SPEAKER 1: Thank you very much. Are there any questions from the live case presentations? All right.

AUDIENCE: Thank you for the nice talks. How important is it to dissect deep in the submucosa for the mucosa preserving EFTR to preserve the mucosa integrity so the mucosa survives when you put it back?

SPEAKER 2: Pardon me, how important--

AUDIENCE: So you know when you are basically closing the defect by putting the mucosa back, the vascular supply is going to be compromised because you have cut the muscles. Now, if you dissect deep in submucosa, you might still preserve some collateral vasculature? Is that a consideration to go deeper into submucosa when you dissect?

SPEAKER 2: Actually, the vessel, like the blood supply is one problem, and another problem is musocal retract. So if you preserve more of the submucosa tissue, actually it makes it easier for you to put the mucosa back and make the final closure. So that's why we actually cut only over the semicircle, and we tried to actually preserve more of the submucosa tissue for the final closure.

AUDIENCE: Thank you so much. I had one more question. Are there any considerations when you're doing let's say early gastric cancer or there's-- in terms of carcinoma, and you have a full thickness resection, when do you start worrying about peritoneal seeding? Because oftentimes you know there are some case reports of peritoneal seeding in the setting of EST with EFTR.

SPEAKER 2: Sorry?

AUDIENCE: Sorry. I'm sorry, so if you have an early gastric cancer, and you're trying to remove that and you go do it in EFTR, some area is scarred and you cannot remove it, it goes in EFTR, do you worry about peritoneal seeding?

SPEAKER 2: Actually, if you do the full thickness resection, I think-- usually I don't worry so much about that because you actually resect the tumor a little bit exceeding the border of the tumor itself, so you are not actually touching the tumor itself. You are dissecting the tumor around the border. And another thing is you can use maybe floss tied on the under clip to actually retract the tumor so that the tumor won't fall inside the abdominal itself.

AUDIENCE: Thank you so much.

SPEAKER 2: You're welcome.

SPEAKER 1: OK, there are some questions from the audience though that I have to answer, and the first one was exactly what you just asked. For a full thickness resection in general that leads to the peritoneal cavity, what about risk for peritoneal seeding for an early cancer? You have to keep it in the lumen. You've got to make sure it stays in the lumen. These are prevalent concerns.

There was a US working group on full thickness resection, and that was one of the main issues that came up to be addressed is how can we maintain oncologic principles and not seed the abdominal cavity when full thickness resection is done for a variety of malignancies that are non-capsulated? So this is a risk. But the answer right now, immediate answer, is keep it in the gastric or the colonic cavity.

The other question that came up for full thickness resection is is antiseptic lavage needed to be done post-procedure? Again, that's been studied in NOSCAR, and the answer to that, the quick answer to that is no. If you're doing a full thickness resection and it happens to be dirty, you're in the colon, and the colon is a less than ideal prep and there is a lot of soiling, you really should clean it up afterwards. So you know, saline, lavage, and irrigation just as if a patient came in with a perforated ulcer that was 48 hours old, you would be lavage the abdominal cavity. So if you've got a relatively clean environment, you're able to keep up with things, there shouldn't be any concern about having to lavage the luminal cavity post-procedure.

Oh, this is a great one. If a patient has failed a prior Heller with a posterior Toupet, what approach would you use for a POEM procedure? So we've got the anterior approach knocked off because the Heller myotomy is done anteriorly laparoscopically, and now the Toupet has been created behind the stomach, posterior, which is a little odd. So what approach can you take? You can frankly make a tunnel in any location around the circumference of the esophagus, and so if you wanted to, you could go at the 9 o'clock position.

That would be between the anterior and poster walls. That would take you towards the greater curve. That could be a difficult passage across the EG junction, which then you're going to drop down into the fundus there. And it's a fairly acute angle. Otherwise, you probably could get away with going posteriorly. That would be my take on that because the Toupet shouldn't interfere too much with that approach. So I'd probably go in between.

Let's see. And here's a good one. Do you worry about mucosal vascular insufficiency post mucosal EFTR? Mucosal soaring? What do you think this is? Oh, I think this-- this was the question that might have been raised about--

SPEAKER 3: Mucosal sparing.

SPEAKER 1: Mucosal sparing EFTR. I think you've answered that. The question I had was there's very noticeable retraction of mucosa once you expose it and cut it out, and I suppose, you could pull it together provided the defect isn't too big, and you can cross it over, but you haven't experienced that.

SPEAKER 2: So far the largest tumor we have ever found [INAUDIBLE] the mucosal [INAUDIBLE] is 3 centimeters.

AUDIENCE:

[INAUDIBLE]

SPEAKER 2: We can still put the mucosa back successfully. So so far, the largest tumor we have resected and used the mucosal preservation is 3 centimeters in size. Yeah, and we have a little bit problem with the mucosal retraction, but still with small incisions on the mucosa, it's easier to actually clutch the mucosa back and drag it, finally make the mucosa. Close the mucosa and the wound.

SPEAKER 1: And I've got a question for her. Thank you very much. So a patient who has had a Heller myotomy and a posterior Toupet, what tunnel approach would you use?

AUDIENCE: Me?

SPEAKER 1: Yeah.

AUDIENCE: For the person who had [INAUDIBLE] as we know, for surgeries always cut to the anterior wall. So [INAUDIBLE] posterior wall to [INAUDIBLE] muscle, and for the pump [INAUDIBLE] positioning or [INAUDIBLE] the patient is in a supine position, the knife comes from 6 o'clock. So [INAUDIBLE] center. [INAUDIBLE] interior wall, otherwise [INAUDIBLE] the posterior. But I want to say the big advantage of the POEM, that is we can make a tunnel at any direction. Right, left, anterior, posterior. At the [INAUDIBLE] 5 centimeters, 7 centimeters, 10 centimeters. I think this is a big advantage of the POEM procedure.

SPEAKER 1: I agree with you. The only concern I would have would be heading towards the lesser curve. The left gastric and its branches up into the esophagus tend to cluster in that area, so I would be a little nervous about that location.