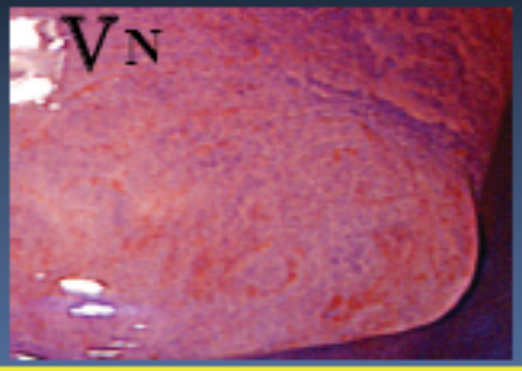


Table 3. Relationship between submucosal invasive area and pit pattern in laterally spreading tumor (LST)-non-granualr (NG)

Subtype	Pit pattern			Total
	Non V	V_I	V_N	
Flat elevated	1 (5) *	19 (86)	2 (9)	22 (100)
Psedodepressed	6 (43) *	7 (50)	1 (7)	14 (100)
				(%)





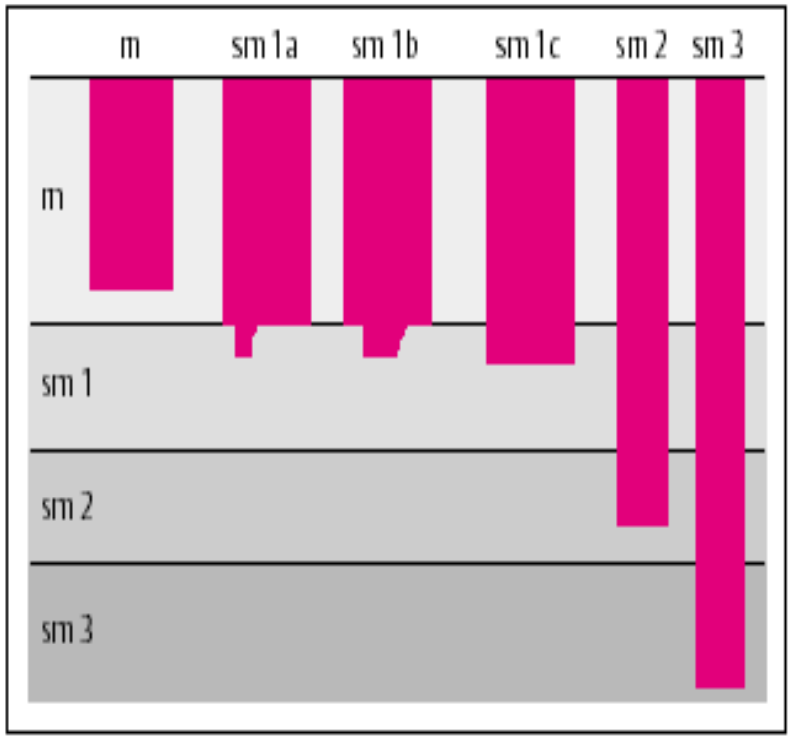
Kudo S et al. J Clin. Pathol.1994;47:880

ECHOENDOSCOPIE : SENSIBILITE ET SPECIFICITE DANS LES CANCERS DU RECTUM T1

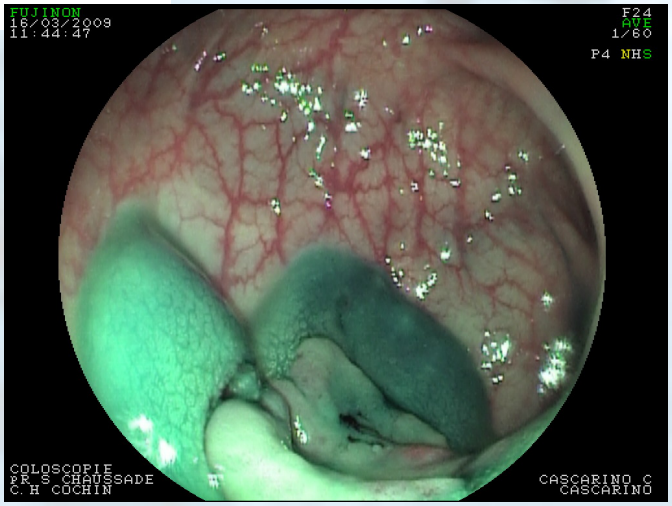
	T0/T1		T2/T3	
T0/T1	65	Sens 96%	2	15%
T2/T3	3	4%	11	Spé 85%

Preoperative staging of patients with rectal tumors suitable for transanal endoscopic microsurgery (TEM) : comparison of endorectal ultrasound and histopathologic findings.Zorcolo et al.Surg Endosc. 2009;23(6):1384-9.

DECOLLEMENT DE LA LESION ET RISQUE D'ENVAHISSEMENT DE LA SOUS MUQUEUSE



Décollement	m	Sm1a Sm1b	Sm1c Sm2	Sm3
Complet facile	42	2	0	0
Complet mais ferme	30	2	5	0
incomplet	0	3	6	3
impossible	0	0	0	8



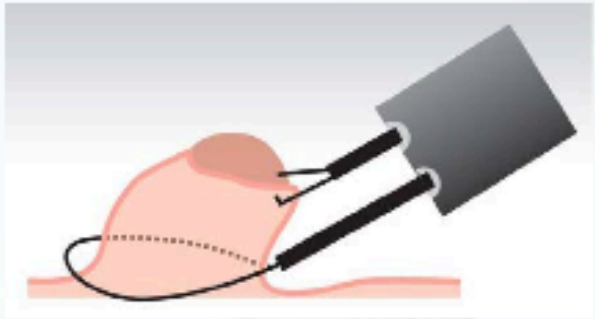
Endoscopy 2001; 33:568-573

TRAITEMENTS : METHODES
LA MUCOSECTOMIE

Endoscopic Mucosal Resection (EMR)

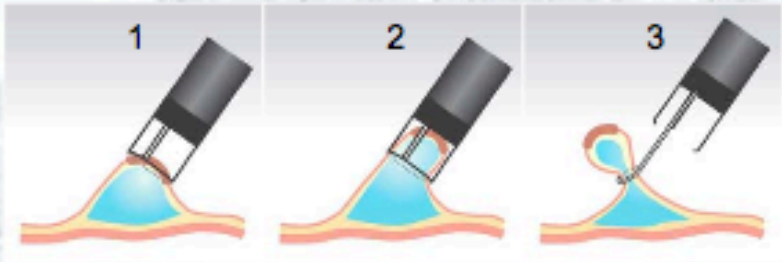
1 Strip Biopsy Technique

Using a 2-channel scope, the specimen is raised with straight grasping forceps, a snare is applied and the specimen is resected.



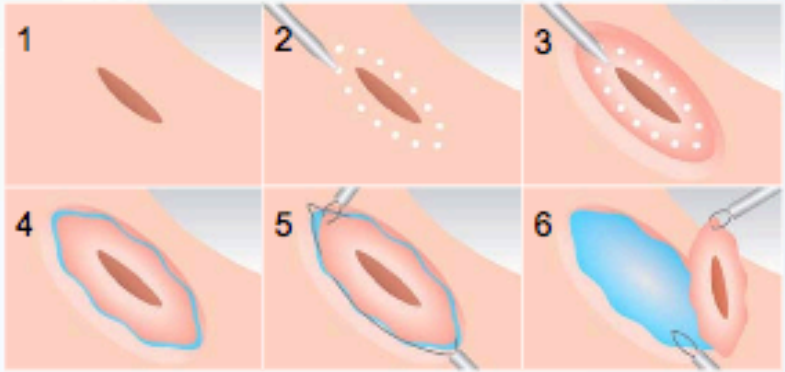
2 Endoscopic Mucosal Resection using a Cap-fitted Panendoscope (EMRC)

1. A cap is attached to the scope and the specimen is raised when suction from the scope is applied. The specimen is then resected by the snare.



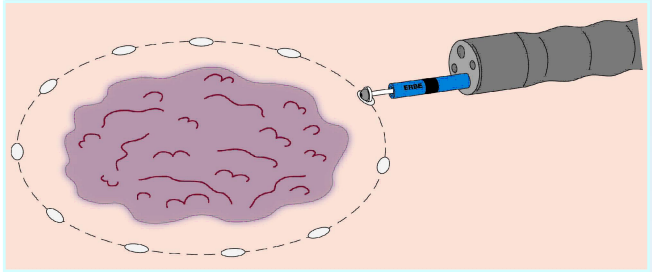
3 Endoscopic Resection Hypertonic Saline-Epinephrine Solution (ERHSE)

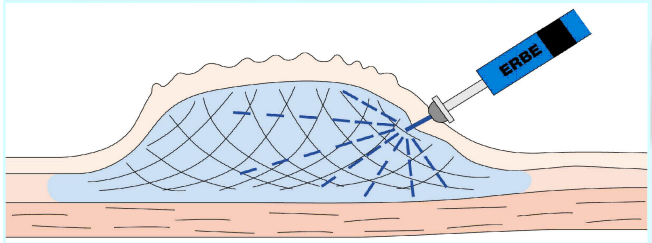
1. The lesion is ascertained.
2. The area is marked.
3. Local HSE injection.
4. Entire circumference of area is cut.
5. The lesion is snared and the area risen.
6. The entire affected area is removed

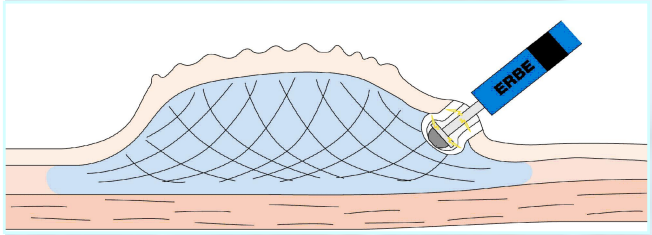


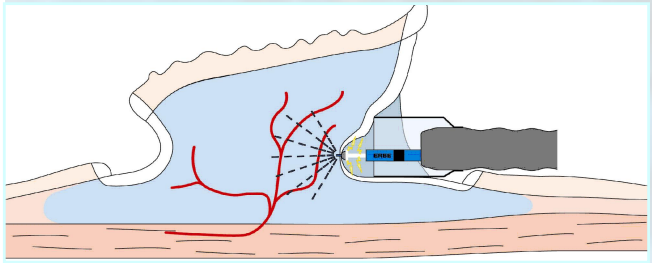
Source: Endoscopia Digestiva Vol.14, No.9

LA DISSECTION ENDOSCOPIQUE (ESD)









1. DELIMITEZ LA LESION
2. MARQUEZ LA LESION
3. INJECTION SOUS MUQUEUSE
4. INCISION PERIPHERIQUE
5. DISSECTION SOUS MUQUEUSE
6. HEMOSTASE ET COAGULATION

The line-up


Flex knife


HookKnife

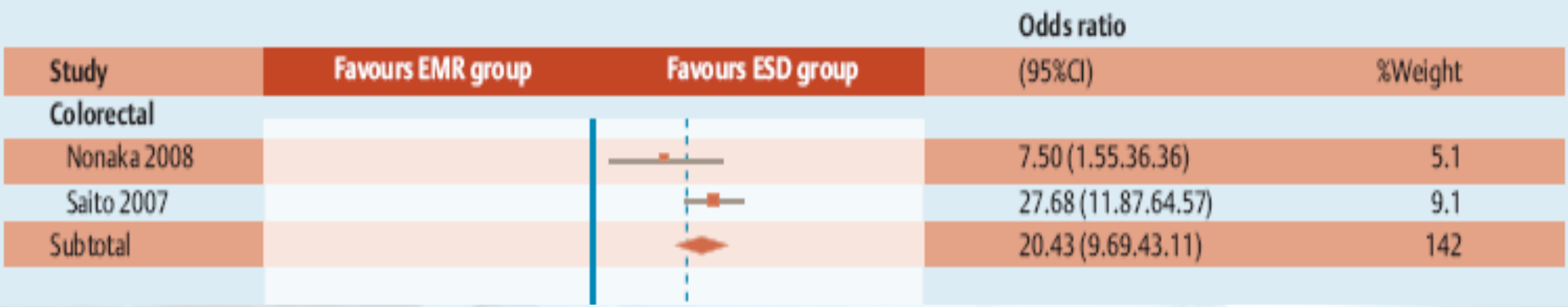

Triangle tip knife


IT2 knife


FlushKnife
3mm
2.5mm
2mm
1.5mm
1.0mm


DualKnife

MUCOSECTOMIE OU DISSECTION ENDOSCOPIQUE DANS LES CANCERS T1 DU RECTUM



INDICATIONS ESD

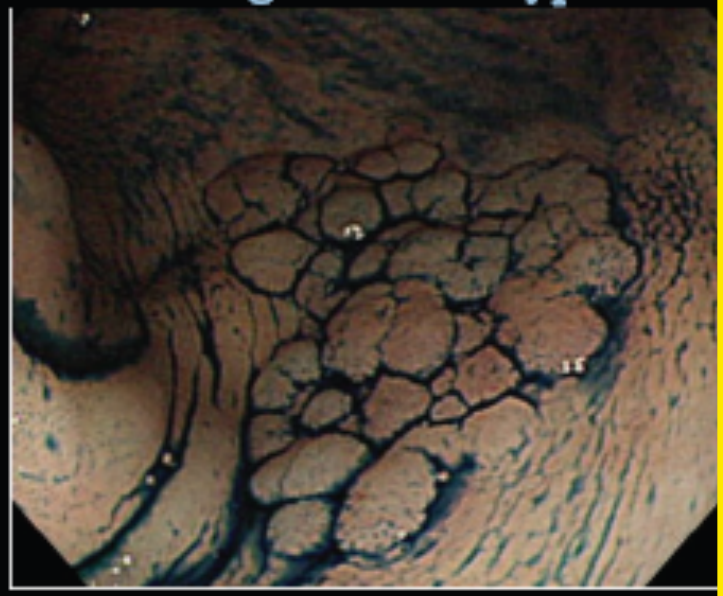
- **Cancer T1**
- **Autres situations où le risque de cancers avec envahissement de la sous muqueuse est important :**
  - **LST-NG > 2cm surtout si aspect de dépression**
  - **LST-G > 3cm**
  - **Lésion IIc > 10mm**

Laterally spreading tumor

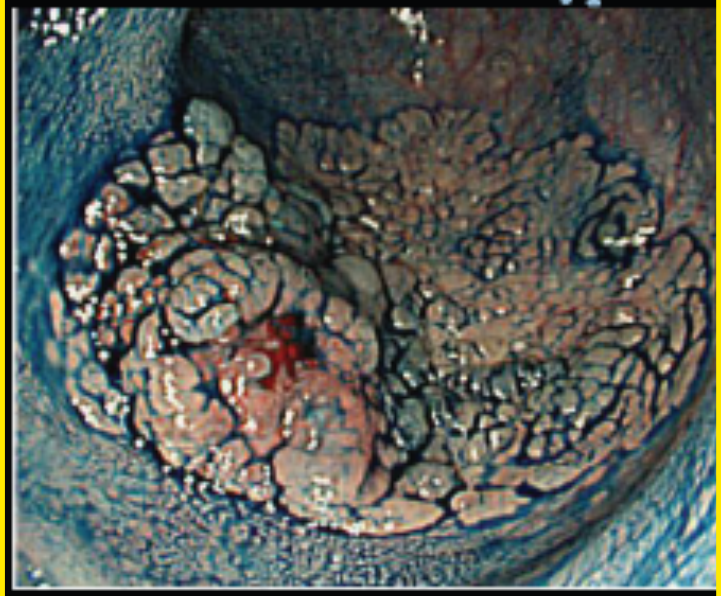
Granular type
(LST-G)

Non-granular type
(LST-NG)

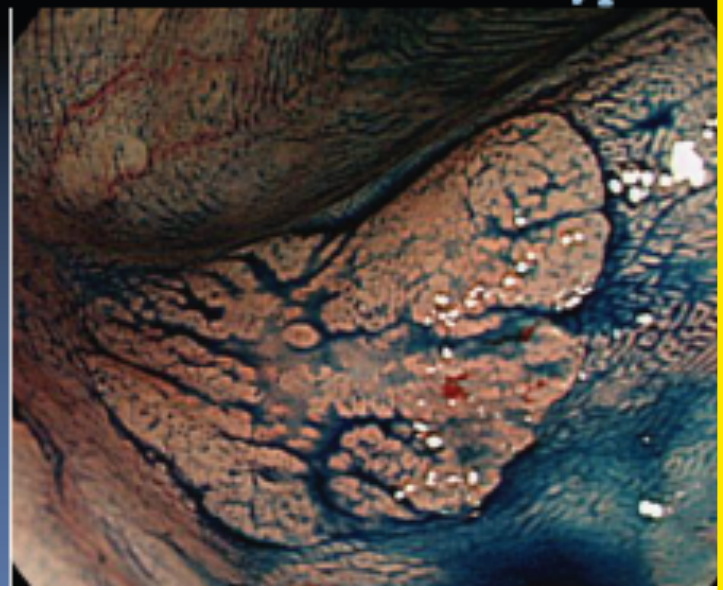
Homogeneous type



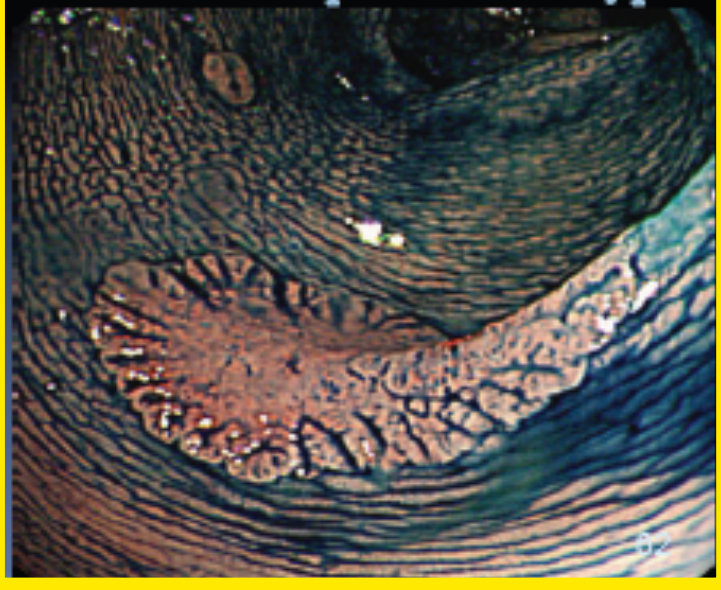
Mixed nodular type



Flat elevated type



Pseudo depressed type

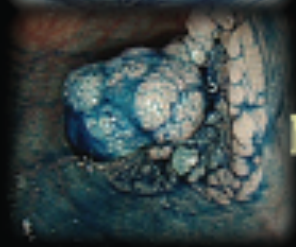


In what type, submucosal invasion is frequently seen?

Granular

Homo

4/302
1.3%



Mix

24/107
22.4%

Mix with big nodule

Non-granular

Flat

32/357
9.0%

Pseudo-Depressed

28/86
32.6%

Pseudo-Depressed type

Apr. 2001～Jun. 2008

RESULTATS AU JAPON

	N pts	« En-bloc »	Taille Médiane (tumeur)	Taille Médiane specimen	Durée	Perfo	Hémorragie
Oeso	138	98.6%	23mm	45mm	61mn	0	0
stomach	1136	99.3%	13mm	42mm	47mn	1.9%	3.3%
Colon-rectum	**361**	**98.6%**	**30mm**	**40mm**	**58mn**	**1.9%**	**1.7%**

Toyonaga, Man-I et coll, DDW 2009, Chicago

CONCLUSION

- Risque ganglionnaire (15%) > à celui du côlon.
- Importance de l'échoendoscopie pour distinguer les tumeurs T1 et T2.
- Importance de l'endoscopie pour prédire le risque d'envahissement de la sm.
- Nécessité d'une concertation en RCP avec le compte rendu anatomo pathologique.
- La chirurgie est indiquée lorsqu'il existe un risque ganglionnaire important.

Table 2. En-bloc resection rate (%)

	En bloc resection rate (%)		
EMR with SI ($n = 24$)	83.3 (20/24)		
Simplified ESD ($n = 44$)	90.9 (40/44)		
ESD ($n = 468$)	98.9 (463/468)		
	≤20 mm	>20 mm	
	100 (97/97)	98.7 (366/371)	

EMR, endoscopic mucosal resection; SI, small incision; ESD, endoscopic submucosal dissection; • $P = 0.0005$; •• $P = 0.0044$.