Hybrid endoscopic submucosal dissection using a full-thickness resection device allows en bloc resection of a large adenoma deeply invading the appendix

Endoscopic full-thickness resection using a full-thickness resection device (FTRD) (Ovesco; Tübingen, Germany) was introduced in 2014 and is mainly used for small colonic laterally spreading tumors (LSTs) with important fibrotic component, non-lifting after submucosal injection, or superficial recurrent lesions located at or near a surgical anastomosis. It has an 81 % R0 resection rate for lesions ≤2 cm, with a 10 % rate of adverse events [1, 2]. The main limitations are large tumor size and proximal colonic lesions, as the FTRD cap is 23 mm in length, which sometimes makes cecal intubation difficult. The most important risks are bleeding, trapping of pericolonic organs when sucking the lesions into the cap, and luminal stenosis due to the clip [3].

We present the case of a large LST invading the appendectomy site. Standard resection using the FTRD was not possible because the lesion (▶Fig. 1; ▶Video 1) was too large (40 mm) to fit into the cap, so we first performed a circumferential incision and endoscopic submucosal dissection using the clip and rubber-band strategy (▶Fig. 2) [4, 5]. We then used the FTRD system to trap the dissected corolla into the cap (▶Fig. 3). The clip was placed safely around the lesion and sectioning was performed using a standard polypectomy snare (failure of cutting with 13-mm FTRD integrated snare).
The resected specimen (Fig. 4) was examined histopathologically and showed an R0 full-thickness resection of a low grade dysplastic adenomatous lesion. The patient was discharged 24 hours later and no complications occurred during 3 months of follow-up.
Photographs of: a the specimen removed by the full-thickness resection device; b the specimen after placement on a cork board.

Bibliography

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