Endoscopic Approach to Gastric Tumors

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65 yo W with diet controlled DM, HTN, 15mm submucosal mass in the cardia, hypoechoic, arising from the fourth endosonographic layer, GIST by FNA. What would we recommend?

A. Obtain an MRI
B. Yearly surveillance with EUS
C. Hybrid procedure
D. Laparoscopic resection
E. Gastrectomy
F. No further follow-up
Proposed algorithm for the management of localized GIST

1. Symptomatic?
   - Yes: Recommend surgery
   - No: Proceed to next step

2. Mass size ≥20mm?
   - Yes: Recommend surgery
   - No: Proceed to next step

3. Suspicious EUS features?
   - Yes: Recommend surgery
   - No: Consider EUS surveillance


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Human hybrid endoscopic and laparoscopic management of mass lesions of the foregut (with video)

Field F. Willingham, MD, MPH, Sagar S. Garud, MD, MS, S. Scott Davis, MD, Meindra M. Lewis, MD, Shari K. Misteli, MD, David A. Kooby, MD

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Gastrointestinal Stromal Tumors (GIST)

Workup of primary presentation:
- EUS: Ultrasound or gastric tissue biopsy
- CT: Computerized tomography
- MRI: Magnetic resonance imaging

NCCN Guidelines in Practice (April 2012): Stomach, Table of Contents, Education

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Gastrointestinal Endoscopy
63 yo Woman referred for upper endoscopy.

Her endoscopy revealed a 3cm mass at the top of the stomach.

Not felt to be resectable endoscopically and was referred for surgical evaluation.

GASTRIC POLYP, BIOPSIES:
- FRAGMENTS OF ADENOMA WITH HIGH GRADE DYSPLASIA.
GASTROINTESTINAL JUNCTION MASS, LAPAROSCOPIC GASTRECTOMY:

INTRAMURAL ADENOCARCINOMA ARISING IN A BACKGROUND OF HIGH GRADE DYSPLASIA,

An additional archival section, level, and deep section of the gastrointestinal junction mass, block #12, showed the intramural adenocarcinoma arising in a background of high-grade dysplasia in an otherwise negative sample. The adenoma/cyst is also completely excised.
Figure 1 Flowchart of patients included in this study: 1370 lesions from 1244 patients were included in endoscopic outcomes.
Hybrid Push-Pull Endoscopic and Laparoscopic Full Thickness Resection for the Minimally Invasive Management of Gastrointestinal Stromal Tumors (GIST).


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ENDOPHYTIC TUMORS
1. Difficult to localize outside stomach
2. Difficult to visualize outside the stomach
3. Difficult to approach laparoscopically
4. Require large resection for negative margins

CARDIA / GEJ TUMORS
1. Difficult to spare a major organ resection

PYLORUS / DISTAL ANTRAL TUMORS
1. Require Billroth type resection

<table>
<thead>
<tr>
<th>No.</th>
<th>Age/Gender</th>
<th>Presenting Symptoms</th>
<th>Size of resected mass (cm)</th>
<th>Depth of invasion</th>
<th>Location of mass</th>
<th>Mitotic rate (per hpf)</th>
<th>Reason for hybridization</th>
<th>Endoscopic Specimen Margin</th>
<th>Laparoscopic Specimen Margin</th>
<th>Duration (min)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>56/F</td>
<td>Melena/anemia</td>
<td>3.0 and 2.8</td>
<td>Muscularis propria</td>
<td>Fundus, near GE junction</td>
<td>1/50</td>
<td>Near GE junction and endophytic</td>
<td>Positive</td>
<td>Negative</td>
<td>209</td>
</tr>
<tr>
<td>2</td>
<td>57/M</td>
<td>Dysphagia</td>
<td>4.2</td>
<td>Muscularis propria</td>
<td>Antrum, posterior wall</td>
<td>1/50</td>
<td>Endophytic; difficult to identify laparoscopically</td>
<td>Positive</td>
<td>Negative</td>
<td>157</td>
</tr>
<tr>
<td>3</td>
<td>75/M</td>
<td>Dyspepsia</td>
<td>2.6 x 1.9</td>
<td>Serosa</td>
<td>Body, anterior wall</td>
<td>2/50</td>
<td>Endophytic; difficult to identify laparoscopically</td>
<td>Positive</td>
<td>Negative</td>
<td>137</td>
</tr>
<tr>
<td>4</td>
<td>68/F</td>
<td>LUQ pain/c chest pain</td>
<td>3.5 x 3.3 x 3.2</td>
<td>Submucosa</td>
<td>Cardia near GE junction</td>
<td>0/50</td>
<td>Near GE junction and endophytic</td>
<td>Positive</td>
<td>Negative</td>
<td>146</td>
</tr>
</tbody>
</table>
Early gastric cancer

4th layer tumors

Submucosal Tumors

• STAGING
• EMR
• ESD

• OBSERVATION
• RESECTION
• PUSH-PULL HYBRID

• OBSERVATION
• EMR
• HYBRID

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