Endoscopic transmural hydro-dissection as a rescue therapy for rectal fibrotic adenoma

The rectum is considered a feasible and safe area in which to perform endoscopic submucosal dissection (ESD) [1, 2]. Therefore, ESD is a suitable approach for the treatment of high risk rectal adenomas. However, scarred and fibrotic polyps have recently been described as the only preoperative predictor of failed ESD in the rectum [2, 3]. Transanal endoscopic microsurgery (TEM) has been shown to be an effective treatment for lower rectal carcinomas staged as T1 or T2 [4], owing to the depth of the resection.

We present the case of a 25 mm 0-Iṣ type adenoma with wide scarred areas caused by two previous failed TEMs, located 3 cm away from the dentate line (Fig. 1), in a 75-year-old man without any relevant medical history. The pocket creation method was adopted because of the expected submucosal fibrotic tissue [5]. The first stage of the tunnel was created without any drawbacks using an Erbejet-2-HybridKnife (Erbe Elektromedizin GmbH, Tübingen, Germany). However, when the area below the lesion was reached, dramatic fibrotic tissue became visible. This finding made it extremely difficult to identify...

▶Fig. 1 Intensely scarred adenoma located 3 cm away from the dentate line.

▶Fig. 2 Transmural dissection planning diagram. a Different layers exposed during the procedure. b Final result. Red line indicates the previous location of the adenoma. SM, submucosal layer; ML, muscular layer.

▶Video 1 Endoscopic transmural hydro-dissection by pocket creation method of a sessile scarred polyp located in the lower rectum.
a feasible cutting line between the submucosal and muscular layers. At this point (stage 2), we decided to carry out a transmural dissection between the transverse and longitudinal muscular layers, in order to reach a feasible cutting line inside the submucosal layer (Fig. 2, Fig. 3, Video 1). Consequently, we successfully achieved en bloc resection of the lesion (stage 3). Subsequently, the muscular defect was closed using endoclips (Resolution; Boston Scientific, Marlborough, Massachusetts, USA). The patient was discharged 72 hours after the procedure.

The histopathological analysis revealed a transmural specimen with high grade dysplasia (R0 resection), intense fibrotic submucosal tissue, and superficial muscular propria layer (Fig. 4).

In conclusion, the pocket creation method performed in fibrotic and scarred lesions located in the lower rectum,
allowed a safe and deep dissection across muscular layers. This approach might support ESD as a rescue therapy following failed TEM.

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Competing interests

None

The authors

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