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## The treatment results of rectal fistulas in Crohn's disease - VAAFT

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Treatment of fistulas of the rectum in Crohn's disease is a difficult task for both gastroenterologists and surgeons. Medicamentous treatment of this pathology is recommended as the first line of therapy, and surgical treatment serves to control severe septic complications. The frequency of relapse in the surgical treatment of rectal fistula with the use of various methods can reach up to 55% and 70% if there is also Crohn's disease. Surgical interventions with the plastic component and the excision of the fistula show good results, but they practically do not make sense in case of Crohn's disease. Mini-invasive interventions video-assisted anal fistula treatment (VAAFT) is becoming increasingly popular, in the treatment of rectal fistulas in Crohn's disease, in particular. Our clinic performed 12 procedures using video-endoscopic technologies (VAAFT) in patients with Crohn's disease, the comparison group included patients who underwent ligation of the fistula in the intersphincteric space (LIFT)-18. In the first stage, setons were put into all the patients, followed by operation in the period from one to three months. Patients of both groups did not differ in age and sex ( $p=34$ ), as well as in fistula types: Trans-sphincteric- VAAFT=8, LIFT=14, extra-sphincteric- VAAFT=4, LIFT=6 ( $p=45$ ). The groups did not significantly differ in the duration of the surgical intervention: VAAFT- $28\pm 5.2$  min, LIFT- $26\pm 5.8$  min ( $p=.12$ ), pain syndrome in the postoperative period (VAS scale) ( $p=.07$ ), postoperative bed-day ( $4\pm 1.2$  and  $4\pm 1.4$ ,  $p=.24$ ). All patients in VAAFT-group underwent the first stage of fistuloscopy, then the fistula was cleared from fibrin overlap, fistula ablation was performed in the direction from the inner to the external opening, the internal opening was excised and sutured. According to the preoperative examination (transanal US, MRI), there was an ischio-rectal lag associated with the fistula in two patients in the VAAFT group and one in the LIFT group, and surgical intervention was supplemented by sanitation and drainage through the external fistula opening. The median follow-up of the total sample of patients was 12.6 months. In two patients of the LIFT group (10%) and the 1<sup>st</sup> group VAAFT (8.3%), the relapse of the disease was detected at different times: 6, 7 and 3 months, respectively ( $p=.18$ ), the setons were put into the patients once again; medicamentous therapy was continued (preparations of 5-ASA, hormones, and biological therapy). Video-endoscopic treatment of rectum fistulas (VAAFT) in Crohn's disease is quite new and promising surgical technique that demonstrates satisfactory results in both early postoperative and distant period. The small-traumatic nature of the technique makes it possible to perform it in multiple and recurrent fistula of the rectum.

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## The endoscopic diagnosis of early gastric cancer

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The incidence of gastric cancer in Japan is very high. Therefore, we always focus on endoscopic diagnosis of early gastric cancer. Early gastric cancer occurs in the mucous membrane and invades to the submucosal layer. The prognosis of gastric cancer depends on its stage. We detect an initial lesion of gastric cancer by observing the mucous membrane closely using an endoscope. It leads to a higher survival rate of gastric cancer. The first step of diagnosing early gastric cancer is to find suspicious lesions by white light endoscopy. Close attention is paid to color changes of the lesions such as reddish or pale and to surface morphology changes such as elevation or depression. The second step is image enhanced endoscopy (IEE). Basically, there are two IEE methods; dye-based IEE (chromo-endoscopy) and equipment-based IEE (optical digital endoscopy). These methods enable us to recognize the demarcation line (DL) of the background mucous membrane and the cancerous lesion. The representative optical digital endoscopy is narrow band imaging system (NBI). NBI light is absorbed by hemoglobin contained in the blood vessels. With this light, we can observe blood vessels in the mucous membrane and the submucosal layer and recognize the mucous membrane microstructure. Consequently, we can diagnose early gastric cancer and identify tumor margins. The third step is magnifying observation of lesions. We can determine whether there are any irregularities of micro-vascular architecture and superficial surface structure. When we find either irregularity, the lesion is diagnosed as cancer.

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