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Sat. Nov 21, 2026 1:30 PM - 2:45 PM JST | Sat. Nov 21, 2026 4:30 AM - 5:45 AM UTC | Room 5 (1F 102)

Symposium 8 Cutting edge of endoluminal/ transanal surgery for colorectal cancer

Moderator: Kotaro Maeda (Himawari Seishinkai Izumi Clinic Medical Checkup Plaza, Japan), Motohiko Kato (Center for Diagnostic and Therapeutic Endoscopy, Keio University School of Medicine, Japan)

[SY8-1] Re-positioning of Endoscopic Ultrasonography in Determining the Treatment Strategy for Colorectal Cancer Suspected of Submucosal Invasion

*Noriko Matsuura[1], Kaoru Takabayashi[2], Motohiko Kato[2] (1. Division of Research and Development for Minimally Invasive Treatment, Cancer Center, Keio University School of Medicine, Japan, 2. Center for Diagnostic and Therapeutic Endoscopy, Keio University School of Medicine)

[SY8-2] Efficacy and Safety of the Water Pressure Method in Colorectal ESD: A Retrospective Comparative Study

*Yutaka Sato[1], Daisuke Minezaki[1], Koshiro Tsutsumi[1], Sotaro Ozaka[1], Masahide Fukuda[1], Yuka Hirashita[1], Kensuke Fukuda[1], Ryo Ogawa[1], Masaaki Kodama[2], Kazuhiro Mizukami[1] (1. Department of Gastroenterology, Oita University Faculty of Medicine, Japan, 2. Department of Advanced Medical Sciences, Oita University Faculty of Medicine)

[SY8-3] Clinical Efficacy and Safety of Endoscopic Submucosal Dissection for Huge Rectal Tumors

*Takashi Akutagawa[1], Daisuke Yamaguchi[2], Ryo Shimoda[1], Motohiro Esaki[2] (1. Department of Endoscopic Diagnostics and Therapeutics, Saga University Hospital, Japan, 2. Division of Gastroenterology, Department of Internal Medicine, Faculty of Medicine, Saga University)

[SY8-4] Technical Innovations and Outcomes of Endoscopic Submucosal Dissection for Colorectal Lesions Involving Diverticula

*Ryosuke Kobayashi[1], Kingo Hirasawa[1], Shin Maeda[2] (1. Gastroenterological Center, Yokohama City University Medical Center, Japan, 2. Gastroenterology, Yokohama City University)

[SY8-5] Dual-operator Endoscopic Tandem Surgery (DuETs) for large colorectal lesions: comparison with single-operator ESD

*Takuma Okamura[1], Tomonari Ikeda[2], Tatsuki Ichikawa[2], Toshimitsu Miyaaki[1] (1. Department of Gastroenterology and Hepatology, Nagasaki University Hospital, Japan, 2. Department of Gastroenterology, Nagasaki Harbor Medical Center)

[SY8-6] Evaluation of the effectiveness of underwater colorectal ESD

*Yuko Miura[1], Yosuke Tsuji[1], Mithuhiro Fujishiro[1] (1. Department of Gastroenterology, Graduate School of Medicine, The University of Tokyo, Japan)

[SY8-7] Clinical Role of PAEM/ EID for pT1b Lower Rectal Cancer

*Yu Maruyama[1], Keigo Sato[1], Moe Aung Paing[1], Nozomi Furuichi[1], Keiichi Oshima[1], Yuki Itoi[1], Hirohito Tanaka[1], Hiroko Hosaka[1], Shiko Kuribayashi[1], Toshio Uraoka[1] (1. Department of Gastroenterology and Hepatology, Gunma University Graduate School of Medicine, Japan)

[SY8-8] Feasibility of Peranal Endoscopic Myectomy for Lower Rectal Lesions: A Single-Center Prospective Observational Study

*Takashi Kanesaka[1], Yoshiaki Ando[1], Shunsuke Yoshii[1], Minoru Kato[1], Yoshimi Tanaka[1], Sachiko Yamamoto[1], Koji Higashino[1], Noriya Uedo[1], Tomoki Michida[1], Ryu Ishihara[1] (1. Department of Gastrointestinal Oncology, Osaka International Cancer Institute, Japan)

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[SY8-9] Treatment Strategy for T1 Rectal Adenocarcinoma with Extensive Involvement of the Anal Canal: ESD or Surgical Resection?

*Nobuhisa Minakata[1], Makoto Arashiyama[1], Arisa Takeda[1], Yuichiro Mikuriya[1], Kazuo Shiotsuki[1], Kohei Takizawa[1] (1. Department of Gastroenterology, Kanagawa Cancer Center, Yokohama, Japan)

[SY8-10] Efficacy and Safety of Collaborative Endoscopic and Surgical Treatment for Challenging Colorectal Neoplasms

*Hidehito Maeda[1], Fumisato Sasaki[1], Kenji Baba[2] (1. Department of Digestive and Lifestyle Diseases, Kagoshima University Graduate School of Medical and Dental Sciences, Japan, 2. Department of Digestive Surgery, Kagoshima University Graduate School of Medical and Dental Sciences)

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Symposium 8 Cutting edge of endoluminal/ transanal surgery for colorectal cancer

Moderator: Kotaro Maeda (Himawari Seishinkai Izumi Clinic Medical Checkup Plaza, Japan), Motohiko Kato (Center for Diagnostic and Therapeutic Endoscopy, Keio University School of Medicine, Japan)

[SY8-1] Re-positioning of Endoscopic Ultrasonography in Determining the Treatment Strategy for Colorectal Cancer Suspected of Submucosal Invasion

*Noriko Matsuura[1], Kaoru Takabayashi[2], Motohiko Kato[2] (1. Division of Research and Development for Minimally Invasive Treatment, Cancer Center, Keio University School of Medicine, Japan, 2. Center for Diagnostic and Therapeutic Endoscopy, Keio University School of Medicine)

＜Background＞
Endoscopic submucosal dissection (ESD) is one of the most precise staging modality of early colorectal cancers. ESD is increasingly performed for lesions suspected of submucosal (SM) invasion; however, the feasibility of curative ESD before treatment has not been fully investigated. Although depth diagnosis is mainly based on white-light and magnifying endoscopy, unexpected muscularis propria invasion is occasionally encountered. Endoscopic ultrasonography (EUS) enables tomographic visualization of the gastrointestinal wall and may therefore be useful for predicting the feasibility of ESD and differentiating T1 from T2 colorectal cancers.
＜Methods＞
We retrospectively investigated the relationship between EUS findings, histopathological depth of invasion, and vertical margin (VM) status in lesions treated with ESD among colorectal lesions suspected of SM invasion between June 2020 and June 2025.
EUS findings were classified according to our previously reported PREDICT classification as follows:
Type I: the third layer (submucosal layer) beneath the lesion was continuously and reproducibly preserved;
Type II: the third layer beneath the lesion was unclear;
Type III: thickening of the fourth layer (muscularis propria).
＜Results＞
Thirty-eight lesions were included in the analysis, including 10 proximal colon, 5 distal colon, and 22 rectal lesions. ESD and surgery were performed in 19 and 19 lesions, respectively. Histopathological depth was pT1a in 10 lesions, pT1b in 20 lesions, and pT2 or deeper in 8 lesions.
According to the PREDICT classification, 19 lesions were classified as Type I, 13 as Type II, and 6 as Type III. The pVM0 rate among the lesions treated with ESD was significantly higher in Type I lesions than in Type II lesions (94% [15/16] vs. 0% [0/3], p<0.01). The proportion of pT2 or deeper cancers was significantly higher in Type II/III lesions than in Type I lesions (47% [9/19] vs. 0%, p<0.01).
<Conclusions>
The PREDICT classification was useful for predicting the feasibility of ESD and differentiating T1 from T2 colorectal cancer.

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[SY8-2] Efficacy and Safety of the Water Pressure Method in Colorectal ESD: A Retrospective Comparative Study

*Yutaka Sato[1], Daisuke Minezaki[1], Koshiro Tsutsumi[1], Sotaro Ozaka[1], Masahide Fukuda[1], Yuka Hirashita[1], Kensuke Fukuda[1], Ryo Ogawa[1], Masaaki Kodama[2], Kazuhiro Mizukami[1] (1. Department of Gastroenterology, Oita University Faculty of Medicine, Japan, 2. Department of Advanced Medical Sciences, Oita University Faculty of Medicine)

[Introduction] Endoscopic submucosal dissection (ESD) is an established treatment for colorectal neoplasms but remains technically demanding and time-consuming. The water pressure method (WPM) has been introduced to improve submucosal visualization and facilitate dissection, but its clinical advantages in colorectal ESD remain unclear. This study aimed to evaluate the efficacy and safety of WPM compared with conventional ESD.
[Methods] We retrospectively analyzed 46 consecutive patients with colorectal lesions ≤50 mm who underwent ESD at our institution between January 2024 and April 2026. Patients were divided into a conventional group (n = 23) and a WPM group (n = 23), including cases with combined use of conventional and WPM techniques. Procedure time, dissection speed, resection outcomes, and adverse events were compared. A subgroup analysis based on operator expertise was also performed.
[Results] Lesion size was comparable between groups (23.0 [IQR 20.0–30.0] vs. 27.0 [22.0–35.0] mm, p = 0.233). The median resection area was 962 [618.5–1310.5] mm^2 in the conventional group and 1196 [899.5–1492.5] mm^2 in the WPM group (p = 0.153). Procedure time did not differ significantly between groups (89 [63–138.5] vs. 67 [38.5–116] min, p = 0.235). Dissection speed was significantly higher in the WPM group (16.20 [10.91–21.05] vs. 9.86 [7.07–11.75] mm^2/min, p = 0.0024). En bloc resection was achieved in all cases, and curative resection rates were comparable between groups (82.6% vs. 87.0%, p = 1.0). Regarding safety, intraoperative perforation and muscle layer injury each occurred in one case in both groups. Delayed adverse events occurred in one case in the conventional group and none in the WPM group, with no significant differences. In a subgroup analysis limited to board-certified endoscopists, dissection speed remained significantly higher in the WPM group (21.0 [15.6–30.8] vs. 10.89 [8.33–15.03] mm^2/min, p = 0.0014).
[Conclusion] WPM improves dissection speed while maintaining comparable efficacy and safety to conventional ESD.

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[SY8-3] Clinical Efficacy and Safety of Endoscopic Submucosal Dissection for Huge Rectal Tumors

*Takashi Akutagawa[1], Daisuke Yamaguchi[2], Ryo Shimoda[1], Motohiro Esaki[2] (1. Department of Endoscopic Diagnostics and Therapeutics, Saga University Hospital, Japan, 2. Division of Gastroenterology, Department of Internal Medicine, Faculty of Medicine, Saga University)

Background: Advancements in minimally invasive colorectal treatments have expanded the boundaries of endoscopic and transanal approaches. Technical improvements in endoscopic submucosal dissection (ESD) have enabled the treatment of giant tumors. This study evaluated the safety and clinical characteristics of ESD for giant rectal tumors.
Methods: A total of 81 cases of rectal tumors treated with ESD at our institution between 2015 and 2025 were analyzed. Patients were divided into two groups based on lesion diameter: Group A (≤50 mm, n=56) and Group B (>50 mm, n=25). We compared the treatment outcomes, complications, and patient backgrounds between the two groups. All procedures in Group B were performed by experts with experience in more than 100 ESD cases.
Results: The median procedure time was significantly longer in Group B (187.0 min) than in Group A (56.0 min) ($p < 0.001$). Conversely, the median dissection speed was significantly higher in Group B (27.14 mm^2/min) than in Group A (20.15 mm^2/min) ($p < 0.05$), suggesting that technical proficiency allows for efficient dissection, even in giant lesions. Regarding safety, Group B had significantly higher rates of severe fibrosis (64.0%, $p < 0.05$) and intraoperative perforation (12.0%, $p < 0.05$); however, all perforations were successfully managed by endoscopic closure. No significant differences were observed in the depth of invasion or lymphovascular involvement. Regarding patient background, Group B was characterized by a significantly lower BMI ($p < 0.05$) and a higher rate of regular laxative use ($p < 0.05$).
Conclusion: ESD for giant rectal tumors remains a challenging owing to the increased risk of fibrosis and perforation. However, advancements in endoscopic closure techniques have allowed for the avoidance of surgical intervention in cases of complications. ESD serves as a potent bridge between endoscopic and surgical resection. For cases where extreme difficulty or severe fibrosis is anticipated, integrating advanced techniques such as per-anal endoscopic myotomy or transanal approaches may further optimize treatment.

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[SY8-4] Technical Innovations and Outcomes of Endoscopic Submucosal Dissection for Colorectal Lesions Involving Diverticula

*Ryosuke Kobayashi[1], Kingo Hirasawa[1], Shin Maeda[2] (1. Gastroenterological Center, Yokohama City University Medical Center, Japan, 2. Gastroenterology, Yokohama City University)

Background
In recent years, ESD for tumors extending into colonic diverticula has been reported. However, technical challenges remain, including secure closure of perforations and prevention of specimen damage. Therefore, we evaluated the treatment outcomes and technical innovations of ESD performed at our institution.
Methods
This retrospective study was conducted at a tertiary referral center and included patients who underwent ESD for colorectal tumors involving diverticula, in which the diverticulum was included in the resection, between March 2013 and April 2026. Treatment outcomes and ESD-related adverse events were evaluated.
Results
A total of 22 patients were included, of whom 10 were male, with a median age of 76 years. Tumor locations were cecum/ascending colon/sigmoid colon in 2/17/3 cases, and macroscopic types were LST-G/NG/0-I in 7/10/5 cases. The median tumor and specimen sizes were 21 (10–52) mm and 32 (15–60) mm. Histological diagnoses were adenocarcinoma/adenoma/SSL/HP in 16/3/2/1 cases.
The median procedure time was 60 (20–200) minutes. A traction band was used in 13 cases, and the water pressure method (WPM) in 17 cases. Myotomy proximal to the diverticulum was performed in 6 cases to enlarge the diverticular space, thereby helping to prevent bleeding and specimen damage. All defects were successfully closed, using the reopenable clip-over-line method in 1 case and a dual-action tissue clip in 4 cases. CT was performed immediately after ESD in 21 cases, and extraluminal air was detected in 16 cases. No patients required emergency surgery. Localized peritonitis occurred in 4 cases, all of which were resolved with conservative management. No postoperative bleeding or delayed perforation occurred. En bloc, R0 and curative resection rates were 100%, 91%, and 91%, respectively. All cases undergoing myotomy achieved R0 resection.
Conclusions
ESD for colorectal lesions involving a diverticulum appears to be an effective and safe treatment option when performed with appropriate adjunctive techniques, including WPM, short myotomy, and reliable defect closure.

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[SY8-5] Dual-operator Endoscopic Tandem Surgery (DuETs) for large colorectal lesions: comparison with single-operator ESD

*Takuma Okamura[1], Tomonari Ikeda[2], Tatsuki Ichikawa[2], Toshimitsu Miyaaki[1] (1. Department of Gastroenterology and Hepatology, Nagasaki University Hospital, Japan, 2. Department of Gastroenterology, Nagasaki Harbor Medical Center)

Background: Large colorectal lesions remain challenging for endoscopic submucosal dissection (ESD) because poor visualization, insufficient traction, and bleeding may prolong the procedure. We developed Dual-operator Endoscopic Tandem Surgery (DuETs), in which two therapeutic endoscopes are used simultaneously: the primary operator performs dissection while the assistant provides traction, suction, hemostasis, insufflation/deflation control, and injection.

Methods: We retrospectively reviewed colorectal ESD for lesions ≥20 mm from January 2020 to April 2026. The primary analysis included expert-performed cases after DuETs introduction in January 2024 and compared DuETs with single-operator ESD. Cases discontinued because of suspected deep invasion, appendiceal involvement, diverticular extension, or anal canal involvement were excluded. The primary outcome was resection speed; secondary outcomes were procedure time, en bloc/R0 resection, and adverse events. A subgroup analysis was performed for lesions ≥40 mm.

Results: The primary analysis included 60 DuETs lesions and 37 single-operator ESD lesions. Median lesion size was larger with DuETs (32.5 vs 24.0 mm), whereas procedure time was not prolonged (30.5 vs 37.0 min). Resection speed was higher with DuETs (35.97 vs 24.98 mm^2/min). En bloc resection was achieved in all cases, and R0 resection rates were 100% and 94.1%. Intraoperative adverse events occurred in 2 vs 1 cases, and postoperative adverse events in 1 vs 0 cases. In lesions ≥40 mm, DuETs shortened procedure time (62.0 vs 85.0 min) and increased resection speed (40.59 vs 25.75 mm^2/min).

Conclusions: DuETs improved resection efficiency without compromising safety. As a dual-operator endoluminal platform, DuETs may contribute to difficult colorectal ESD.

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[SY8-6] Evaluation of the effectiveness of underwater colorectal ESD

*Yuko Miura[1], Yosuke Tsuji[1], Mithuhiro Fujishiro[1] (1. Department of Gastroenterology, Graduate School of Medicine, The University of Tokyo, Japan)

Objective
Underwater colorectal endoscopic submucosal dissection (uESD) has been reported to facilitate submucosal dissection by utilizing mucosal buoyancy and improving procedural visibility. This study evaluated the effectiveness of uESD by comparing treatment outcomes before and after its introduction by intermediate-level endoscopists.
Methods
Patients with lesions up to pT1 carcinoma who underwent colorectal ESD by four endoscopists (experience: 30–150 cases) were included. Cases were divided into three groups for each endoscopist: pre-introduction, early introduction phase (first 10 uESD cases), and late introduction phase (subsequent 10 cases). Outcomes included dissection speed, R0 resection rate, self-completion rate, and adverse events.
Results
A total of 122 cases were analyzed. A tendency toward a higher proportion of T1 cancers was observed in the two groups after uESD introduction. In the comparison between the pre introduction and early introduction phase groups, there were no significant differences in dissection speed ($p = 0.96$), R0 resection rate (59.0% vs. 62.5%, $p = 0.82$), or perforation rate (5.1% vs. 10.0%, $p = 0.68$). However, the self-completion rate tended to be higher in the early introduction group (79.5% vs. 87.5%, $p = 0.38$).
In the comparison between the early and late introduction phase groups, no significant differences were observed in the R0 resection rate (62.5% vs. 74.4%, $p = 0.34$) or self-completion rate (87.5% vs. 90.7%, $p = 0.73$). In contrast, dissection speed showed a tendency to be higher in the late introduction phase group (11.05 ± 6.94 vs. 13.53 ± 7.11 mm^2/min, $p = 0.11$), while the perforation rate tended to be lower (10.0% vs. 2.3%, $p = 0.19$).
Conclusions
The introduction of uESD improved the self-completion rate among intermediate-level endoscopists. Moreover, procedural proficiency in uESD appeared to be achieved after approximately 10 cases, with a subsequent tendency toward further improvement in treatment outcomes. These findings suggest that the introduction of uESD may further enhance therapeutic outcomes in colorectal ESD

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[SY8-7] Clinical Role of PAEM/ EID for pT1b Lower Rectal Cancer

*Yu Maruyama[1], Keigo Sato[1], Moe Aung Paing[1], Nozomi Furuichi[1], Keiichi Oshima[1], Yuki Itoi[1], Hirohito Tanaka[1], Hiroko Hosaka[1], Shiko Kuribayashi[1], Toshio Uraoka[1] (1. Department of Gastroenterology and Hepatology, Gunma University Graduate School of Medicine, Japan)

Background & Aims: Total mesorectal excision (TME)-based radical resection is standard for cT1b or deeper lower rectal (Rb) cancer, but it may compromise anal function and require a stoma. With an aging population and increasing demand for function preservation, local resection has gained attention. Surgical approaches such as MITAS are applied up to cT1b despite oncological limitations, whereas conventional endoscopic resection is not indicated due to difficulty in securing a negative vertical margin. Per-anal endoscopic myectomy and endoscopic intermuscular dissection (PAEM/EID) has recently emerged as a novel endoscopic approach. We evaluated the clinical outcomes of PAEM/EID for cT1b Rb.
Methods: PAEM/EID are indicated for cT1b Rb cancer patients with high surgical risks or who refuse surgery, and for lesions with severe fibrosis where securing vertical margins via ESD is difficult. We retrospectively analyzed seven pT1b Rb cancer cases treated with PAEM/EID from Sept 2024 to Oct 2025.
Results: The median age was 76 years (range, 47-83) and the median tumor size was 25mm (range, 15-105). En bloc resection was achieved in all cases. Endoscopic closure of the muscle defect was complete in 2, incomplete in 2, not performed in 3. One delayed bleeding occurred and was successfully managed endoscopically. Pathology revealed lymphatic invasion in 3, venous invasion in 4. All achieved pHM0 and pVM0. Additional surgery was performed in 2 cases. Despite short follow-up, no recurrence occurred in 5 cases without additional surgery.
Discussion: PAEM/EID provides an en bloc specimen that enables precise assessment of pathological risk for lymph node metastasis, which is essential for individualized decision-making. However, the optimal surveillance strategy after R0 resection of pT1b cancer, particularly in patients who do not undergo additional surgery despite risk factors, remains unclear.
Conclusion: In our series, PAEM/EID demonstrated favorable short- and middle-term outcomes and may serve as a selective organ-preserving strategy for cT1b lower rectal cancer.

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[SY8-8] Feasibility of Peranal Endoscopic Myectomy for Lower Rectal Lesions: A Single-Center Prospective Observational Study

*Takashi Kanesaka[1], Yoshiaki Ando[1], Shunsuke Yoshii[1], Minoru Kato[1], Yoshimi Tanaka[1], Sachiko Yamamoto[1], Koji Higashino[1], Noriya Uedo[1], Tomoki Michida[1], Ryu Ishihara[1] (1. Department of Gastrointestinal Oncology, Osaka International Cancer Institute, Japan)

Background: Although the usefulness of peranal endoscopic myectomy (PAEM) for lower rectal tumors has been reported, prospective studies on PAEM remain limited.

Methods: We conducted a single-center prospective observational study to evaluate the feasibility, safety, and preservation of anal function following PAEM. Patients with cT1 lower rectal cancer or lower rectal neuroendocrine tumors, as well as salvage cases diagnosed pathologically as having a positive or indeterminate vertical margin (VM1/X) after endoscopic resection, were enrolled. The primary endpoint was the technical success rate, defined as en bloc resection with histological confirmation of inner circular muscle inclusion. Secondary endpoints included procedure time, R0 resection rate, adverse events, and postoperative anorectal function.

Results: Between April 2024 and April 2026, 30 patients were enrolled, and PAEM was performed in 29 after excluding 1 patient with an upper rectal lesion (23 initial treatment cases and 6 salvage cases). The median age was 59 years (interquartile range [IQR], 53–73), with 14 males and 15 females. The technical success rate was 96.6% (28/29; 95% confidence interval [CI], 82.2–99.9%); 1 procedure was discontinued because muscularis propria invasion was suspected. The median procedure time was 73 minutes (IQR, 56–109), and the R0 resection rate was 86.2% (25/29). No severe intraoperative adverse events occurred, and delayed bleeding was observed in 1 patient (3.4%). The median Cleveland Clinic Incontinence Score was 0 preoperatively, 4 within 28 days postoperatively, and 0 thereafter, indicating transient deterioration of anal function with recovery to baseline after 28 days.

Conclusions: PAEM demonstrated a high technical success rate and may represent a feasible organ-preserving treatment option for selected lower rectal lesions.

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[SY8-9] Treatment Strategy for T1 Rectal Adenocarcinoma with Extensive Involvement of the Anal Canal: ESD or Surgical Resection?

*Nobuhisa Minakata[1], Makoto Arashiyama[1], Arisa Takeda[1], Yuichiro Mikuriya[1], Kazuo Shiotsuki[1], Kohei Takizawa[1] (1. Department of Gastroenterology, Kanagawa Cancer Center, Yokohama, Japan)

Background:
Endoscopic resection is widely accepted for early colorectal cancer. However, for T1 tumors extensively involving the anal canal, endoscopic treatment can be technically challenging due to severe pain and limited maneuverability, and achieving en bloc resection may be difficult. In such cases, transanal local excision or even abdominoperineal resection (APR) may be considered. We report a case of T1 rectal adenocarcinoma with extensive involvement of the anal canal that was treated with endoscopic submucosal dissection (ESD).
Case:
A 76-year-old man with a history of prior lung cancer surgery and a brainstem tumor under observation presented with hematochezia. Colonoscopy revealed a 30-mm type 0-Is lesion extending approximately 1.5 cm into the anal canal from the rectum, which was diagnosed as cT1a–T1b adenocarcinoma. Although surgical resection was considered, diagnostic endoscopic resection was initially planned due to its lower invasiveness. Given the anticipated severe pain, ESD was performed under general anesthesia.
En bloc resection was successfully achieved using the underwater technique, pocket-creation method, and a tapered hood(CAST hood; TOP, Tokyo, Japan). Histopathological findings were as follows: tub1 > tub2, 22 × 19 mm, pT1a (submucosal invasion: 600 μm), BD1, ly0, v1, HM0, and VM0, indicating R0 resection. The estimated risk of lymph node metastasis was approximately 3.0%. After explaining these findings, the patient opted for close surveillance and has remained recurrence-free to date.
Discussion:
In this case, ESD under general anesthesia enabled en bloc and R0 resection without complications, providing both diagnostic and therapeutic benefits. However, the optimal treatment strategy for T1 rectal adenocarcinoma with extensive involvement of the anal canal remains unclear and should be individualized based on tumor characteristics and institutional expertise.

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[SY8-10] Efficacy and Safety of Collaborative Endoscopic and Surgical Treatment for Challenging Colorectal Neoplasms

*Hidehito Maeda[1], Fumisato Sasaki[1], Kenji Baba[2] (1. Department of Digestive and Lifestyle Diseases, Kagoshima University Graduate School of Medical and Dental Sciences, Japan, 2. Department of Digestive Surgery, Kagoshima University Graduate School of Medical and Dental Sciences)

Background:
Colorectal ESD is widely used, but severe adhesions, fibrosis, or unfavorable location can make ESD alone difficult. We have used collaborative endoscopic and surgical treatment for such challenging colorectal neoplasms.

Aim:
To evaluate the efficacy and safety of this approach.
Methods:
We retrospectively reviewed 11 patients with 12 colorectal lesions treated between October 2016 and April 2026. Clinical features, procedures, histology, and adverse events were analyzed.
Results:
The mean age was 71.8 years; 8 patients were male. Lesions were located in the cecum (n=1), ascending colon (n=2), transverse colon (n=2), sigmoid colon (n=3), and rectum (n=4). Macroscopic types were protruded (n=6), superficially elevated (n=5), and depressed (n=1). Seven lesions with severe adhesions underwent laparoscopic adhesiolysis plus ESD; 5 were resected endoscopically, whereas 2 with suspected muscularis propria invasion underwent surgical resection on the same day. Four protruded rectal or anal canal lesions underwent transanal minimally invasive surgery plus ESD, and all were resected. One severely fibrotic lesion at a postoperative anastomosis, initially considered for full-thickness resection, was resected by ESD alone. Histology of the 10 endoscopically resected lesions showed adenoma in 3, intramucosal carcinoma in 2, SM1 carcinoma in 3, and SM2 carcinoma in 2. Postoperative bleeding occurred in 1 patient, but no perforation, anastomotic leakage, or other severe adverse events occurred.
Conclusions:
Collaborative endoscopic and surgical treatment may be a useful and safe minimally invasive option for selected challenging colorectal neoplasms.

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