

1 How many years have you been in practice?

Years:

2 How many of the following procedures do you perform per year (estimate)?

Gastroscopy¹:

Colonoscopy²:

¹Gastroscopy: Screening of esophagus, stomach, and small bowel

²Colonoscopy: Screening of rectum, colon, and caecum

3 How many endoscopic mucosal resections do you perform per year approximately?

Esophagus:

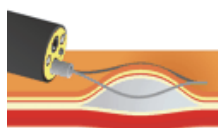
Stomach¹:

Colon²:

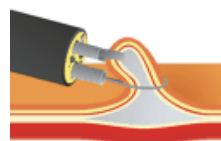
¹Stomach: including duodenum

²Colon: including caecum and rectum

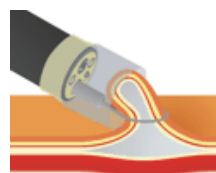
4 How often do you perform the following procedures per year (estimate)?



Inject and cut¹



Inject, lift, and cut²



EMR with cap³



EMR with ligation⁴

Other⁵:

Other⁵:

¹Inject and cut (injection-assisted snare polypectomy, submucosal-injection polypectomy, strip-off biopsy): The lesion is lifted by a submucosal injection, strangulated, and resected by a snare [1].

²Inject, lift, and cut (strip biopsy): The lesion is grasped by a forceps and pulled into a snare. The lesion is resected by closing the snare [1].






³EMRC (EMR with cap, cup and suction): A plastic cap is fitted on the tip of the endoscope. A snare is prelooped into the groove of the rim of the cap. The lesion is suctioned into the cap and resected by closing the snare [1].

⁴EMRL (EMR with ligation, endoscopic variceal ligation method, band and snare): The lesion is suctioned into the cap and a ligation is placed around the lesion. The lesion is then resected by a snare above or below the rubber band [1].

⁵Other: please specify. Some other techniques are [2, 3]

- inject, precut, and cut (Endoscopic resection with hypertonic saline-epinephrine, ER-HSE)
- Inject, precut, and exfoliate
- lift and cut with an overtube
- Esophageal endoscopic mucosal resection (EEMR, Makuuchi tube method)
- negative-pressure endoscopic esophageal mucosectomy (np-EEM, modified Makuuchi tube method)
- EMR with insulated-tip diathermic knife (IT-EMR)
- Endoscopic double-snare polypectomy (EDSP)
- simple suction method

5 In your practice, how many of the different types of lesions do you remove endoscopically per year and what are the typical sizes?

Type ¹	Number	Size from	to
 Protruded, pedunculated (lesion type Ip)	<input type="text"/>	<input type="text"/> mm	<input type="text"/> mm
 Mostly protruded, sessile (lesion type Is)	<input type="text"/>	<input type="text"/> mm	<input type="text"/> mm
 Mostly superficial, elevated (lesion type IIa)	<input type="text"/>	<input type="text"/> mm	<input type="text"/> mm
 Mostly flat (lesion type IIb)	<input type="text"/>	<input type="text"/> mm	<input type="text"/> mm
 Mostly superficial shallow, depressed (lesion type IIc)	<input type="text"/>	<input type="text"/> mm	<input type="text"/> mm

¹According to the Paris endoscopic classification of superficial neoplastic lesions [4]. Type III lesions are no generally accepted indication for EMR [1].

6 Up to which size would you desire a lesion to be resectable en-bloc?

Size: mm

7 How necessary would you rate the improvement of the following steps of EMR regarding technical simplicity and safety?

0 = improvement not necessary
4 = improvement strongly required

Step	Technical simplicity	Safety
Introduction of the endoscope	① ② ③ ④	① ② ③ ④
Positioning of the endoscope towards the lesion	① ② ③ ④	① ② ③ ④
Grasping / Fixation of the lesion	① ② ③ ④	① ② ③ ④
Resection of the lesion	① ② ③ ④	① ② ③ ④
Retrieval of the resected specimen	① ② ③ ④	① ② ③ ④
Haemostasis of the resected area	① ② ③ ④	① ② ③ ④

8 Regarding specimen handling, how important would you consider the following options?
0 = not important
4 = very important

Option	Importance
Protection of the resected specimen during retrieval (e.g. for preventing the resected specimen from damage)	① ② ③ ④
Protection and preservation (e.g. in formalin) of the resected specimen in a single step	① ② ③ ④

9 For designing a novel EMR method, how important would you consider the following issues?
0 = not important
4 = very important

Issue	Importance
Less time consuming method	① ② ③ ④
More technically simple method	① ② ③ ④
More safe method	① ② ③ ④
Lower risk of blood loss during the procedure	① ② ③ ④
Lower risk of blood loss postoperatively	① ② ③ ④
Lower risk of perforation compared to current EMR methods	① ② ③ ④
Ability to resect lesions greater than 20mm en-bloc	① ② ③ ④
Good visual conditions during assessment of the lesion (e.g. unaffected by a distal cap)	① ② ③ ④
Good visual conditions during resection of the lesion (e.g. unaffected by trapped tissue)	① ② ③ ④
Untouched flexibility of the distal end of the endoscope	① ② ③ ④
Less personnel required	① ② ③ ④
Use of a single-channel endoscope	① ② ③ ④
No withdrawal of the endoscope between diagnosis and resection (e.g. for attaching a cap on the endoscope)	① ② ③ ④
Less expensive method	① ② ③ ④

Comments:

Personal data ¹(optional):

Title/Name: _____

Institution: _____

Address: _____

E-Mail²: _____

¹Personal data will only be used for statistical purposes related to this survey.

²If you are interested in the survey's results, it will be processed to this E-mail address.

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- [3] Kojima T, Parra-Blanco A, Takahashi H, Fujita R. Outcome of endoscopic mucosal resection for early gastric cancer: review of the Japanese literature. *Gastrointest Endosc* 1998;48:550-5.
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