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Combined Laparoscopic-Endoscopic Techniques for Removal of Small Gastric Tumors: Advantages and Tricks

Dear Editor,

We read with great interest the article entitled “Endoscopic full-thickness resection combined with laparoscopic surgery” published by Kim.¹ This article discussed the minimally invasive techniques for the removal of small gastric tumors that do not require wide gastric resection.

Up to now, minimally invasive techniques for the removal of small gastric tumors include endoscopic and combined laparoscopic-endoscopic resections. Furthermore, the combined laparoscopic-endoscopic resection can be categorized as “cut first and then suture” and “suture first and then cut”.

We agree with the author that removing the lesion from the inside of the gastric cavity is advantageous for the treatment of stromal and/or small tumors, which allows for a direct endoscopic visualization of the tumor during resection and avoids excessive gastric tissue resection in addition to all of the advantages for minimally invasive approaches.^{2,3}

Some authors, including us, have previously performed a combined laparoscopic-endoscopic removal of gastric tumors.^{2,4-6} In our case, the tumor was an iuxta-cardial gastrointestinal stromal tumor. In the technique that we described previously,⁴ two 5-mm radially expandable trocars were inserted into the gastric cavity through the abdomen and then the gastric walls. An endoscopic polypectomy snare was introduced through the mouth, which was used to grasp and gain traction on the gastric iuxta-cardial lesion, allowing for good exposure of the excision site. The iuxta-cardial lesion was excised with its full thickness by laparoscopy and placed in a small plastic bag. After the specimen was retrieved through the mouth by means of the endoscopic snare, the gastric holes were laparoscopically sutured.

However, we would like to draw attention to some very important features that were not discussed by Kim.¹

First, either endoscopic or combined laparoscopic-endoscopic resection of gastric tumors enables the surgeon to resect tumors situated at the gastric location that are difficult to reach by open or laparoscopic surgery.

Secondly, the author did not describe whether the specimen was pulled away from the mouth via the endoscopic snare during the laparoscopic and endoscopic cooperative surgery, as we did in our described technique,⁶ or through an abdominal wall incision by laparoscopy after it was placed in a plastic bag.

Thirdly, it is possible to spare the vagus nerve branches at the outer gastric wall by the minimally invasive techniques cited above, since sparing the tissue around the tumor is easier and safe to perform, and gastric stasis may therefore be avoided.

Conflicts of Interest

The authors have no financial conflicts of interest.

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