Laparoscopic and endoscopic cooperative surgery for difficult resection of posterior esophagogastric junction gastrointestinal stromal tumors

The esophagogastric junction (EGJ) is a rare location for gastrointestinal stromal tumors (GIST) and resection remains challenging in posterior/fundic lesions [1]. Laparoscopic and endoscopic cooperative surgery (LECS) is a new combined minimally invasive method [2–4]. Recently, a large series of 126 patients who underwent LECS for gastric submucosal tumors (86 GISTs) was published showing a high rate of feasibility and less than 5% morbidity [5]. We report our experience in difficult gastric GIST resections.

Three patients underwent the procedure for posterior EGJ GISTs with various symptomatology. The absence of metastasis and the location of the GIST were confirmed by esophagogastroscope and computed tomography scan (Fig. 1). All procedures were performed under general anesthesia and with orotracheal intubation. The LECS steps were (Fig. 2, Video1): 1) exposing the esophagus and liberating the angle of His by laparoscopy; 2) full-thickness incision around the tumor by endoscopy (Hook knife; Olympus, Tokyo, Japan); 3) exposure of the tumor pedicle to the surgeon (forceps); 4) laparoscopic resection with linear stapler; 5) gastrotomy suturing.

All LECS procedures were performed successfully in a mean time of 107 minutes (range 90 – 120 minutes). The blood loss was very low and did not require any blood transfusion. There were no immediate perioperative complications such as spleen wound, pneumothorax, vagus nerve injury, or any other adverse event. The mean tumor size was 5.3 cm, with the largest diameter measuring 5.5 cm, 4.5 cm, and 6 cm, respectively, and with Miettinen grade considered as low or very low risk of recurrence. The mean fasting duration, including nasogastric tube time, was 5 days (range 2 – 8 days), and the median hospital stay was 9.3 days (range 5 – 14 days). No rehospitalization or latest complications were reported during a mean follow-up of 14 months. There was no recurrence of the tumors.

LECS following a rigorous surgical protocol is safe, and offers easiest accessibility and lower morbidity for complicated gastric GIST resection.
Competing interests

Professor Barthet is a consultant for Boston Scientific.

The authors

Jean-Michel Gonzalez1, Antoine Debourdeau1, Guillaume Philouze1, Laura Beyer2, Stéphane Berdah2, Marc Barthet1

1 Department of Gastroenterology, Assistance Publique Hopitaux de Marseille, Aix-Marseille Université, Hôpital Nord, Marseille, France
2 Department of Digestive Surgery, Assistance Publique Hopitaux de Marseille, Aix-Marseille Université, Hôpital Nord, Marseille, France

Corresponding author

Jean-Michel Gonzalez, MD
Département de Gastroenterology, AP-HM, Aix-Marseille Université, Hôpital Nord, Marseille, France
Fax: +33-4-91968737
jmgonza05@yahoo.fr

References


Bibliography

DOI https://doi.org/10.1055/s-0043-121136
Published online: 14.11.2017
Endoscopy 2018; 50: 178–179
© Georg Thieme Verlag KG
Stuttgart · New York
ISSN 0013-726X

ENDOSCOPY E-VIDEOS
https://eref.thieme.de/e-videos

Endoscopy E-Videos is a free access online section, reporting on interesting cases and new techniques in gastroenterological endoscopy. All papers include a high quality video and all contributions are freely accessible online.

This section has its own submission website at https://mc.manuscriptcentral.com/e-videos

Video 1 Endoscopic intraluminal dissection of the tumor using carbohydrate gas. Transmural dissection of all layers of the stomach around the tumor was progressively and carefully performed using a diathermic electrosurgical knife. Laparoscopic resection of the tumor using a linear stapler. Tumor could then be removed in a bag and extracted by one of the port orifices.