Removal of a large, 40-mm, submucosal leiomyoma using submucosal tunneling endoscopic resection and extraction of specimen using a distal mucosal incision

Submucosal tunneling endoscopic resection (STER) combines the techniques of peroral endoscopic myotomy [1] and endoscopic submucosal dissection for removal of upper gastrointestinal tract submucosal tumors (SMTs). STER has been used for removal of small SMTs below 20 mm with low complication rates [2–4]. This report describes the removal of a large 40-mm esophageal SMT using STER, and describes a novel technique to aid the en bloc extraction of large SMTs during STER. A 57-year-old man presented with dysphagia. Upper endoscopy (Video 1) and endoscopic ultrasound (Fig. 1) confirmed a 40-mm SMT in the mid esophagus. The novel technique used for the removal of the SMT is shown in Fig. 2. A single-channel endoscope with a transparent distal cap attachment was used. Following injection of diluted indigo carmine, a mucosal incision was made using a triangle tip knife, 4 cm proximal to the tumor. A submucosal tunnel was created towards the tumor (Video 2), and peritumoral dissection was accomplished by division of submucosal fibers and attachments (Video 3). After completion of peritumoral dissection, removal of the SMT by various endoscopic retrieval devices, including snares and nets, was unsuccessful because of the size of the SMT and the limited working space available within the submucosal tunnel (Video 4). A novel second distal mucosal incision technique was performed for en bloc removal of the resected specimen, as illustrated in Fig. 3. A submucosal tunnel was created 4 cm distal to the tumor, and a mucosal incision was made from within the submucosal tunnel (Video 4). The SMT was then pushed using the endoscope from the submucosal tunnel into the true lumen of the distal esophagus and into the stomach through the distal mucosal incision. With adequate working space in the stomach, a net could be deployed easily over the SMT, and the SMT was retrieved.
The mucosal defects were closed using endoscopic clips and endoloops (Video 5). The entire procedure took 245 minutes. The final resected specimen (Fig. 4) measured 40 mm, and histopathological examination confirmed a diagnosis of a leiomyoma.

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Competing interests: None

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References

Bibliography
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