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Rectal Carcinoid Tumors: Pitfalls of Conventional Polypectomy

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See “Endoscopic Resection for Rectal Carcinoid Tumors: Comparison of Polypectomy and Endoscopic Submucosal Resection with Band Ligation” by Sang Heon Lee, Seun Ja Park, Hyung Hun Kim, et al., on page 89-94

Endoscopic therapy has been accepted as an appropriate and safe therapeutic option for small (≤ 10 mm), well-differentiated rectal carcinoid tumors without any signs of infiltration to the muscularis propria, lymphovascular invasion, or lymph node metastases. However, in terms of both complete resection and complications, the best modality of endoscopic therapy is a matter of debate. The article by Lee et al.¹ suggests endoscopic submucosal resection with band ligation (ESMR-L) as a feasible method with a lower rate of complication and a higher rate of the complete resection in comparison to conventional polypectomy.

Since the incidence of rectal carcinoid tumors is recently on the rise by the widespread performance of screening colonoscopy and the size of the tumors is also becoming smaller when they are incidentally identified, endoscopic therapy such as snare polypectomy is frequently performed in various medical facilities including private clinics.² However, rectal carcinoid tumors demonstrate various clinical behaviors, from benign to metastatic tumors, although they are relatively slow-growing.³ Therefore, complete resection is important; however, conventional polypectomy has a high possibility of incomplete resection due to slipping during snaring. Furthermore, rectal carcinoid tumors originate from deep mucosal layer and invades submucosal layer; conventional polypectomy is more appropriate for the management of tumors originating from the mucosal layer.⁴ This article high-

lights the potential risk of remnant tumors using conventional polypectomy by showing a high rate of incomplete resection (19/55, 34.5%) compared to ESMR-L (2/33, 6.1%).

However, this study is limited by its retrospective design, the small number of patients enrolled in the study (33 cases in ESMR-L vs. 55 cases in conventional polypectomy), and participation of only two institutions which differed in their preferred endoscopic resection methods, as mentioned in the article. Accordingly, further multi-center, large-scaled studies for comparing the rate of complete resection and complications among various modalities of endoscopic therapies are warranted. In addition, how to treat remnant tumors left by incomplete resection after primary resection by either conventional polypectomy or ESMR-L deserves consideration. Particularly, because the rate of incomplete resection in even ESMR-L (2/33, 6.1%) is not low enough to be considered safe, residual scars by ESMR-L are wider and deeper than those by conventional polypectomy, and resection of the remnant tumors is not as simple as primary resection because of the submucosal fibrosis of residual tissue, it is questionable how 21 patients with remnant tumors by incomplete resection (two patients in ESMR-L and 19 patients in conventional polypectomy) were treated after confirmation of the positive resection margin. In a recently published article concerning the salvage therapy for remnant rectal carcinoid tumors,⁵ although all patients with a positive resection margin showed negative endoscopic and histological findings on a biopsy of the scarred tissue during the surveillance by endoscopic follow-up, the pathologic results from all tissues obtained by salvage resection proved to be microscopic margin positive. This implies that a biopsy alone should not be used to confirm the absence of remnant tumors because of false negative results due to embedding of the residual remnant tumor during tissue healing after the primary resec-

Received: March 3, 2012 Revised: March 6, 2012

Accepted: March 12, 2012

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tion. Thus, cases with a positive resection margin require salvage resection. Thereby, careful selection of an appropriate primary resection method for complete resection is important to avoid salvage therapy of remnant carcinoid tumors.

Nevertheless, this article is significant to reaffirming the risk of conventional polypectomy as a modality of endoscopic therapy for rectal carcinoid tumors in terms of incomplete resection and to corroborate the feasibility of ESMR-L as a therapeutic option with a relatively high rate of complete resection and a low rate of complications.

Conflicts of Interest

The authors have no financial conflicts of interest.

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