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Clinical outcomes of endoscopic submucosal dissection for large colorectal laterally spreading tumors in older adults☆

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ABSTRACT

Background and Aims: The colorectal endoscopic submucosal dissection (ESD) remains technically challenging, especially for older patients who frequently encounter complex chronic diseases and have a loose colon. However, only limited number of studies are available for the safety of ESD in older patients with especially large laterally spreading tumors. Therefore, in this retrospective study, we compared the outcomes of ESD for laterally spreading tumors (LST) ≥ 3 cm(cm) in older patients to that in younger patients.

Methods: Consecutive patients with LSTs 3 cm or larger were enrolled from May 2010–2016. These patients were divided into two groups: the younger group (<65 years) and the older group (≥ 65 years). The clinicopathologic findings and the outcomes of ESD procedures were compared between the two groups.

Results: A total of 70 patients in the younger group and 73 patients in the older group were treated by ESD for colorectal LSTs larger than 3 cm. No significant differences were observed in the gender ratio, tumor morphological type, tumor location, and tumor size between the two groups. The en bloc resection rates were 85.7 and 89.0%, respectively, without a significant difference. The procedural time was similar between the younger and older patients (71.8 ± 34.7 min vs. 70.6 ± 29.5 min). The duration of hospital stay was not significantly different between the two groups (4.1 ± 2.2 days vs. 4.4 ± 2.5 days). No significant differences were observed between the two groups with respect to ESD-related complications including delayed bleeding, perforation, and stricture.

Conclusions: ESD appears to be an effective and safe method for LSTs larger than 3 cm in older patients.

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1. Introduction

The life expectancy in older patients has increased worldwide dramatically. The number of older individuals in China has also increased gradually in the recent years. In our daily endoscopic clinical practice, treating diseases in older people is common. Laterally spreading tumors (LSTs) are defined as lesions ≥ 10 mm, which extend laterally and circumferentially rather than vertically along the colonic wall. Previously, LSTs were usually removed by the endoscopic mucosal resection (EMR); however, such large tumors may usually require a piecemeal resection if resected by the EMR method [1,2]. Endoscopic submucosal dissection (ESD) was initially performed for early gastric cancer and is now also considered an effective method in en bloc manner to treat large colorectal neoplasia. Nevertheless, colorectal ESD remains technically challenging because of the anatomical characteristics of the colon, including a narrow lumen, thin walls, a sparse

muscle layer, and tortuous folds, which adversely affect the performance of ESD [3], especially for older patients who frequently encounter complex chronic diseases and have a loose colon. Thus, endoscopists are often reluctant to perform ESD for large LSTs owing to greater technical difficulty, prolonged procedural time, and consequently increased complications. However, only limited number of studies are available for the safety of ESD in older patients with colorectal tumors, especially large laterally spreading tumors [4,5]. In this retrospective study, we compared the outcomes of ESD for LST ≥ 3 cm in older patients to that in younger patients.

2. Methods

2.1. Patients

This is a retrospective cohort study including patients who had undergone colonic ESD for LSTs at a large-volume, tertiary-care endoscopy center. Data from May 2010–2016 were collected. The study was approved by ethical committees of Zhongshan hospital. The inclusion criteria for the patients were as follows: 1) age >20 years, 2) newly diagnosed LSTs ≥ 30 mm in diameter located in the colorectum as assessed

☆ There is no conflict of interest in this study.

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by colonoscopy. The exclusion criteria were biopsy-confirmed invasive cancer, failed tolerance to the procedure owing to severe cardiopulmonary or renal comorbidities, pregnant and lactating women, and non-lifting sign after submucosal injection. Patients with ≥ 2 lesions of LSTs were also excluded from this analysis. The included patients were categorized into two groups according to the age: an older group consisting of patients ≥ 65 -year-old and a younger group consisting of patients < 65 -year-old. LSTs were divided into two subtypes according to the endoscopic presentations: LST-Gs with nodules or granules distributed evenly or not on the surface of the lesion and LST-NGs with a smooth surface without nodules or granules. LST-Gs were further divided into homogeneous (LST-G-H) and nodular mixed (LST-G-M), and LST-NGs were divided into flat-elevated (LST-NG-F) and pseudo-depressed (LST-NG-PD) [6].

2.2. ESD Procedure

All the included patients were admitted to our institution two days before ESD and evaluated by the anesthesiologist. Patients administering

oral aspirin or antiplatelet agents were requested to discontinue the medication at least five days prior to the procedure. After receiving full communication about the ESD procedure, all patients signed the informed consent and underwent ESD under general anesthesia (intravenous anesthesia). ESD was performed by experienced operators (XMD, ZPH, CWF, ZYS) with sufficient expertise in ESD (>100 ESDs of the colon) (Fig. 1). The procedures of colorectal ESD were described previously [7–9]. Consequently, all patients had to fast at least 24 h. The doctors advised the time to begin oral intake according to the patients' abdominal symptoms, temperature, and blood examinations.

2.3. Histopathological Assessment

The histopathological diagnosis was based on the classification by World Health Organization [10]. The lesion size, depth of invasion, degree of differentiation, resection margins, and lymphovascular invasion were evaluated histopathologically. The “en bloc resection” was defined as a tumor removed in a single piece. “En bloc R0 resection” was defined

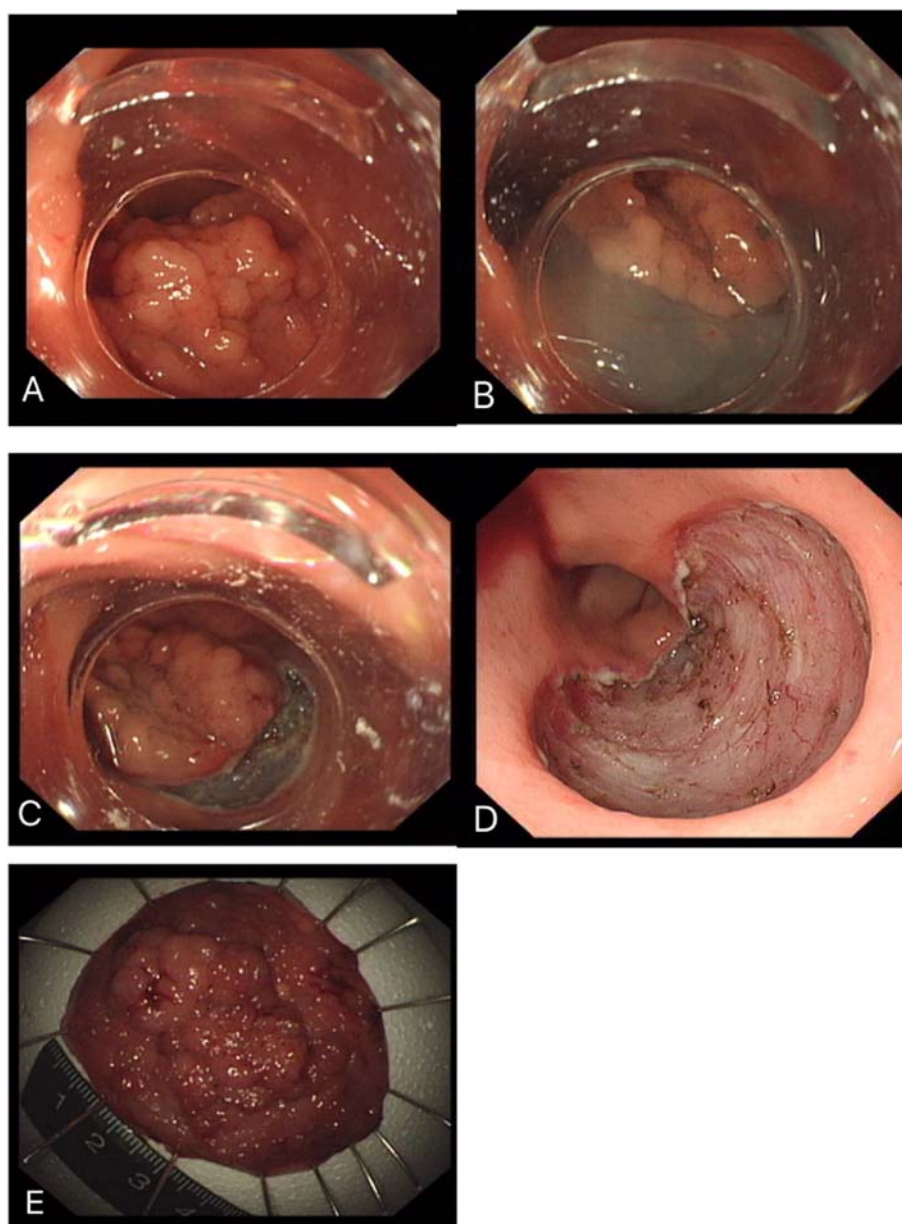


Fig. 1. A. A 5 cm LST in the rectum. B. After injection of the lesion. C. Full circumferential mucosal resection was performed. D. The ulceration after removal of the lesion. E. The resected specimen.

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