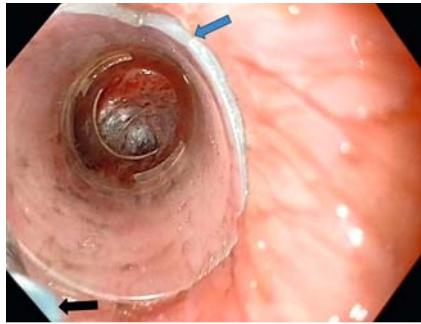


Dislodged hood stuck in submucosal tunnel: retrieval during peroral endoscopic myotomy



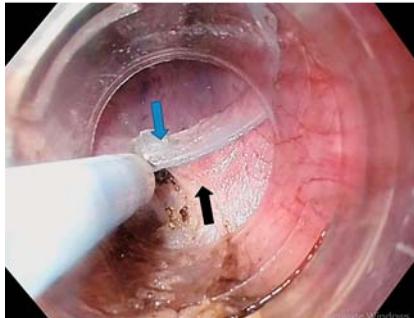
► Fig. 1 Dislodged hood in the submucosal tunnel, with a chipped margin (blue arrow) and the chipped-off segment (black arrow) with rat-tooth forceps.



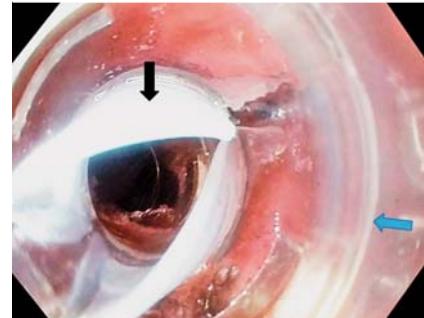
► Fig. 2 Dislodged hood in the submucosal tunnel. **a** Mucosal prolapse around the hood into the submucosal tunnel (blue arrow), obstructing the removal of the dislodged hood. **b** Esophageal luminal view of the dislodged hood (blue arrow).

A 42-year-old man with type II achalasia cardia underwent peroral endoscopic myotomy (POEM) by posterior approach. The procedure was started using a gastroscope fitted with a conical hood (DH-28GR, Fujifilm, Tokyo, Japan). The gastroesophageal junction (GEJ) was tight when the scope reached the lower end during the creation of the submucosal tunnel. The scope was maneuvered to pass beyond the GEJ. However, the hood became stuck at the tight GEJ and slipped off the gastroscope. During an attempt to remove the hood using a rat-tooth forceps, one portion of the hood chipped off (►Fig. 1). The hood was tightly stuck in the submucosal tunnel and the mucosa prolapsed inside the tunnel (►Fig. 2). Forceful removal of the hood could have caused mucosal injury.

We decided to proceed with myotomy to decrease the pressure in the submucosal tunnel and create more space. Myotomy was continued until we reached the hood and was carefully extended between the muscle and the hood (►Fig. 3). The hood immediately became loose and was removed using a rat-tooth forceps (►Fig. 4, ►Video 1). The submucosal tunnel was extended beyond the GEJ and the myotomy was



► Fig. 3 Extension of myotomy between the muscle (black arrow) and the dislodged hood (blue arrow) in order to decrease the pressure in the submucosal tunnel.



► Fig. 4 Pulling the dislodged hood (black arrow) into the replacement hood (blue arrow) for safe removal.

completed. The patient made an uneventful recovery.

This case illustrates that the hood can become dislodged in the submucosal tunnel during POEM and can usually be removed easily [1]. However, if it becomes difficult to remove the hood, as in the present case, myotomy should be carefully performed posteriorly to the hood, which should relieve the pressure in the tunnel and loosen the hood in the submucosal space. One should catch the hood from the mucosal side in order to avoid the prolapse of mucosa around

the hood and to facilitate hood removal. Pulling the dislodged hood into the replacement hood will aid safe removal, as for the removal of a foreign body.

Endoscopy_UCTN_Code_CPL_1AH_2AJ

Competing interests

None



Reference

- [1] Baldaque-Silva F, Marques M, Ramalho R et al. Case description of cap retention in the submucosal tunnel during peroral endoscopic myotomy. *Am J Gastroenterol* 2012; 107: 1586

Bibliography

DOI <https://doi.org/10.1055/a-0658-0955>
Published online: 14.8.2018
Endoscopy 2018; 50: E314–E315
© Georg Thieme Verlag KG
Stuttgart · New York
ISSN 0013-726X

Video 1 Removal of the dislodged hood in the submucosal tunnel during peroral endoscopic myotomy.

The authors

Deepak Gunjan, Saransh Jain, Pramod Garg
Department of Gastroenterology, All India Institute of Medical Sciences, New Delhi, India

Corresponding author

Deepak Gunjan, MD, DM
Room No. 3111, Department of Gastroenterology, 3rd Floor, Teaching Block, All India Institute of Medical Sciences, New Delhi, India
Fax: +91-11-26588663
drdg_01@rediffmail.com

ENDOSCOPY E-VIDEOS

<https://eref.thieme.de/e-videos>



Endoscopy E-Videos is a free access online section, reporting on interesting cases and new techniques in gastroenterological endoscopy. All papers include a high quality video and all contributions are freely accessible online.

This section has its own submission website at
<https://mc.manuscriptcentral.com/e-videos>