A 60-year-old man with abdominal discomfort was referred to our hospital. Abdominal computed tomography (CT) revealed a tumor in the hepatic flexure and colonoscopy showed a giant protruding polyp (▶ Fig. 1). The biopsies were interpreted as adenoma with areas of high grade dysplasia.

Therapeutic endoscopy was performed using scissor-type forceps (Sumitomo Bakelite, Japan) and a RetroView colonoscope (Pentax, Japan) with a distal attachment cap (Olympus, Japan) (▶ Video 1).

First, we took advantage of the polyp's own weight to exert traction in order to form a pseudo-peduncle (▶ Fig. 2). We began cutting the mucosal layer to expose the submucosa. Then, countertraction with a soft straight distal cap facilitated exposure of the dissection plane between the lesion and the muscle layer (▶ Fig. 3). We coagulated the larger vessels in advance. At one point, some muscle fibers were identified by means of the muscle-retraction sign [1] (▶ Fig. 4). The resection was completed within 70 minutes without adverse events. The endoscopic resection defect was closed with endoscopic clips (Boston Scientific, United States). Pathology examination showed an adenoma 48 × 35 mm in size with low grade dysplasia. Resection margins were clean and included muscle fibers of the main muscle layer (▶ Fig. 5). In the 24-month follow-up no residual adenomatous tissue was observed.

Unfortunately, most cases of endoscopic resection of complex polyps are limited to a piecemeal technique because of the types of polypectomy snare used [2]. However, we now have fast, easy, and safe endoscopic submucosal dissection (ESD) devices [3], that can help in performing en bloc resection.

This case report, similarly to previous ones [4], demonstrates that the scissor-style knife can safely speed en bloc resection in a western setting. Further studies are needed to assess the efficacy and safety of this device when used in the resection of protruding polyps by nonexpert ESD endoscopists.

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**Competing interests**

None
The authors

Felipe Ramos-Zabala1, 2, Alejandra Alzina-Pérez1, 2, Jorge Vásquez-Guerrero1, 2, Marian García-Mayor1, Ana Domínguez-Pino1, Irene Rodríguez-Pérez4, Luis Moreno-Almazán1, 2

1 Department of Gastroenterology, HM Montepríncipe University Hospital, Boadilla del Monte, Madrid, Spain
2 Department of Clinical Sciences, School of Medicine, University of CEU San Pablo, Boadilla del Monte, Madrid, Spain
3 Department of Anesthesiology and Resuscitation, HM Montepríncipe University Hospital, Boadilla del Monte, Madrid, Spain
4 Department of Pathological Anatomy, HM Puerta del Sur University Hospital, Móstoles, Madrid, Spain

Corresponding author

Felipe Ramos-Zabala, MD, PhD
Department of Gastroenterology, HM Montepríncipe University Hospital, Av. de Montepríncipe, 25, 28660 Boadilla del Monte, Madrid, Spain
Fax: +34-91-7089900
framoshdiaz@gmail.com

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Video 1
Endoscopic resection of a giant protruding polyp in the hepatic flexure, using scissor-type forceps.

Fig. 3 Use of the distal cap facilitates exposure of the dissection plane between the lesion and the muscular layer.

Fig. 4 The muscle-retraction sign was seen.

Fig. 5 a The resected specimen was 48×35 mm in size. b Histological examination revealed a tubular adenoma with low grade dysplasia. The resection margins were clean and included muscle fibers of the main muscle layer.