

## Cancer recurrence with severe fibrosis after cold snare polypectomy resected by means of endoscopic submucosal dissection

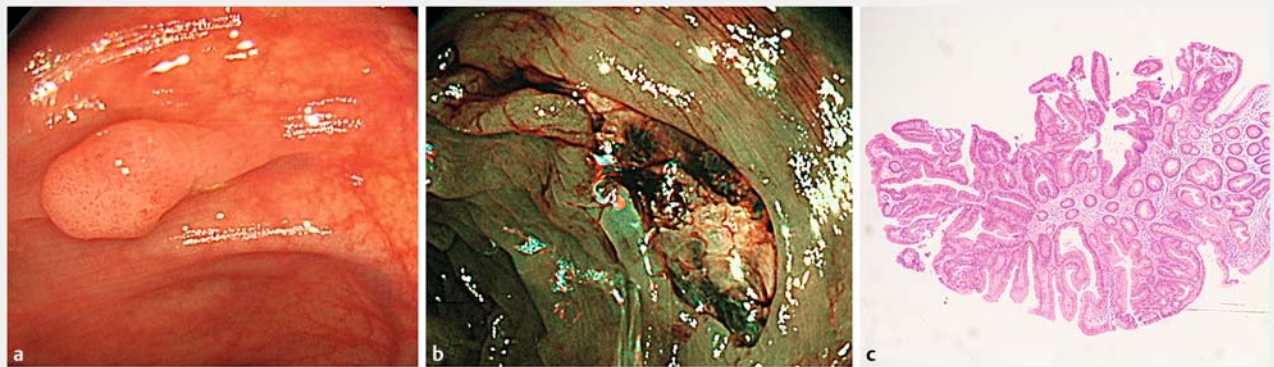
Generally, local recurrence is a major problem after various endoscopic resections for colorectal tumors, and we have previously reported a recurrence rate after cold snare polypectomy (CSP) of 1.9% [1]. Endoscopic salvage treatment for recurrent neoplasms is sometimes difficult due to fibrosis.

According to Japanese Gastroenterological Endoscopy Society guidelines, recurrent intramucosal cancer after endoscopic resection is one of the indications for endoscopic submucosal dissection

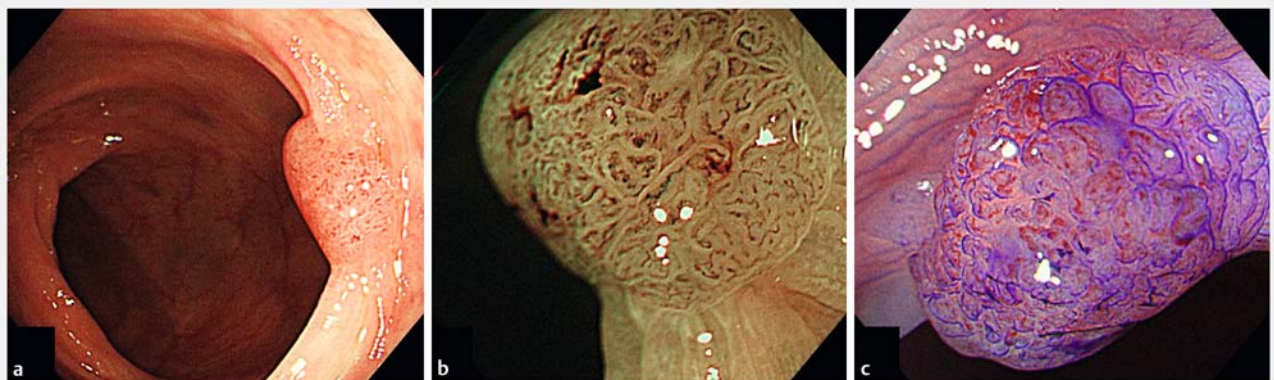
(ESD) [2]. In this report, we present a case in which ESD was used to treat a recurrent lesion showing severe fibrosis after CSP using a scissors-type knife (ClutchCutter 3.5 mm; Fujifilm, Tokyo, Japan) and a traction device (S-O clip; Zeon Medical, Tokyo, Japan).

A polypoid lesion 5 mm in size was detected in the transverse colon and CSP was performed (► Fig. 1 a, b). The histopathological diagnosis was intramucosal adenocarcinoma with serrated architecture showing a positive cancer margin (► Fig.

1 c). Two months after CSP, a recurrent lesion 6 mm in size was detected on the scar (► Fig. 2 a). Magnified narrow-band imaging showed an irregular surface and vessel pattern, and chromoendoscopy with crystal violet staining showed not an amorphous pattern but an irregular pit pattern (► Fig. 2 b, c). We diagnosed the lesion as intramucosal cancer and tried ESD. After injection of 0.2% hyaluronic acid solution with indigo carmine, the nonlifting sign was detected. We performed a full circumferential mucosal in-



► **Fig. 1** Cold snare polypectomy (CSP) used to treat an intramucosal adenocarcinoma. **a** Polypoid lesion 5 mm in size on the transverse colon. **b** An ulcer after CSP showing no definite residual lesion with NBI. **c** Histopathological diagnosis was intramucosal adenocarcinoma with serrated architecture showing a positive cancer margin.



► **Fig. 2** Recurrence after CSP. **a** Recurrent lesion 6 mm in size on the CSP scar. **b** Magnified narrow-band imaging showed an irregular surface and vessel pattern. **c** Chromoendoscopy with crystal violet staining showed an irregular pit pattern.



**Video 1** Endoscopic submucosal dissection using a traction device and a scissors-type knife for the recurrence after the CSP.

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cision, followed by deployment of an S-O clip on the anal side of the lesion [3,4]. Sufficient traction was achieved, and this enabled us to dissect the severe fibrosis safely using a ClutchCutter [4,5]. Finally, the lesion was resected en bloc in 59 min (►Video 1). We then disconnected the loop of the S-O clip with the clip device and took the lesion out with the ClutchCutter. The histopathological diagnosis was intramucosal cancer with free margins. Surveillance colonoscopy 3 months after ESD showed no recurrence.

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## Competing interests

Naohisa Yoshida received a research grant from Fujifilm. The other authors declare no conflict of interest for this article.

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