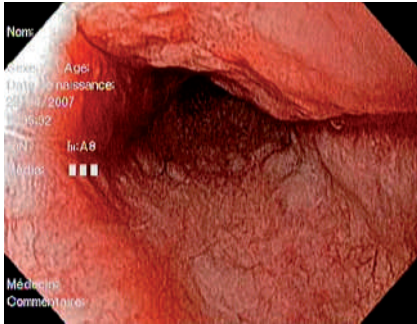


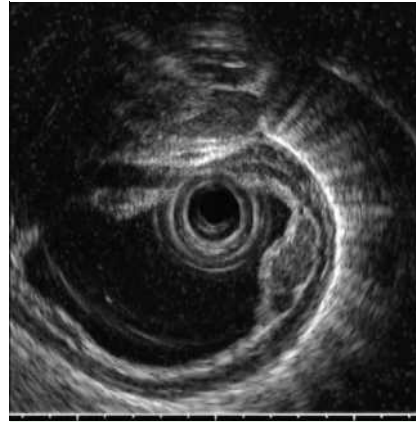
## Esophageal varices and early esophageal cancer: can we perform endoscopic mucosal resection (EMR)?



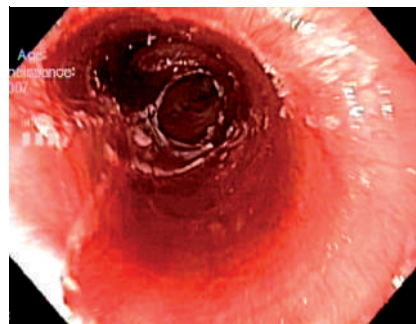
**Fig. 1** A superficial carcinoma type 0-IIb, 5 cm in length, stretched over three-quarters of the esophageal circumference (patient #4).



**Fig. 2** Endoscopic view of the upper part of the lesion after Lugol 2% chromoscopy. Note the unstained pink/orange neoplastic area (patient #4).



**Fig. 3** Esophageal varices in the submucosa beneath the lesion as demonstrated by endoscopic ultrasound examination. Lesion staged uT1mN0 (patient #4).



**Fig. 4** Endoscopic aspect immediately at the end of the endoscopic mucosal resection session (patient #4).

We present four patients (#1–4) with esophageal varices due to alcoholic liver cirrhosis diagnosed between June 2006 and July 2007 with early esophageal squamous cell carcinoma (SCC). Cancers were treated by endoscopic mucosal resection (EMR).

Patients were male smokers with a mean age of 64 years. Cirrhosis classifications were Child–Pugh A or B (6 or 7 points), and variceal grades were 1 or 2 [1]. Two patients had a history of esophageal variceal ligation (EVL) for primary (#4) and secondary (#2) variceal bleeding prophylaxis, 3 and 5 years before current cancer diagnosis, respectively.

Cancers were found during cirrhosis initial evaluation (#1 and #3) or esophageal varices surveillance (#2 and #4). Lesions were superficial type 0-II [2], were 2–5 cm in length, occupied a third to three-quarters of the esophageal circum-

ference, and were staged uT1N0 by endoscopic ultrasound (EUS). EUS also noticed esophageal varices passing in the submucosa beneath the lesions (● Fig. 1–3).

Before EMR, variceal eradication by EVL (1–3 sessions) was carried out in all patients except one (#1), in whom ligation was performed at the same time as EMR. All lesions were resected piece-meal using the cap-assisted technique during a single EMR session (● Fig. 4). There were no complications apart from two immediate bleedings, which were stopped by metallic clips (#2) and hot forceps (#4). Coagulation factor V level was 58% to 92%, and platelet count was 88 000/cmm to 158 000/cmm.

One patient (#2) died of mesenteric infarction 1 week after EMR, whereas the

other three patients were disease free after a median follow-up of 7 months (range 5–17).

Three similar reports were found in the literature [3–5], in all cases sclerotherapy or EVL were done before EMR. Here for one patient EVL was done at the same time as EMR.

Overall EMR is feasible for early esophageal SCC in liver cirrhosis patients with esophageal varices.

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### Bibliography

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