

Hemorrhage from the point of traction on the opposing wall after colonic endoscopic submucosal dissection using countertraction: a rare adverse event

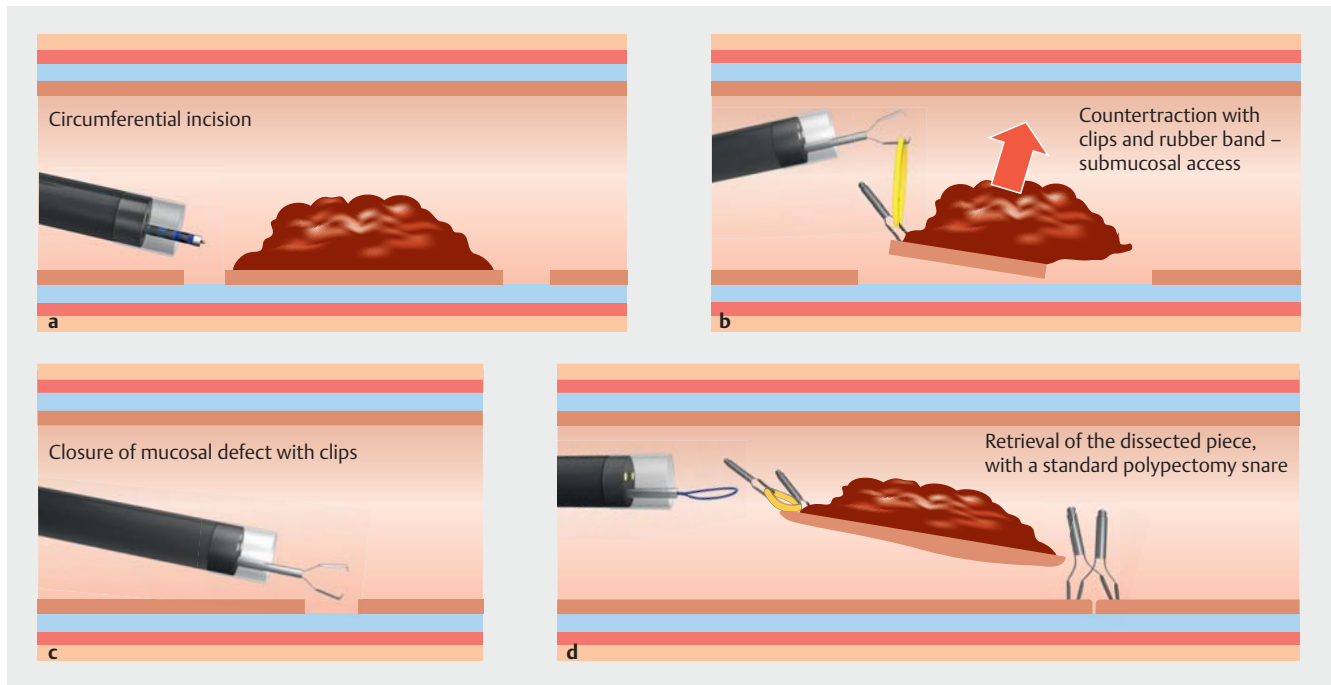
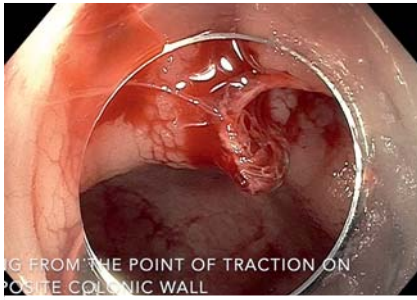


Fig. 1 Schema of the endoscopic procedure showing: **a** the circumferential incision; **b** countertraction with clips and a rubber band; **c** closure of the mucosal defect; **d** retrieval of the resected specimen.

Endoscopic submucosal dissection (ESD) is recommended for complete en bloc resection of colonic lesions that are larger than 20 mm and with a high risk of limited submucosal invasion, based on depressed morphology and an irregular or non-granular surface pattern [1]. Recent studies have shown that countertraction techniques using clips and a rubber band increase the R0 resection rate and significantly decrease the procedure time, while also decreasing the complication rates (perforation and bleeding) [2]. We report here the case of an 87-year-old patient who was on no anticoagulant or antiplatelet treatment and had no prior coagulation disorder. A pseudodepressed nongranular 15-mm laterally spreading tumor (Paris 0-IIa+0-IIc, Kudo Vn, Sano IIIb, JNET III, NICE III) was found in



Video 1 Endoscopic submucosal dissection using countertraction is performed for a colonic laterally spreading tumor; bleeding is later identified from the opposite colonic wall and endoscopic hemostasis is achieved.



► **Fig. 2** Endoscopic view showing bleeding from the opposite colonic wall.

the right colon. Although right hemicolectomy would have been the standard therapy, because of the small size of the lesion and the advanced age of our patient, we decided to perform a diagnostic en bloc resection using ESD with countertraction (► **Fig. 1**). A 30×25-mm piece was retrieved and the dissection scar was closed with three hemostatic clips (Resolution 360; Boston Scientific, USA) (► **Video 1**).

Several hours after the procedure, the patient presented with significant rectorrhagia, so a second colonoscopy was performed. Active bleeding was observed from the colonic wall that was opposite to the dissection scar, corresponding to the point where the traction clip had been previously placed (► **Fig. 2**; ► **Video 1**). Hemostasis was obtained using a hot biopsy forceps (Endo-Jaw Hot; Olympus, Japan) and two hemostatic clips. The patient was discharged

48 hours later, having experience no other adverse events.

To the best of our knowledge, this is the first report of active bleeding from the opposing normal colonic wall, where a traction clip had been placed. Although very rare, this case highlights the importance of gentle traction on the parietal clip when retrieving the dissection specimen, and careful inspection of the site prior to completion of the procedure.

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Competing interests

The authors declare that they have no conflict of interest.

The authors

Adrien Patenotte¹, Alexandru Lupu¹, Jérémie Jacques², Jérôme Rivory¹, Florian Rostain¹, Mathieu Pioche¹

- 1 Gastroenterology and Endoscopy Department, Edouard Herriot Hospital, Lyon, France
- 2 Service de Gastroenterologie, Dupuytren Hospital, CHU, Limoges, France

Corresponding author

Alexandru Lupu, MD
Edouard Herriot Hospital, 5 Pl Arsonval,
Lyon 69003, France
alexandru.c.lupu@gmail.com

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