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## Expanding the Boundaries of Endoscopic Resection: Circumferential Laterally Spreading Lesions of the Duodenum

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Lateral spreading lesions (LSL) of the duodenum are uncommon. They may or may not involve the papilla Vateri and are usually solitary flat adenomas that harbor a malignant potential similar to colonic adenomas and removal is therefore recommended.<sup>1,2</sup> Endoscopic mucosal resection (EMR) is well-established as effective and safe for removal of large colonic LSLs and in recent years has gained acceptance in the treatment of duodenal LSL with good overall results.<sup>3,4</sup> Complete resection is achieved in 79%-100% of cases at the index procedure, with bleeding and perforation occur at rates of 33% and 3%, respectively, and recurrence seen in 10%-37%. LSL is usually managed effectively during scheduled endoscopic surveillance.<sup>5-7</sup> Lesion size may influence efficacy and procedural outcomes. Data on EMR for circumferential duodenal LSL (CD-LSL) is absent, nor have long-term outcomes been reported. Herein, we describe the technique, efficacy, and long-term outcomes of EMR for extensive subtotal and CD-LSL.

### Description of Patients and Technology

Over an 8-year period, 11 patients (mean age, 71.5 years; range, 58-80) with CD-LSL were identified from our prospectively collected database of duodenal LSLs (n = 107). The mean longitudinal extent was 72 mm (range, 60-80). All lesions had  $\geq 80\%$  circumferential involvement and 6 lesions had complete circumferential involvement. Three lesions were not suitable for endoscopic resection owing to luminal stenosis and/or suspicion of invasive disease, and were referred for surgery. Eight lesions were treated endoscopically. One of these patients had substantial comorbidities. Seven of the 8 lesions were resected completely in a single session. Minor intraprocedural bleeding occurred in all cases and was easily controlled with snare tip soft coagulation or coagulation forceps. No patient required operative management after endoscopic resection. Routine postprocedural admission was undertaken in all 8 cases (median duration of hospital stay, 3.5 days; range, 2-15). Four patients had a completely uneventful

postprocedural course and were discharged home within 2-4 days. One patient was in the hospital for 15 days owing to postprocedural bleeding followed by nosocomial pneumonia. Delayed bleeding occurred in 4 of 8 patients. In 3 of these patients, endoscopic hemostasis was required and performed successfully. Symptomatic luminal stenosis was encountered and managed successfully by serial balloon dilatations in 1 patient; 2 others had asymptomatic stenosis on surveillance endoscopy, which was also treated by balloon dilatation. In the 4 of 8 cases with papillary involvement, no papillary stenosis was observed and no pancreatobiliary complications were encountered. All patients followed a standardized surveillance protocol with first surveillance endoscopy (SE1) at 4-6 months after resection and subsequent surveillance at 12-month intervals if no recurrence was seen. If residual/recurrence was seen and treated, the next surveillance was in 6 months again. Routine biopsies of the scar were taken in all cases even if no recurrence was seen. The median follow-up was 12.5 months (range, 8-24). Residual/recurrent neoplasia was identified and treated endoscopically in 3 of the 8 patients (37%) at SE1. One patient had a small late recurrence at second surveillance after a negative SE1, which was easily treated. One patient had a small amount of persistent residual disease, which was difficult to access endoscopically. A combination of snare resection, cold avulsion, and argon plasma coagulation were used to treat this over the course of 4 procedures at intervals of 3-4 months. Overall, at the last surveillance endoscopy 7 of the 8 patients (87.5%) were free of disease.

### Video Description

Duodenal LSLs involving  $\geq 80\%$  of the luminal circumference are endoscopically resected using standard inject and resect EMR technique.<sup>3</sup> Lesions with papillary involvement undergo staging with magnetic resonance cholangiopancreatography before papillectomy and stenting by endoscopic retrograde cholangiopancreatography. We always start with a side-viewing duodenoscope and verify the

**Abbreviations used in this paper:** CD-LSL, circumferential duodenal lateral spreading lesion; EMR, endoscopic mucosal resection; LSL, lateral spreading lesion; SE1, first surveillance endoscopy.

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**Table 1.** Patient, Lesion, Procedure Characteristics, and Outcomes

Characteristic	Case 1	Case 2	Case 3	Case 4	Case 5	Case 6	Case 7	Case 8	Case 9	Case 10	Case 11
Age, y (sex)	72 (F)	75 (F)	79 (F)	66 (F)	59 (M)	70 (F)	78 (F)	58 (F)	80 (M)	77 (F)	73 (F)
Location	D2+	D2+	D2+	D1-D2	D2-D3	D2	D2+	D3	D2+	D2+	D2+
Longitudinal extent (mm)	60	70	60	80	60	60	80	80	80	80	80
Circumferential extent (%)	80	100	90	100	100	80	80	95	100	100	100
Histology	TVA+LGD	TVA+LGD	TVA+LGD	TVA+LGD	TVA+LGD	TVA+LGD	TVA+LGD	TVA+LGD	Whipple - TVA+HGD	Whipple - invasive CA	Whipple - invasive CA
Endoscopic resection attempted	Yes (C)	Yes (IC)	Yes (C)	Yes (C)	Yes (C)	Yes(C)	Yes (C)	Yes (C)	No (luminal stenosis – surgery)	No (luminal stenosis + non lifting – surgery)	No (depressed area with altered pit-pattern – surgery)
Procedure time (min)	180		250	180	120		180		NA	NA	NA
Intra-procedural bleeding	Yes (minor)	Yes (minor)	Yes (minor)	Yes (minor)	Yes (minor)	Yes (minor)	Yes (minor)	Yes (minor)	NA	NA	NA
Delayed bleeding	Minor melena and HB drop – no Tx.	Hematemesis on POD1. Spurting vessel on endoscopy treated with coagulation graspers. PCX2	Nil	Melena and HB drop POD 1. Spurting vessel on endoscopy – treated with injection and clip.	Hematemesis POD 10. Spurting vessel on endoscopy treated with coagulation grasper	Nil	Nil	Nil	NA	NA	NA
Days in hospital post procedure	3	15	3	9	7	2	4	3	NA	NA	NA
Stenosis (# of dilatations)	Nil	Nil	Nil	Yes (3)	Yes (3)	Nil	Yes (1)	Nil	NA	NA	NA
SE1	Diminutive residual – treated	Residual – treated endoscopically	Two foci of residual. Treated endoscopically	Clear	Clear	Clear	Clear	Clear	NA	NA	NA

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