

# Paris classification (2003)

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# JGCA classification

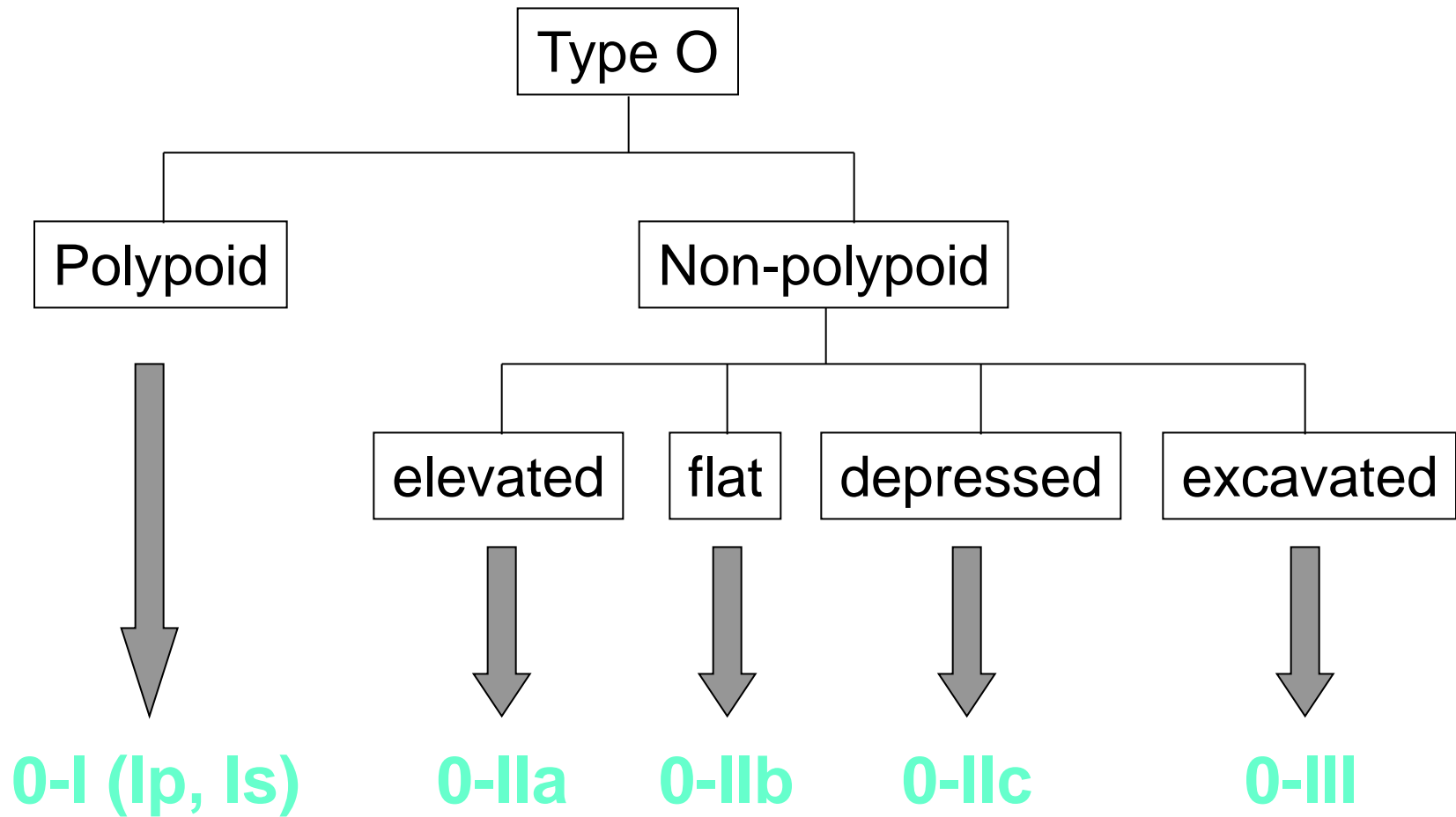
- *Japanese Gastric Cancer Association* -

- *Type 0* – superficial polypoid, flat/depressed, or excavated tumors
- *Type 1* – polypoid carcinomas, usually attached on a wide base
- *Type 2* – ulcerated carcinomas with sharply demarcated and raised margins
- *Type 3* – ulcerated, infiltrating carcinomas without definite limits
- *Type 4* – nonulcerative, diffusely infiltrating carcinomas
- *Type 5* – unclassifiable advanced carcinomas

# West *vs* East

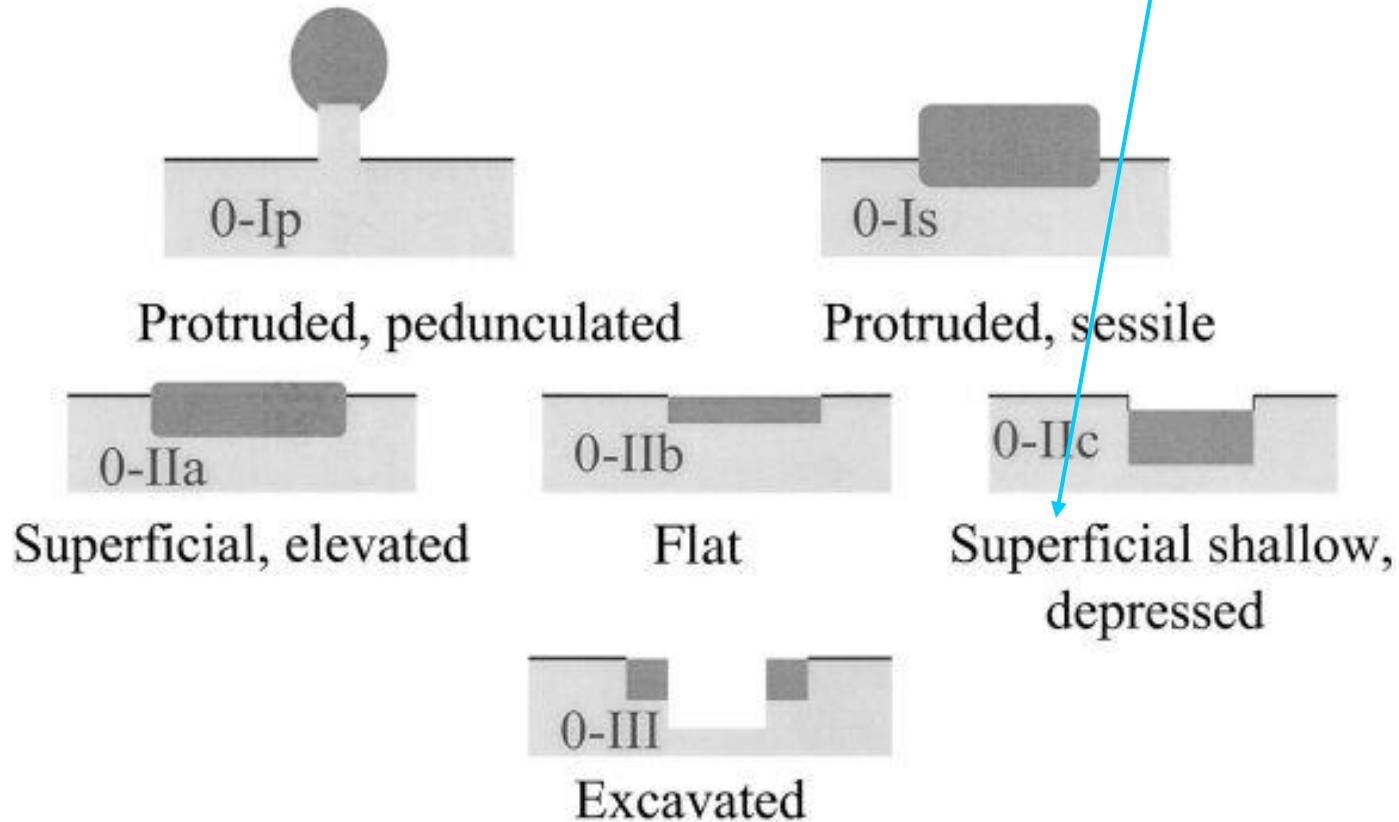
- Western endoscopists consider the Japanese classification to be a botanical hobby, too complex for practical use.
- Japanese endoscopists have found that endoscopic classification of a lesion can be an important determinant when endoscopic therapy is considered.
- The East and West points of view are now much closer.

# Superficial neoplastic lesions



# Superficial neoplastic lesions

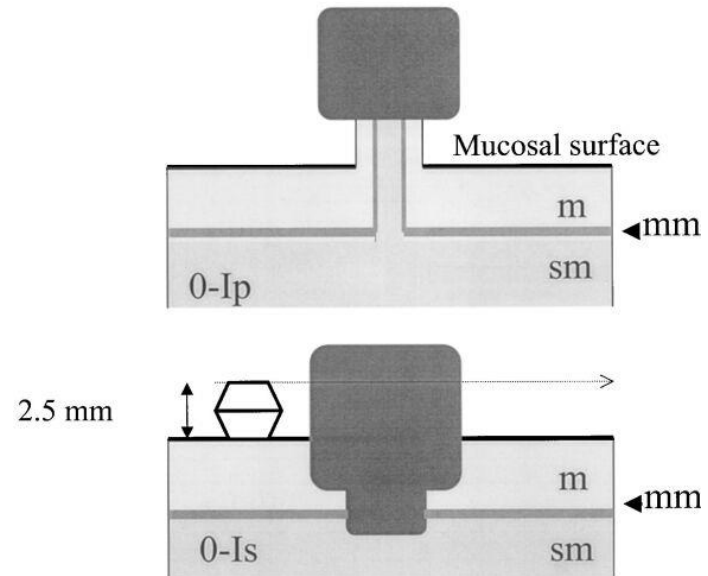
Different meaning: really confusing



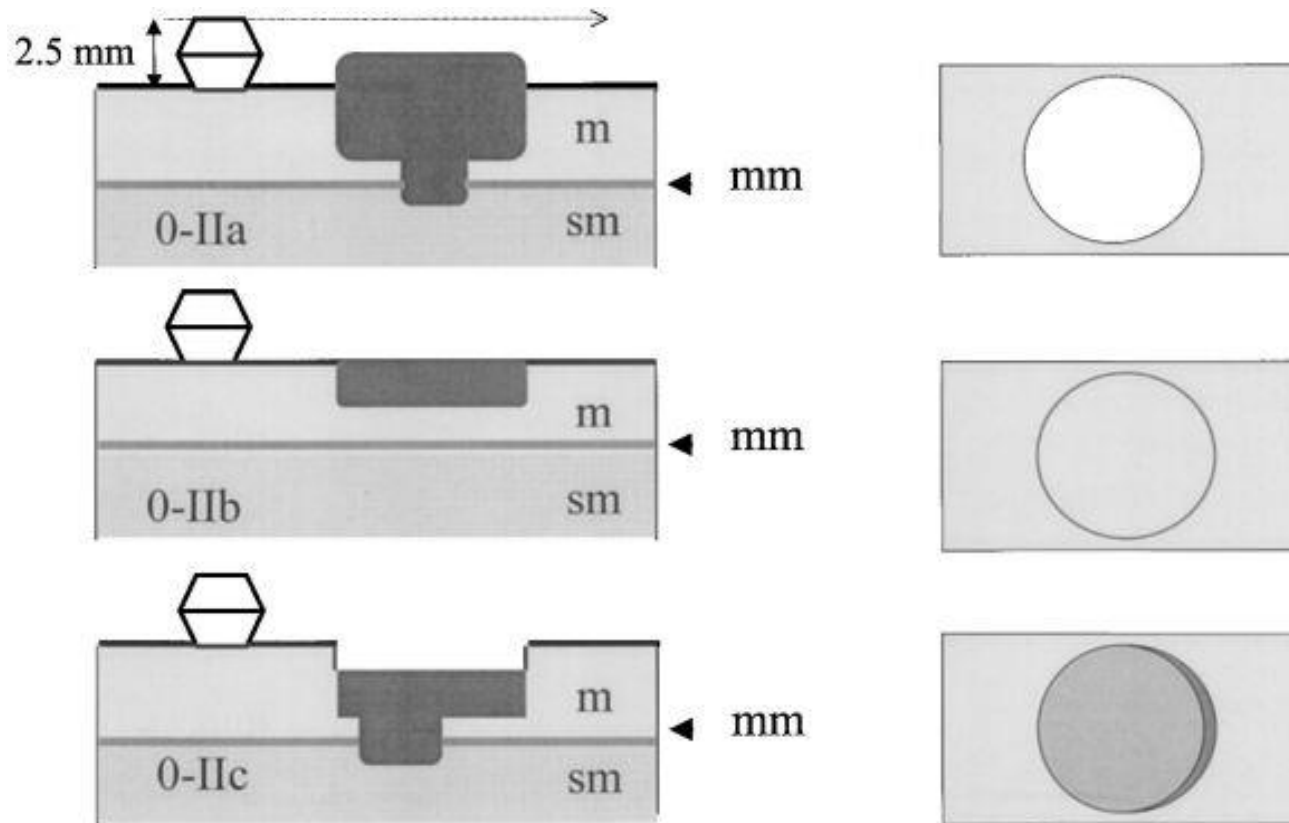
- ❖ Semi-pedunculated (Isp) polyps should be managed as sessile polyps.

# What is polypoid and what is flat?

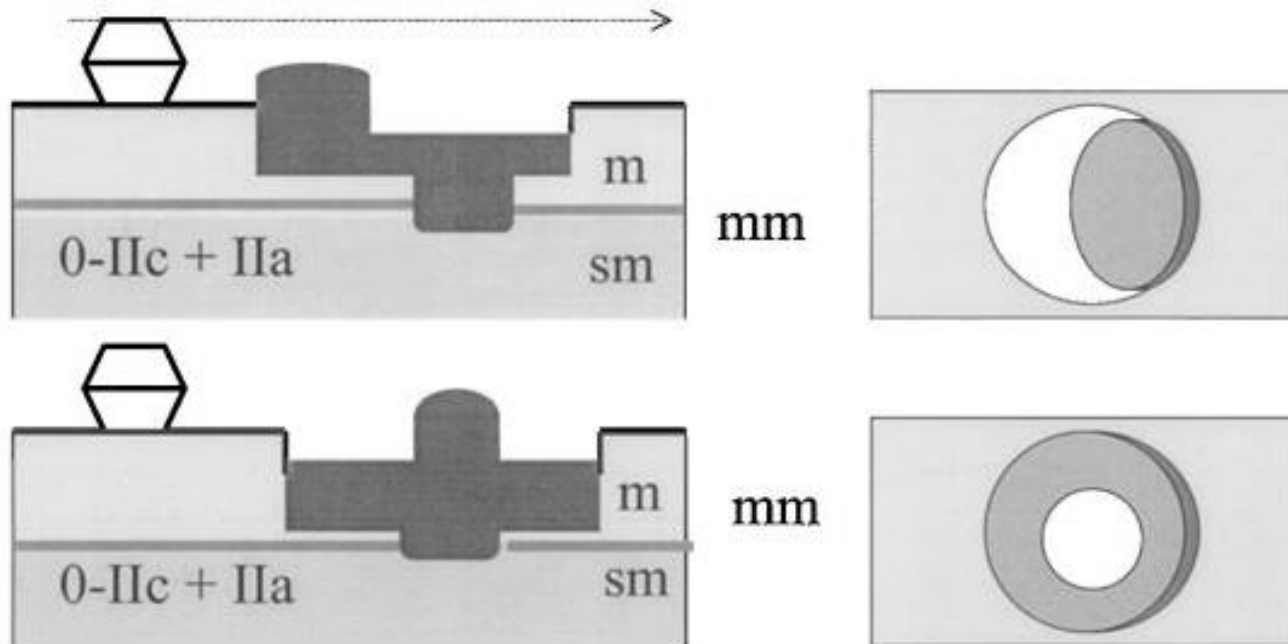
- In the operative specimen, the height of polypoid lesion is more than double the thickness of the adjacent mucosa.
- During endoscopy, the height of the closed cups of the biopsy forceps (2.5 mm) is the discriminating point.



# Type O-II lesions

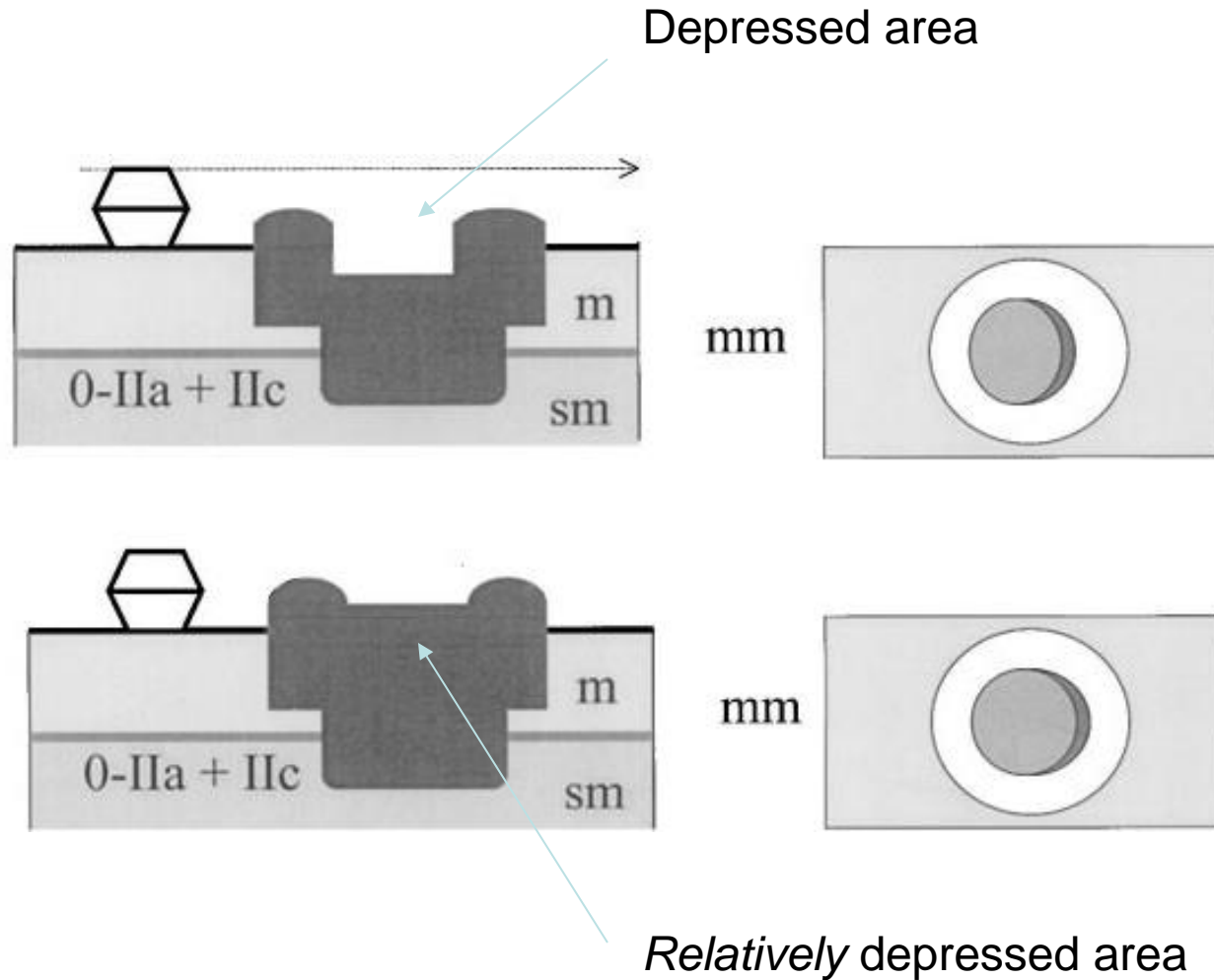


# IIc + IIa lesions

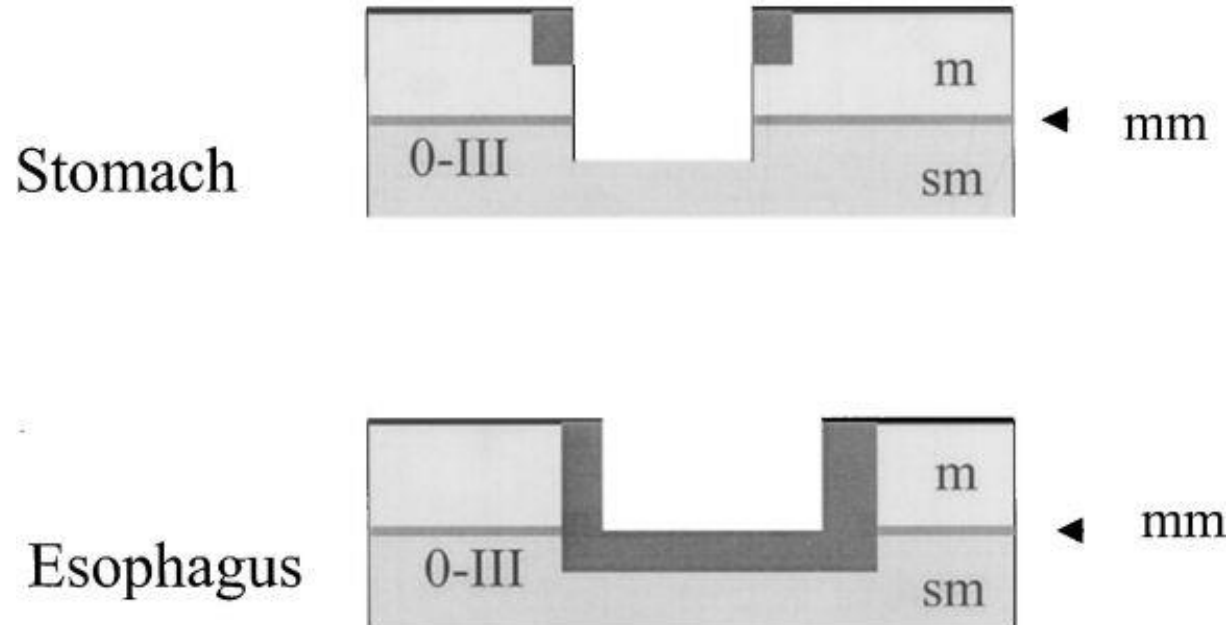




# IIa + IIc lesions with two variants

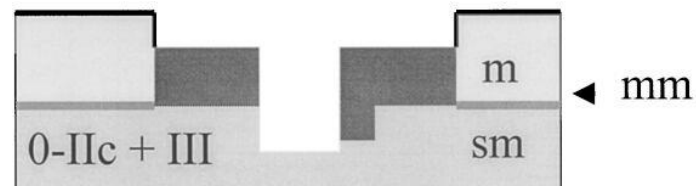


# Type 0-III lesions

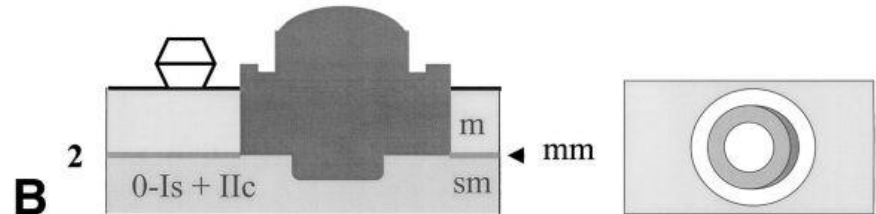
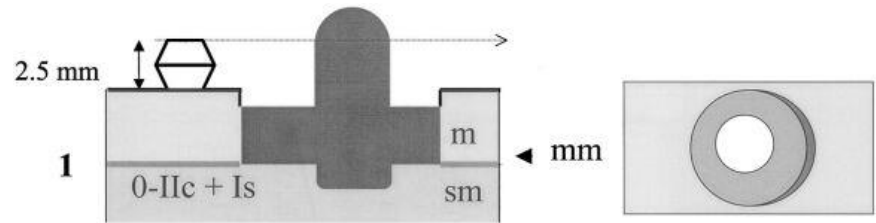


- ❖ In the stomach, the bottom of the lesion is non-neoplastic.
- ❖ In Barrett's esophagus, the neoplastic area covers the entire surface of the lesion.

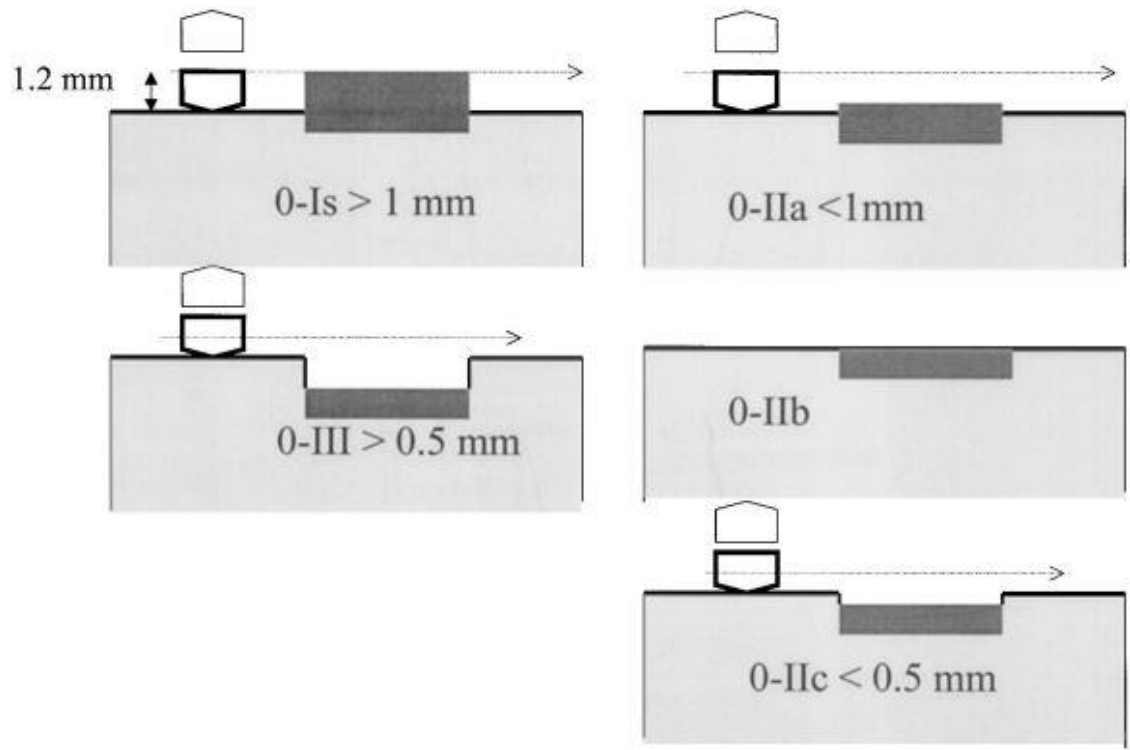
# Various combinations: *is it really useful?*



**A**



**B**



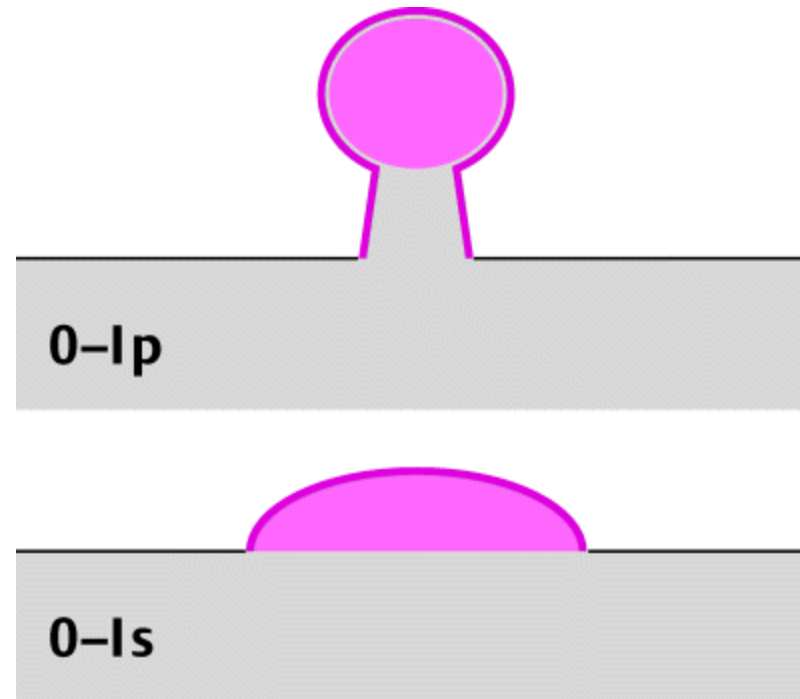
# Updated Paris (2005)

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# Update on the Paris classification of superficial neoplastic lesions in the digestive tract

- The endoscopic morphology of superficial lesions can be assessed with a standard video endoscope after spraying of a dye - an iodine-potassium iodide solution for the stratified squamous epithelium, or an indigo carmine solution for the columnar epithelium.
- In 2002, a workshop was held in Paris to explore the relevance of the Japanese classification.
- The conclusions were revised in 2003 in Osaka in relation to the definition of the subtypes used in endoscopy and the evaluation of the depth of invasion into the submucosa.

# Update on the Paris classification of superficial neoplastic lesions in the digestive tract



The cut-off limit is *2.5 mm* in the columnar epithelium and 1.2 mm in the stratified epithelium of the esophagus.

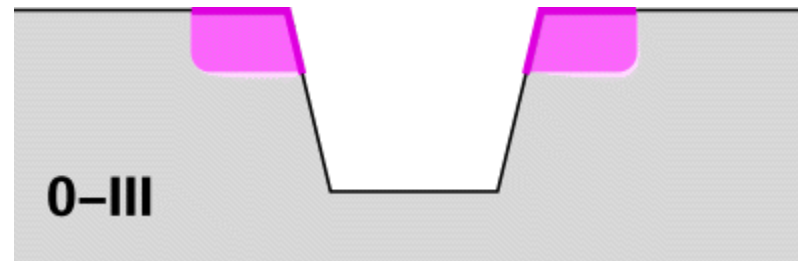
# Update on the Paris classification of superficial neoplastic lesions in the digestive tract



The cut-off limit is *1.2 mm* in the columnar epithelium and 0.5 mm in the stratified epithelium of the esophagus.



# Update on the Paris classification of superficial neoplastic lesions in the digestive tract

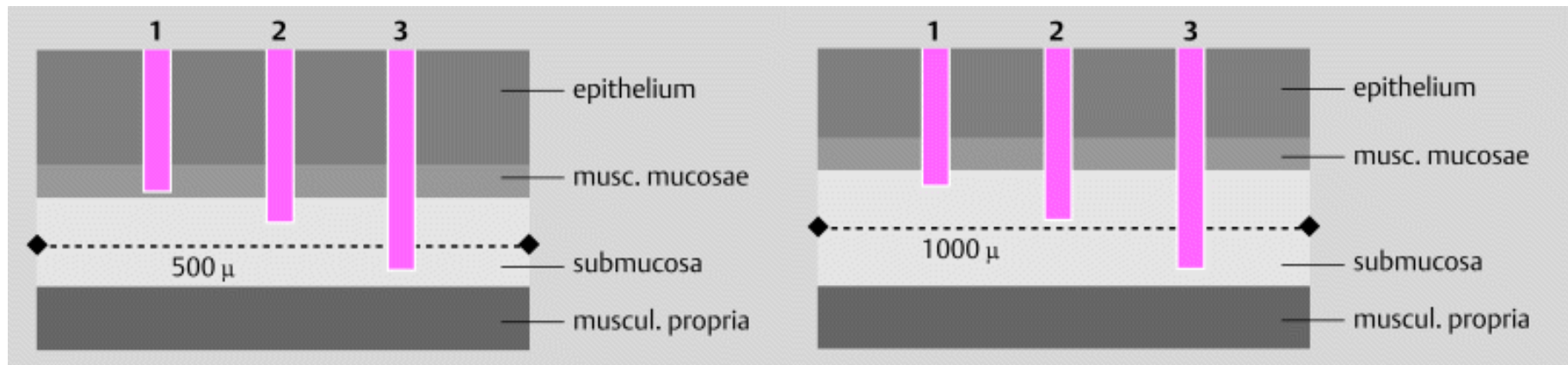


Endoscopic appearance of a superficial neoplastic lesion on the surface of the digestive-tract mucosa: excavated type (0 - III).  
An ulcer is seen.

# Update on the Paris classification of superficial neoplastic lesions in the digestive tract

- Micrometer measurement should be generally used to allow comparison of outcomes after either surgery or endoscopic mucosal resection (EMR).
- With regard to the depth of invasion into the submucosa, the empirical cut-off limit adopted in Japan for safety after mucosectomy (EMR) varies depending on the site of the lesion.
- It is estimated as less than 200  $\mu\text{m}$  in the esophagus, 500  $\mu\text{m}$  in the stomach, and 1000  $\mu\text{m}$  in the large bowel.
- In the large bowel, this cut-off value only applies to sessile lesions.

# Update on the Paris classification of superficial neoplastic lesions in the digestive tract



In stomach

In colon

Japanese	Western	Vienna classification
normal and benign lesion with no atypia	negative for dysplasia	1. negative for neoplasia/dysplasia
benign no neoplastic lesion		
borderline lesion*	indefinite for dysplasia	2. indefinite
	low grade adenoma/dysplasia	3. noninvasive low grade neoplasia
	high grade adenoma/dysplasia	4.1. high grade adenoma/dysplasia
lesions strongly suspected of carcinoma		
carcinoma		4.2. carcinoma in situ
	suspicious for invasive carcinoma	4.3. suspicion of invasive carcinoma
	invasive carcinoma	invasive carcinoma

\* borderline lesion: adenoma, lesions difficult to decide as regenerative or neoplastic

# Endoscopic staging

- The less than perfect reliability of endoscopic staging can be improved by EUS, particularly with high frequency probes (20 MHz).
- ***Endoscopy tends to understage superficial lesions, and EUS tends to overstage them.***
- When the two methods agree, the predictive value is high. (Yanai. GE 1997;46:212-216)