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SAFETY AND EFFICACY OF THE BRIDGE TECHNIQUE FOR ENDOSCOPIC SUBMUCOSAL DISSECTION IN GASTROINTESTINAL LESIONS: A MULTICENTER INTERNATIONAL STUDY

Society: ASGE**Track:** Technologies and Procedural Innovation**Author(s) and Affiliation(s):**

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Aims: This study aims to assess the safety and efficacy of the Bridge technique for endoscopic submucosal dissection (ESD) in resecting gastrointestinal (GI) lesions, using data from multiple centers and countries.

Methods: A retrospective, multicenter study analyzed Bridge ESD data from 9 countries with 15 centers included. Data included patient demographics, comorbidities, use of anticoagulants/antiplatelets, lesion characteristics (site, size, circumference, Paris and JNET classifications), preoperative workup, procedural details (starting tunnel, number of tunnels, underwater technique, traction methods, intermuscular dissection, procedure time, and en bloc resection), Intra- and post-procedural complications, histopathological findings, R0 resection rates, and recurrence during follow up.

Results: A total of 378 patients, with a mean age of 65 years (50.8% male), were included. Lesions were most commonly located in the rectum (56.1%), stomach (10.3%), and sigmoid colon (10.1%), with sizes ranging from 15 mm to 230 mm (mean: 50.9 mm). Predominant lesion types included Paris IIa+Is (30.7%) and IIa (25.4%), with JNET classifications of Type 2B (41.2%) and 2A (35.2%). Complete circumferential involvement was noted in 5.9% of cases, while less than 90% involvement was noted in (89.4%) of cases. The starting tunnel was cecal in 34.4%, anal in 56.3%, and oral in 9.3%. A single tunnel was created in 90.5% of cases, two tunnels in 6.9%, three tunnels in 2.4% and four tunnels in one case. Underwater ESD was performed in 5.8%, and traction was only needed in 12.5%, with the clip-and-band method being most common. En bloc resection was achieved in 94.7%, with a mean procedure time of 119 minutes and a mean hospitalization of 2.3 days. Technical success was achieved in 365/378 (96.5%) of cases, and R0 resection rate was confirmed in 90.2%. Histopathology revealed high-grade dysplasia (44.4%), low-grade dysplasia (22%), intramucosal carcinoma (13.8%), submucosal carcinoma (11.4%), and invasive carcinoma (1.6%). Complications included intraprocedural perforation in 9.5% of cases (66.7% managed with endoclips, 13.9% with purse-string sutures, and the rest with X-tack, or vacuum-assisted closure). Post-procedural bleeding occurred in 9.2% (71.4% managed endoscopically and 28.6% managed conservatively). Post-procedural perforation occurred in 2.1% of cases, with 62.5% managed using endoclips, 25% with X-tack, and one case required surgical intervention). Stricture was reported in 1.1% of cases. The recurrence rate was 3.4% during follow-up. Histopathology, location (rectum), lymphovascular emboli, and en bloc resection are significantly correlated with R0 resection (p-values < 0.001, 0.012, 0.001, and 0.001, respectively).

Conclusions: The Bridge technique demonstrates high efficacy and safety in ESD for GI lesions, achieving high R0 and en bloc resection rates.

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