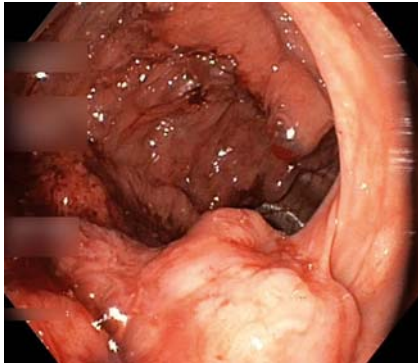
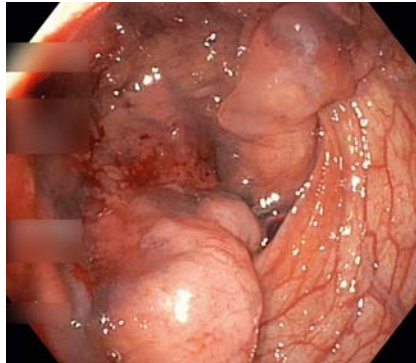


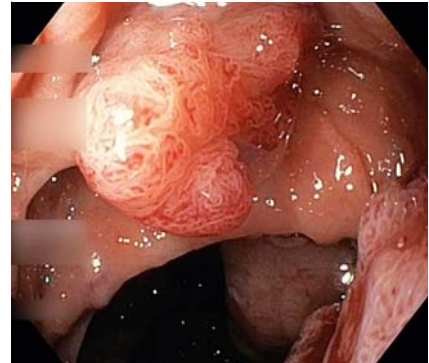
Pushing the frontier of endoscopic submucosal dissection in the management of colorectal lesions



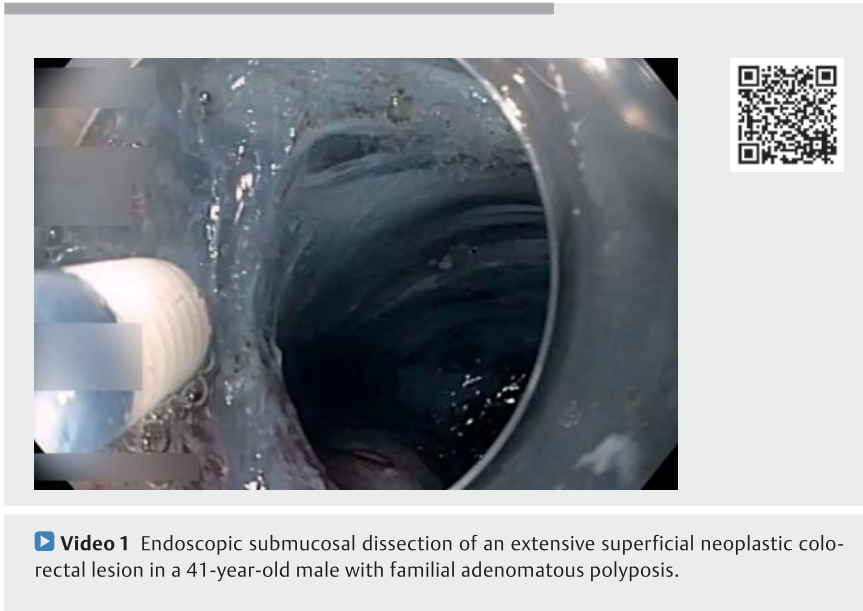
► **Fig. 1** Laterally spreading tumor of the granular nodular mixed type (Paris endoscopic classification 0-IIa + Is) extending from the pectinate line to the distal sigmoid colon.



► **Fig. 2** Exudative superficial neoplastic colorectal lesion involving 70% of the luminal circumference.



► **Fig. 3** No endoscopic signs of invasive cancer (vessel and surface pattern type 2B according to the classification of the Japan NBI Expert Team).



► **Video 1** Endoscopic submucosal dissection of an extensive superficial neoplastic colorectal lesion in a 41-year-old male with familial adenomatous polyposis.



► **Fig. 4** Stretching and pinning of the resected lesion; dimensions: 238 × 215 mm (maximum length of 270 mm).

A 41-year-old man with familial adenomatous polyposis (FAP) recommended for prophylactic colectomy with ileorectal anastomosis was proposed for endoscopic submucosal dissection (ESD) of a superficial neoplastic colorectal lesion (► **Fig. 1**, ► **Fig. 2**). The lesion extended from the pectinate line to the distal sigmoid colon and involved 70% of the luminal circumference. After thorough

endoscopic evaluation with virtual chromoendoscopy, no evidence of invasive disease was found (► **Fig. 3**).

ESD was technically demanding owing to lesion size and extension (► **Video 1**). En bloc resection was achieved within a total procedure time of 510 minutes. Minor intraprocedural bleeding occurred and was adequately controlled with vessel coagulation. The excised specimen

measured 238 × 215 mm, with a maximum length of 270 mm (► **Fig. 4**). Histopathology confirmed R0 resection of a traditional serrated adenoma with low-grade and focal high-grade dysplasia. Endoscopic management of rectal lesions is feasible in FAP, allowing selected patients to avoid proctectomy as long as intensive endoscopic surveillance of the residual rectum is performed [1,2]. Nowadays ESD is frequently used for the resection of colorectal lesions, including

rectal remnant polyps in FAP [3,4]. However, extensive lesions can be challenging for the endoscopist owing to the loss of orientation caused by rolling of the mucosal flap and the progressive fall of the resected lesion into the lumen. This procedure turned out to be more complex than initially perceived. The extreme effort of the endoscopist allowed sparing of the rectum and consequently improved the quality of life of a patient who would otherwise have been proposed for a proctocolectomy. Therefore, albeit a time-consuming strategy, ESD seems a reasonable approach for the management of exceedingly large colorectal lesions. As more Western endoscopists gain experience in ESD, FAP patients who are candidates for rectal sparing should not be managed with proctocolectomy unless endoscopic management is considered unfeasible.

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Competing interests

The authors declare that they have no conflict of interest.

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