

OESO Newsletter – February 2022

Message to the members of OESO,
and to all those who have interest in Esophagology



The OESO-SEMPIRE VIRTUAL EDUCATIONAL CHANNEL 17th meeting

Hosted by

Beijing, Shanghai and Guangzhou
OESO-SEMPIRE Pilot Centers

Tuesday, February 22, 2022

- **Asia: China**
8 – 10 pm
 - **Europe CET**
Paris: 1 – 3 pm
 - **North America:**
West Coast: 4 – 6 am
East Coast: 7 – 9 am
 - **South America:**
São Paulo, 9 – 11 am
 - **Africa:** Bomet, Kenya, 3 – 5 pm
 - **Malaysia:** 8 – 10 pm
 - **Australia:** Melbourne,
11 pm – 1 am (Feb 23, 2022)
- Zoom technology applied



Special address by Professor Jie He

Director, National Cancer Center (NCC) of China
President, Cancer Hospital
Chinese Academy of Medical Sciences

Case 1

Immunotherapy-induced pneumonia following neo-adjuvant chemoradiation plus PD-1 inhibitor in a patient with locally advanced esophageal squamous cell carcinoma.

GIST OF THE 1ST CASE

A 61-year-old female with a lesion at the lower thoracic esophagus found by gastroscopy in routine check-up.
– Squamous cell carcinoma confirmed by biopsy.

Presentation of the case: Yong Yang – Zerui Zhao (Guangzhou)

- EUS and contrast CT scan showed a cT2N1 locally advanced esophageal squamous cell carcinoma.
- Normal respiratory function and diffusion capacity.

The patient signed a consent for participation in a phase II trial (NCT04006041) on feasibility of combination of Toripalimab (PD-1 inhibitor) and neoadjuvant chemoradiation in esophageal cancer.

- Chemoradiation on April 1st, 2021, with
 - 44 Gy in 20 fractions over 4 weeks.
 - 4 cycles of Paclitaxel with Cisplatin carried out weekly simultaneously.
 - 2 doses of PD-1 inhibitor on day 1 and day 22 during the same time.
- Re-do EUS showed tumor shrinkage (Figure 1), but the subcarinal lymph node (endo-bronchial ultra-sound guided needle aspiration) suggested the existence of several atypical cells tumor metastases suspected.
- Minimally invasive McKeown esophagectomy performed about 8 weeks following completion of neoadjuvant treatment.
- The pathological report showed a pathological complete response with no evidence of tumor in both primary tumor and resected lymph nodes.

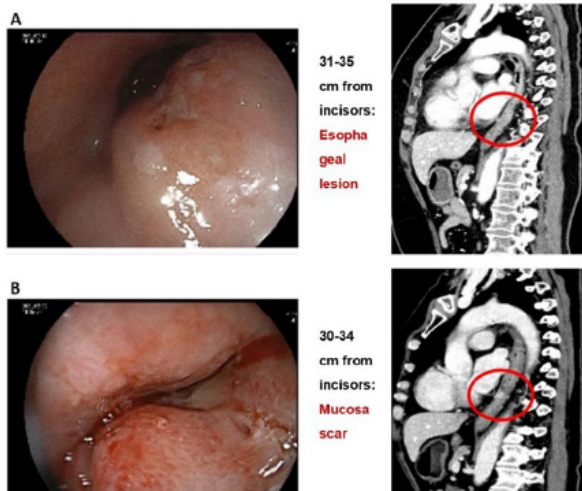


Figure 1:
EUS and CT images
before (A)
and after (B)
neo-adjuvant
treatment showing
tumor shrinkage

The development of pulmonary dysfunction required mechanical ventilation during the first postoperative week, but the symptoms of dyspnea did not remiss following antibiotic treatment (Figure 2).

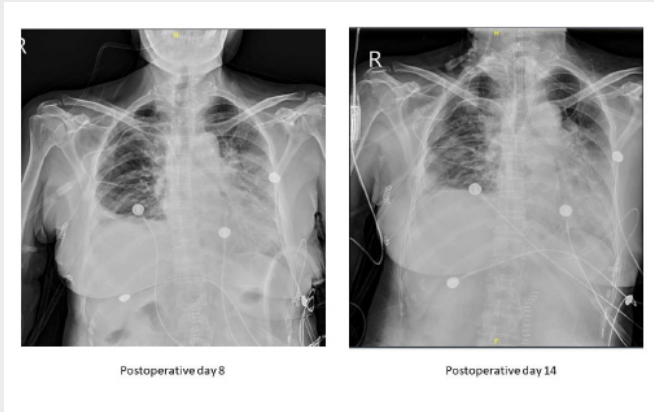


Figure 2:
Chest X-ray showing pulmonary effusion persisting after antibiotherapy

Besides, only mild elevation of white blood cells and procalcitonin was found by several blood tests.

A CT scan carried out on postoperative day 15 showed bilateral lung effusion and pneumonia (Figure 3).

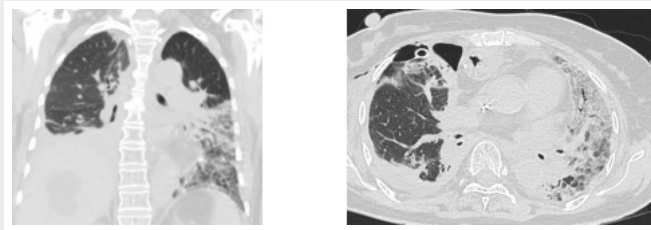


Figure 3:
CT scan performed 15 days postoperatively showing extensive bilateral effusion and pneumonia

Hence, the multi-disciplinary team specialists in our Institute suggested that the patient might be experiencing immunotherapy induced pneumonia.

- Administration of Prednisolone / 10 days resulted in significant remission of the pneumonia showed by CT scan on postoperative day 25 (Figure 4).

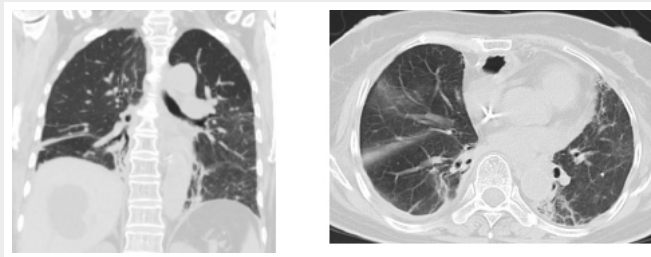


Figure 4:
CT scan performed 25 days postoperatively (10 days) following administration of prednisolone showing regression of pneumonia

The patient was discharged on postoperative day 27 and recovered uneventfully in the out-patient visit 6 months after surgery.

Discussion – Moderator: Yousheng Mao (Beijing)

- Yongtao Han (Sichuan) – Jufeng Liu (Hebei) – Yin Li (Beijing) – Zhigang Li (Shanghai) – Zhen Wang (Beijing)
- Stéphane Bonnet (Paris) – Stefan Mönig (Geneva) – Michael Mwachiro (Bomet, Kenya) – Edoardo DeMoura (Sao Paulo) – Matthew Read (Melbourne)

Summary: Jianhua Fu (Guangzhou)



Case 2

Removal of an esophageal foreign body penetrating into the mediastinum by minimally invasive transcervical mediastinoscopy-assisted approach

Background

Ingestion of foreign bodies, especially animal bones, is one of the most common endoscopic emergencies, especially in China. Foreign bodies can be fishbones, pills, capsules, bottle lids and even false teeth. Fortunately, most of them can be easily be removed by skilled endoscopists, thanks to the development of endoscopic techniques. Only 1% or less require surgery, including foreign bodies with sharp-ends which penetrate the esophageal wall, causing esophageal perforations and remaining in the mediastinum space. The perforating esophageal foreign bodies may cause severe complications, including bleeding and migration.

Traditional approach can be surgery through cervical skin incision. However, for foreign bodies which penetrate in the thoracic esophagus (more than 20 cm from incisors), cervical approach may not be effective and surgery through the chest wall would be inevitable.

In our case, instead of a traditional transcervical approach, we tried a novel, minimal invasive approach with the help of a mediastinoscope.



A 65-year-old woman swallowed a fishbone 10 hours before she was admitted to our hospital with substernal pain.

Presentation of the case: Lijie Tan – Zongwei Chen (Shanghai)

- CT scan and EUS showed upper-thoracic esophageal perforation caused by a foreign body, the distal end being at the level of aortic arch.

The foreign body was located outside the esophageal wall and was adjacent to the upper edge of the aortic arch.

- A transparent cap was attached to the front of the endoscope, showing a longitudinal ulcer, about 0.8 cm/length, 20 cm from the incisors.
- A hook knife was used to cut the esophageal wall along the damaged area, and to expose the submucosal and muscular layers. In spite of careful examination, no foreign body was found.
- After hemostasis with hot biopsy forceps, the wound was closed with clips (Figure 1).

Surgery was therefore needed.

The patient was placed in supine position under general anesthesia with bilateral lung ventilation.

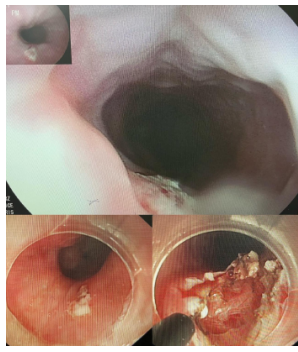


Figure 1:
Endoscopic
procedures

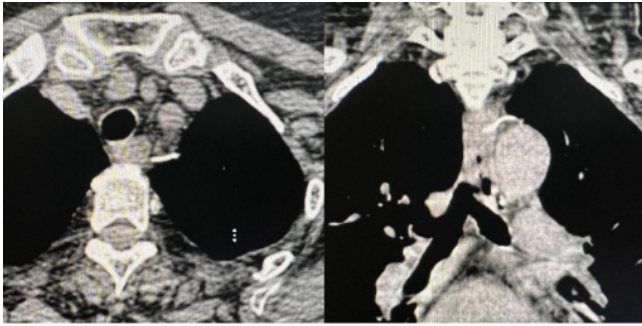


Figure 2:
CT scan prior to
surgery

- A 5cm incision was made about 1cm lateral to the SCM.
- A lap-protector (*FF00707 Hakko Co Ltd, Japan*) with matched retractor (*Hakko Co Ltd, Japan*), each pre-inserted with three E-Z Trocars (*5-70mm Short Hakko Co Ltd, Japan*), was inserted into the cervical incision.

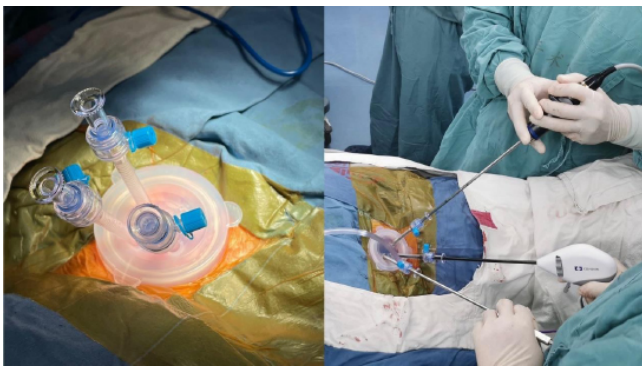


Figure 3:
Cervical skin incision
and port placement
for transcervical
approach

- Carbon dioxide was insufflated at a pressure of 8mmHg into the mediastinum to enlarge the very limited mediastinal surgical field, and VISERA ELITE II System OTV-S300 with deflectable laparoscope (*Olympus Corporation, Tokyo Japan*) was used as mediastinoscope to ensure the maximal surgical view for the operator.
- The operator first inserted a *Ligasure™ Maryland Jaw sealer (Medtronic)* held in the right hand into the upper mediastinum under endoscopic vision, and then inserted a suction stick (which also acted as a retractor) held in the left hand set into the upper mediastinum to provide counter traction on the operative field and remove smoke produced by Ligasure. In the meantime, the assistant surgeon controlled a 5mm Olympus deflectable laparoscope.
- Mobilization of the upper thoracic esophagus was then performed, starting from the left and posterior side of the esophagus.
- The tip of the fishbone was found in the mediastinum before reaching the aortic arch, and a dissecting forceps was used to remove the whole fishbone from the mediastinum.
- The incision was closed after a drainage tube was placed in the surgical field. The patient was discharged two days after surgery and had a quick recovery.

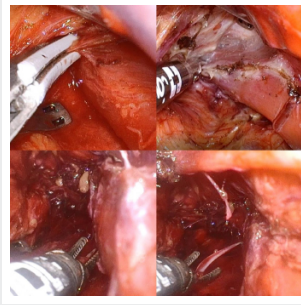


Figure 4:
Mediastinoscopic
procedure



Figure 5:
Cervical incision and
the fishbone

Discussion

For most cases of esophageal foreign bodies, a gastroscopie is effective. However, once penetrating the esophageal wall, the foreign body cannot be found by gastroscopie, and surgery is needed. In this case, referring to mediastinoscope and laparoscope-assisted esophagectomy,

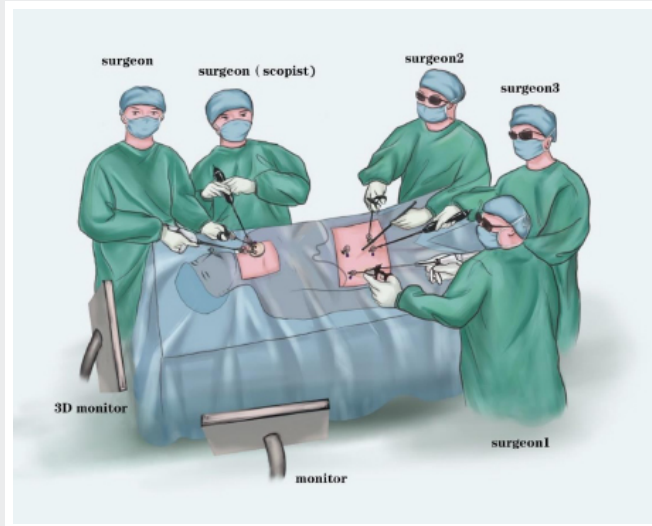


Figure 6

we used the minimally invasive transcervical approach with the help of a deflectable laparoscope to remove the foreign body in the mediastinal space

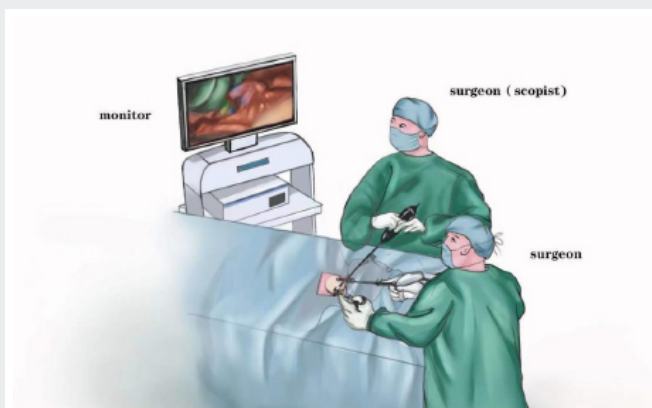


Figure 7

Preoperative workup is crucial, to investigate the location of the foreign body as to the surrounding important tissues and organs or arteries.

Previous reports demonstrated that CT was useful for a precise, definitive diagnosis of an esophageal foreign body, or when complications were suspected.

CT should be performed again before surgery, because of the risk of migration of the foreign body following the previous maneuvers such as EUS, or movements of the patient.

Discussion – Moderator: Zhentao Yu (Shenzen)

- Keneng **Chen** (Beijing) – Wentao **Fang** (Shanghai) – Xuefeng **Leng** (Sichuan) – Liang **Dai** (Beijing) – Xufeng **Guo** (Shanghai)
- Stéphane **Bonnet** (Paris) – Stefan **Mönig** (Geneva) – Michael **Mwachiro** (Bomet) – Edoardo **DeMoura** (Sao Paulo) – Matthew **Read** (Melbourne)

Summary: Lijie Tan (Shanghai)



Registration is free, but mandatory:

Free registration



*Eighteen Pilot Centers worldwide are currently listed in the network of the OESO-SEMPIRE Platform of Excellence in Esophagology to take part in the program of the **OESO Virtual Educational Channel** in Esophagology. Such a program is in line with true multi-disciplinarity, the essence of OESO since its creation, and the mission defined by UNESCO in the **Chair of Digital Education** attributed in 2018, at the University of Geneva, to the OESO Foundation.*



The first sixteen "Staff meeting discussions" were organized in

- **2020:** May 28 (Pilot Center of Milan), July 22 (Pilot Center of Stanford), October 3 (Pilot Center of Bomet, Kenya), October 29 (Pilot Center of Beijing), December 10 (Pilot Center of Geneva),
- **2021:** January 29 (Pilot Center of Melbourne), February 25 (Pilot Center of Bordeaux), March 19 (Pilot Center of Stanford), April 15 (Pilot Center of Paris), May 26 (Pilot Center of Milan), June 23 (Pilot Center of Sao Paulo), August 21 (Asian Pacific Digestive Week), October 19 (Pilot Center of Mainz), November 22 (Pilot Center of Bordeaux), December 9 (Pilot Center of Geneva) and
- **2022:** January 20 (Pilot Center of Kota Bharu).



- **Wherever you are in the world,**
- **Whatever your specialty,**
- **Whatever your level,**

the 17th clinical case of the OESO-SEMPIRE Platform will afford you the opportunity to participate in a global multidisciplinary staff meeting dedicated to 2 challenging cases of esophagology. It will involve specialists in various disciplines, and participants from any country can connect to the discussions.

Looking forward to seeing you soon!

Robert Giuli, MD, FACS

Professor of Surgery

Founder & Deputy Executive Director of OESO

The next clinical case coming up for discussion will be proposed in March by the Pilot Center of Boston, headed by Prof. Hiroshi **Mashimo**.

Date and details on time will be announced on the OESO website and in next Newsletters.

OESO Head Office
2, Bd Pershing
75017 Paris, France
Tel. + 33 (0)1 55 37 90 15
email: michele.liegeon@oeso.org
www.oeso.org



OESO will not supply your Personal Data to any third party for marketing purposes, whether directly or indirectly.

This email has been sent to nicole.schranz@architecturevisualdesign.ch
You received this email because you are registered by OESO.

[Unsubscribe](#)



© 2022 OESO

[Show in browser](#)