



Figure 1-1. (A) Long segment of BE with HGD lesion (arrowheads), (B, C) band-ligation mucosectomy, and (D) final aspect of local resection.

alternative because the risk of lymph node involvement or hematogenous dissemination is absent in HGD and negligible in cancers restricted to the mucosal layer. Endoscopic therapy may be performed through local endoscopic mucosal resection or through endoscopic ablation using photodynamic therapy (PDT), argon plasma coagulation (APC), or, more recently, radiofrequency ablation (RFA).

Endoscopic mucosal resection (EMR) is safe and effective for complete HGD local resection and early BE cancer. Usually, 2 endoscopic techniques are applied: cap technique and band-ligation technique (Figure 1-1). In both techniques, piecemeal resection is required when the lesion is larger than 10 to 15 mm. More recently, another technique called *endoscopic submucosal dissection* (ESD) has been used for the resection of a large lesion en bloc, but specific accessories and training are required for this procedure. For BE more than 3 cm in length, the complete circumferential removal of the mucosa may cause an esophageal stricture. One of the most frequently studied endoscopic therapies for HGD in BE is PDT. It is an expensive method with limited availability, and long-term results are not well described. There is a 40% rate of esophageal stenosis, and small foci of invasive cancer may be left untreated. Ablative therapies, such as PDT and APC, do not provide a specimen for histopathological evaluation and usually the depth of eradication is limited. Residual BEs under restored squamous epithelium after endoscopic tissue