A 60-year-old man with abdominal discomfort was referred to our hospital. Abdominal computed tomography (CT) revealed a tumor in the hepatic flexure and colonoscopy showed a giant protruding polyp (Fig. 1). The biopsies were interpreted as adenoma with areas of high-grade dysplasia. Therapeutic endoscopy was performed using scissor-type forceps (Sumitomo Bakelite, Japan) and a RetroView colonoscope (Pentax, Japan) with a distal attachment cap (Olympus, Japan) (Video 1).

First, we took advantage of the polyp's own weight to exert traction in order to form a pseudo-peduncle (Fig. 2). We began cutting the mucosal layer to expose the submucosa. Then, countertraction with a soft straight distal cap facilitated exposure of the dissection plane between the lesion and the muscle layer (Fig. 3). We coagulated the larger vessels in advance. At one point, some muscle fibers were identified by means of the muscle-retraction sign [1] (Fig. 4). The resection was completed within 70 minutes without adverse events. The endoscopic resection defect was closed with endoscopic clips (Boston Scientific, United States). Pathology examination showed an adenoma 48 × 35 mm in size with low-grade dysplasia. Resection margins were clean and included muscle fibers of the main muscle layer (Fig. 5).

In the 24-month follow-up no residual adenomatous tissue was observed. Unfortunately, most cases of endoscopic resection of complex polyps are limited to a piecemeal technique because of the types of polypectomy snare used [2]. However, we now have fast, easy, and safe endoscopic submucosal dissection (ESD) devices [3], that can help in performing en bloc resection. This case report, similarly to previous ones [4], demonstrates that the scissor-style knife can safely speed en bloc resection in a western setting. Further studies are needed to assess the efficacy and safety of this device when used in the resection of protruding polyps by nonexpert ESD endoscopists.

Competing interests

None
The authors

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Video 1 Endoscopic resection of a giant protruding polyp in the hepatic flexure, using scissor-type forceps.

Video 1

Fig. 3 Use of the distal cap facilitates exposure of the dissection plane between the lesion and the muscular layer.

Fig. 4 The muscle-retraction sign was seen.

Fig. 5a The resected specimen was 48×35 mm in size. b Histological examination revealed a tubular adenoma with low grade dysplasia. The resection margins were clean and included muscle fibers of the main muscle layer.