

## Polypectomy of a giant sessile polyp in the hepatic flexure using scissor-type forceps and a gravity traction method to create a pseudo-peduncle

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.

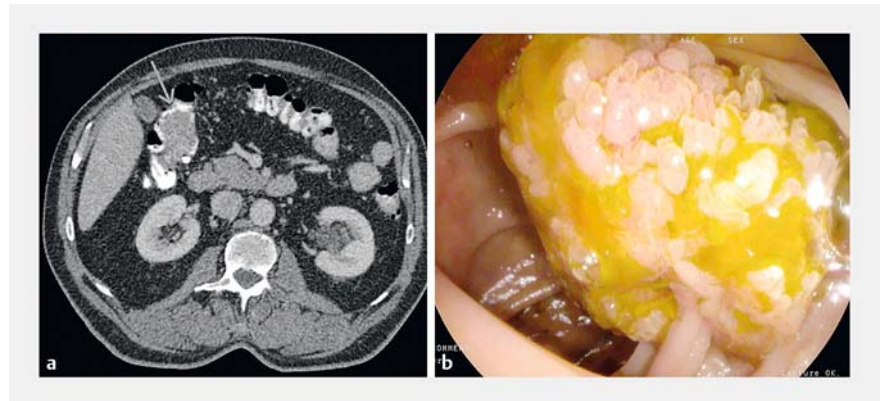
Therapeutic endoscopy was performed using scissor-type forceps (Sumitomo Bakelite, Japan) and a RetroView colonoscope (Pentax, Japan) with a distal attachment cap (Olympus, Japan) (► **Video 1**).

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**).

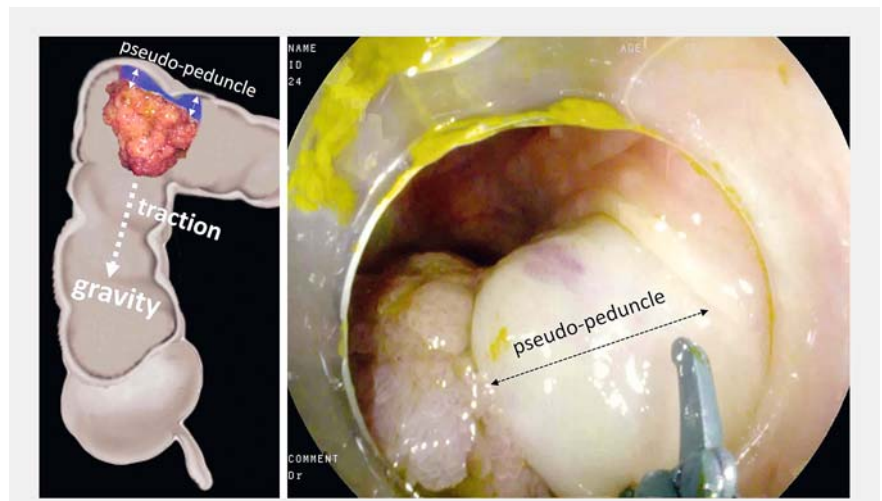
In the 24-month follow-up no residual adenomatous tissue was observed. Unfortunately, most cases of endoscopic resection of complex polyps are limited to a piecemeal technique because of the types of polypectomy snare used [2].

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 re-



► **Fig. 1** a Abdominal computed tomography revealed a tumor (arrow) in the hepatic flexure, without lymphadenopathy or infiltration of the pericolic fat. b Diagnostic colonoscopy revealed a giant protruding polyp, type 0-Is in the Paris classification.



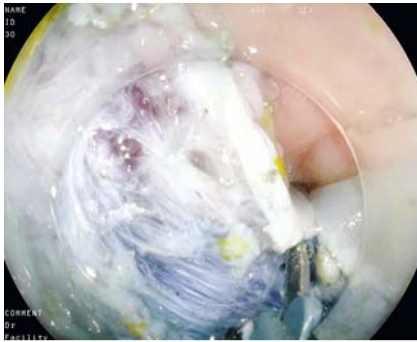
► **Fig. 2** Creation of a pseudo-peduncle, taking advantage of gravity (gravity traction method).

section 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.

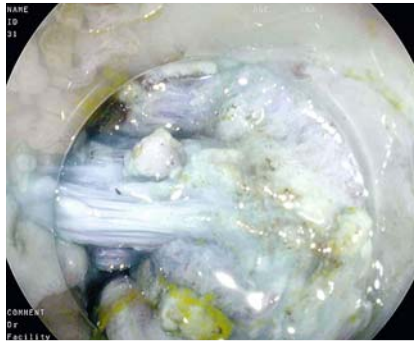
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### Competing interests

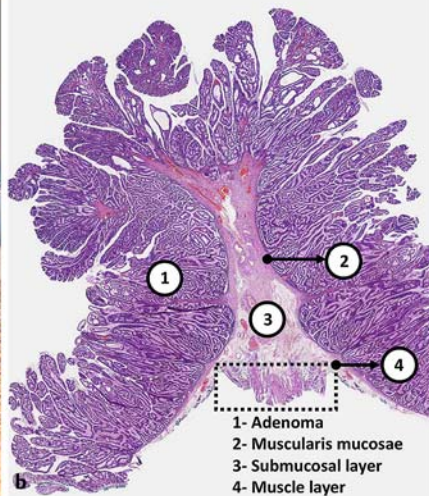
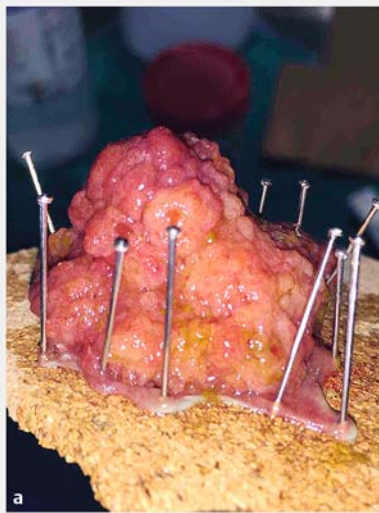
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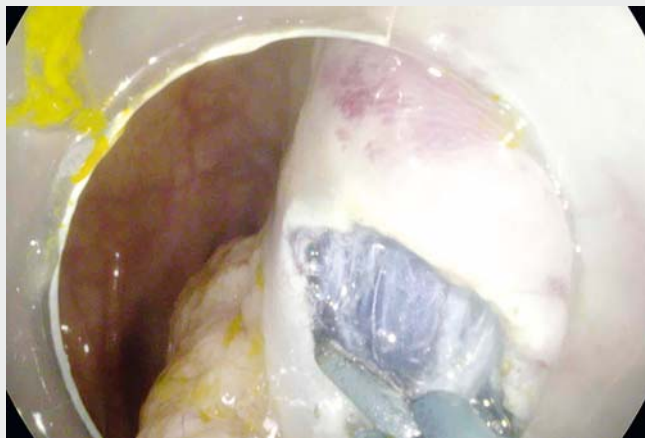
► **Fig. 3** Use of the distal cap facilitates exposure of the dissection plane between the lesion and the muscular layer.



► **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.



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

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