Endoscopic submucosal dissection (ESD) is a time-consuming and technically demanding technique [1–3]. The main difficulty is the lack of triangulated countertraction with current endoscopes [4]. To improve speed and efficacy of the procedure, an intriguing pulley method using dental floss together with endoscopic clips has recently been described [5]. However, current clip technology is unlikely to provide a robust and dependable anchor for this “pulley” technique.

To create a more stable pulley mechanism, we used a novel endoscopic suturing device (Overstitch, Apollo-Endosurgery, Austin, Texas, USA; Fig. 1). The device consists of a suture with an anchor/needle threaded through one endoscopic working channel. The anchor can be linked to a curved suturing-arm manipulated via a system-handle on the proximal end of a dual-channel therapeutic gastroscope (Video 1). We believe the use of this system could greatly facilitate ESD by providing endoluminal triangulation and retraction (Fig. 2).

In an anesthetized 45-kg pig, hypothesized gastric lesions (n=2) were marked by mucosal burns (diameter 3 cm). After lifting the area with saline, a circumferential mucosal incision was performed using a standard needle knife. With the suturing device a suture was first endoluminally anchored at an anterior gastric fold (Fig. 3), distal from the lesion. A second bite was placed through the lateral proximal edge of the specimen and the anchor/needle, serving as a lifting retainer, was released. To generate triangulation, another endoluminal pulley was created (Fig. 4) at the contralateral mucosal edge. Both suture tails were withdrawn through the mouth and separately clamped with a hemostat. An isolated tip needle knife (IT-knife, Olympus, Center Valley, Pennsylvania, USA)

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**Video 1**
The curved suturing-arm and the anchor/needle are manipulated via a system-handle mounted onto the proximal end of the endoscope (endoscopic and external view).
was used for submucosal dissection while alternately pulling on the sutures to lift and retract the specimen (Fig. 5). All suture-pulleys (n = 4) were easily created within 5.3 ± 0.3 min. Subsequent submucosal dissections were successfully performed in 34.0 ± 1.4 min, without perforations (Fig. 6, Video 2).

The use of an endoscopic suturing device could facilitate dissection of large superficial gastrointestinal lesions by enabling endolumenal triangulation.

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Compared to significant improvements in safety, this technique may enable performance of submucosal dissection of lesions that currently appear to be challenging to achieve. Potential indications for this technique include large superficial gastrointestinal lesions, where endoscopic resection is challenging due to the lesion size or location.

References