Colorectal endoscopic submucosal dissection (ESD) is becoming the standard of care for colorectal tumors; however, troubleshooting for complications remains a challenge, particularly when dealing with large intraoperative perforations [1–3]. Here, we present a case where such a large perforation was successfully treated with polyglycolic acid (PGA) sheets and a purse-string suture method using a detachable snare.

A 76-year-old woman was referred to our institution for treatment of a large flat-elevated rectal tumor. Colonoscopy revealed that the tumor involved two-thirds of the circumferential surface, and covered the area above and below the peritoneal reflection, and extended to the anal margin (▶Fig.1). The entire lesion was soft, and magnifying chromoendoscopy using crystal violet staining identified type IV and V irregular low-pit patterns; thus, we diagnosed the lesion as adenoma or intramucosal adenocarcinoma. Computed tomography (CT) showed no lymph node or distant metastasis, and ESD was performed.

The lesion was difficult to dissect because of the high degree of fibrosis. However, when approximately 90% of the dissection was completed, a large, approximately 40 mm, perforation was identified (▶Fig.2). The lesion was excised as quickly as possible, and the purse-string suture method was used to close the perforation (▶Fig.3). The detached snare was spread around the perforation and fixed to the muscle layer or mucosa with clips. By tightening the fixed detachable snare, the purse-string suture method was used to close the perforation. Polyglycolic acid sheets filled the gap, and fibrin glue was sprayed.

CT, obtained immediately after the procedure, showed fluid retention, increased lipid density around the rectum, and retroperitoneal emphysema extending around the right kidney. The patient was managed conservatively, and although colorectal perforation occurred, no local recurrence occurred (▶Fig.4). The resected specimen was 80×66 mm in size and contained a 78×64 mm tumor. Histopathological analysis revealed high-grade tubular adenoma.

Although colonoscopy performed 8 weeks after discharge showed mild postoperative stenosis, partial obstruction was not observed, and no local recurrence occurred. She resumed eating 7 days post ESD and was discharged on Day 11.

Acknowledgement

We would like to thank Editage (www.editage.com) for English language editing.
Competing interests

Mitsuhiro Fujishiro has received research grants from Olympus Corporation, Fujifilm Corporation, and HOYA Pentax Corporation, and honoraria from Olympus Corporation and Fujifilm Corporation. Yosuke Tsuji has received research grants from Olympus Corporation, GUNZE and HOYA Pentax Corporation. The remaining authors declare that they have no conflict of interest.

The authors

Daisuke Ohki, Yosuke Tsuji, Rina Cho, Miho Obata, Hiroya Mizutani, Yoshiki Sakaguchi, Mitsuhiro Fujishiro

Department of Gastroenterology, Graduate School of Medicine, The University of Tokyo, Japan

Corresponding author

Yosuke Tsuji, MD
Department of Gastroenterology, Graduate School of Medicine, The University of Tokyo, 7-3-1 Hongo, Bunkyo-ku, Tokyo 113-0033, Japan
ytsuji@q.ecc.u-tokyo.ac.jp

References


Bibliography

Endoscopy
DOI 10.1055/a-1887-6207
ISSN 0013-726X
published online 2022
© 2022. The Author(s).

This is an open access article published by Thieme under the terms of the Creative Commons Attribution-NonDerivative-NonCommercial License, permitting copying and reproduction so long as the original work is given appropriate credit. Contents may not be used for commercial purposes, or adapted, remixed, transformed or built upon. (https://creativecommons.org/licenses/by-nc-nd/4.0/)

Georg Thieme Verlag KG, Rüdigerstraße 14, 70469 Stuttgart, Germany