Endoscopic intermuscular dissection (EID) of a severely fibrotic benign rectal lesion in an area affected by radiation proctitis

The rectum is the ideal part of the large bowel in which to perform deep excision for dysplastic lesions [1, 2]. However, in cases of severe submucosal fibrosis and deep invasion of a carcinoma into the submucosa, performing endoscopic submucosal dissection can be very difficult. The intermuscular plane of dissection and myectomy of the inner muscular layer (endoscopic intermuscular dissection) previously have been described for treatment rectal neoplastic lesions, overcoming the compactness of the submucosa layer [3, 4, 5].

An 85-year-old man was referred to our department for a flat, 15-mm, dysplastic lesion (high-grade dysplasia [HGD]) close to the dentate line (Fig. 1). Morphologically, the polyp was a Paris Classification 0-IIa, NICE Classification: 2 and LST-Classification: NG-Type/Flat elevated. The patient had completed radiotherapy for prostate cancer 14 months before our evaluation and was treated with mesalamine enemas. The surrounding rectal mucosa was scarred and compact with white stripes and telangiectasias as a secondary effect of radiation. We decided to perform a deeper excision into the intermuscular plane to avoid the severely fibrotic submucosal plane (Fig. 2, Fig. 3, Fig. 4 and Video 1). A single dose of broad-spectrum antibiotics was given interprocedurally to the patient. The defect remained open after the excision without any adverse events, such as bleeding, fever or pain, and the patient was discharged the next day (Fig. 5). The pathology report revealed tubular adenoma with HGD radically resected. Follow-up endoscopy in 6 months later revealed almost complete healing of the defect (Fig. 6).

The dissection was performed between the inner circular and outer longitudinal muscles, instead of between the submucosal and muscle layers. The myectomy was achieved by using a Hook Knife (Olympus, Tokyo, Japan). Resecting be-

Fig. 1 A 15-mm flat polyp in the area affected by radiation proctitis.

Fig. 2 Inability to lift the compact and fibrotic submucosal space by fluid injection.

Fig. 3 Fluid injection into the intermuscular space.

Fig. 4 Dissection between the inner (circular) and outer (longitudinal) muscle layers.

Fig. 5 Open defect after removal of the dysplastic rectal lesion.

Fig. 6 Healing of the dissection on follow-up endoscopy (6 months).
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Conflict of Interest

The authors declare that they have no conflict of interest.

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Video steps

HGD in the area affected by radiation proctitis
Starting mucosal incision without adequate lifting due to fibrosis
Compact and fibrotic submucosal space
Changing knife for myotomy
Entering intermuscular space
Injection to expand the tiny intermuscular space
Cautious intermuscular dissection
After completing circumferential incision, continuing with dissection

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