The triumph of fingers: mechanical hemostasis for postpolypectomy bleeding using the fingers

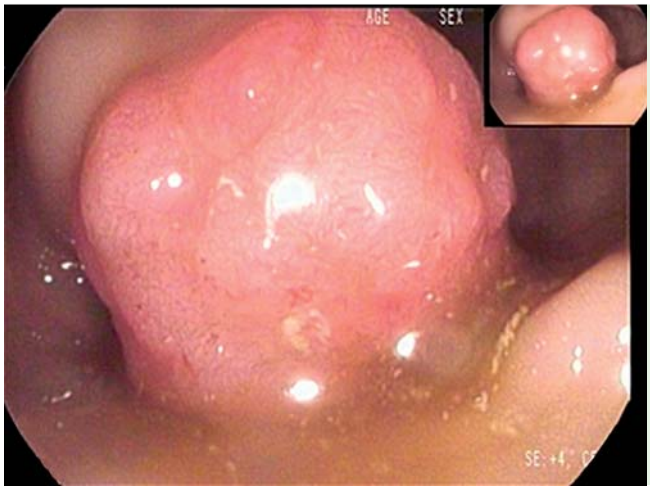

Fig. 1 A 3 × 3-cm sessile polyp located in the sigmoid colon about 15 cm from the anal verge.

A 67-year-old woman complaining of intermittent lower abdominal discomfort and hematochezia was referred to our endoscopy center. Colonoscopy revealed a 3 × 3-cm sessile polyp located in the sigmoid colon (about 15 cm from the anal verge) (▶ **Fig. 1**). The polyp was hidden behind colonic folds and was difficult to access with a colonoscope. After submucosal injection, the polyp was snared using electrocautery (endocut mode) in a piecemeal fashion (▶ **Fig. 2**).

Significant arterial bleeding occurred immediately after polyp removal, and instant repeated coagulation by thermocautery forceps was not effective (▶ **Fig. 3**). Subsequent application of hemoclips in an attempt to stop the bleeding also failed because endoscopic vision was largely blurred by excessive blood (about 800 mL) and the source of bleeding was in a difficult position. Finally, as a last attempt before surgery was indicated, two fingers were inserted into the anus, the rectum and sigmoid colon were pulled downward gently, and pressure was applied for 10 minutes to the bleeding point, which was accurately localized by the hemoclips. The colonoscope was then advanced and retroflexed, and revealed that the bleeding had stopped. Blood scabs and fibrins were observed on the hemoclips after the fingers had been withdrawn (▶ **Fig. 4**). No delayed bleeding occurred. When all advanced endoscopic devices for hemostasis failed, our fingers excelled and saved the patient from surgery.

Significant intraoperative bleeding can be a major disaster for endoscopists during colonic polyp snaring or endoscopic mucosal resection, especially when the target lesion is in an awkward location making it difficult for endoscopic hemostatic methods to be used effectively [1]. In this case, the simplest, seemingly primitive, method turned out to be the most effective one. From a practical perspective, our fingers can access the sigmoid colon as far as 20 cm from the anal verge, and this simple method is an option for all endoscopists in similar emergencies.

Endoscopy_UCTN_Code_TTT_1AQ_2AZ

Competing interests: None

Jiaoyang Lu[1], Taotao Jiao[2], Minhua Zheng[1], Xuefeng Lu[3]

[1] Department of General Surgery, Ruijin Hospital, Shanghai Jiao Tong University School of Medicine, Shanghai, China
[2] Department of Statistics, Shandong Provincial Hospital, Jinan, China
[3] Department of Gastroenterology, Qilu Hospital, Shandong University School of Medicine, Jinan, China

Reference

1 *Fyock CJ, Draganov PV*. Colonoscopic polypectomy and associated techniques. World J Gastroenterol 2010; 16: 3630 – 3637

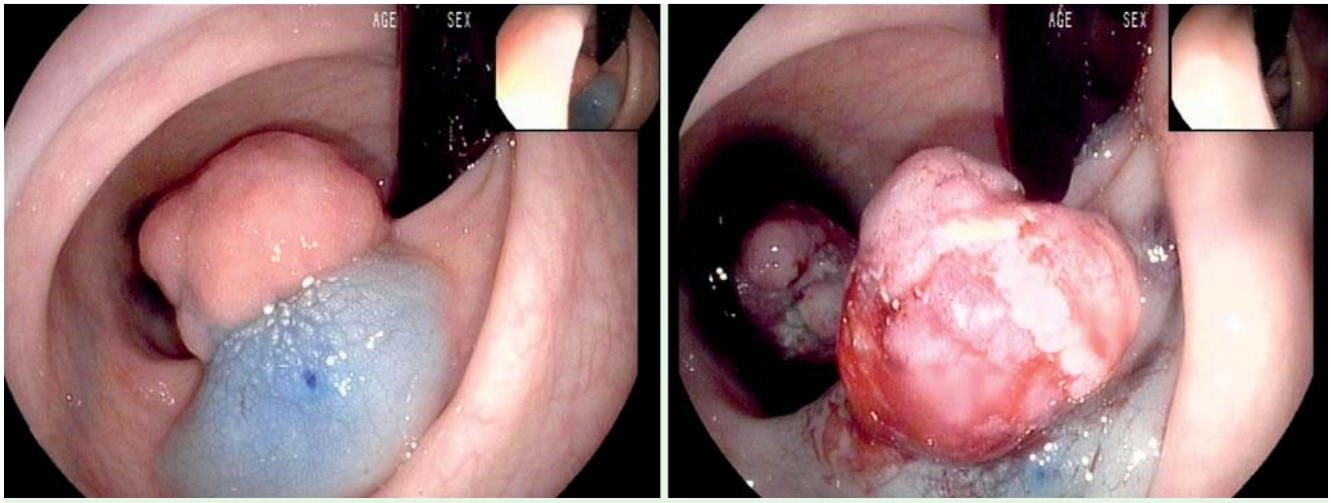

Fig. 2 After submucosal injection, the polyp was snared in a piecemeal fashion.

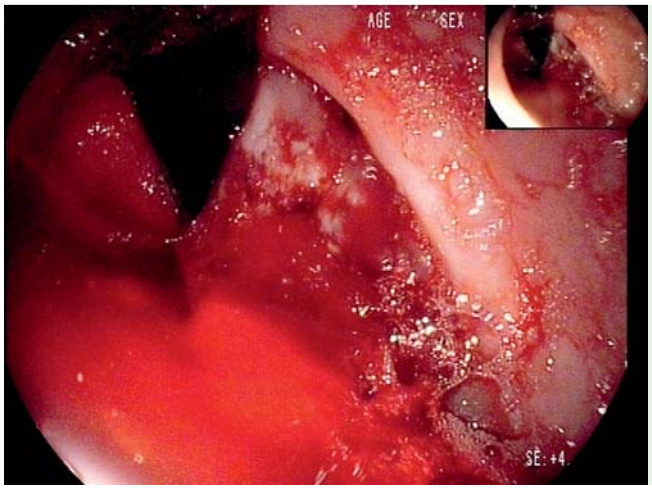

Fig. 3 Significant, uncontrolled arterial bleeding occurred immediately after polyp removal.

Bibliography
DOI http://dx.doi.org/10.1055/s-0034-1377406
Endoscopy 2014; 46: E415–E416

Stuttgart · New York
ISSN 0013-726X

Corresponding author
Xuefeng Lu, MD
Department of Gastroenterology
Qilu Hospital
Shandong University School of Medicine
Jinan, Shandong
China, 250012
Fax: +86-531-82166095
lu0801shanyi@163.com

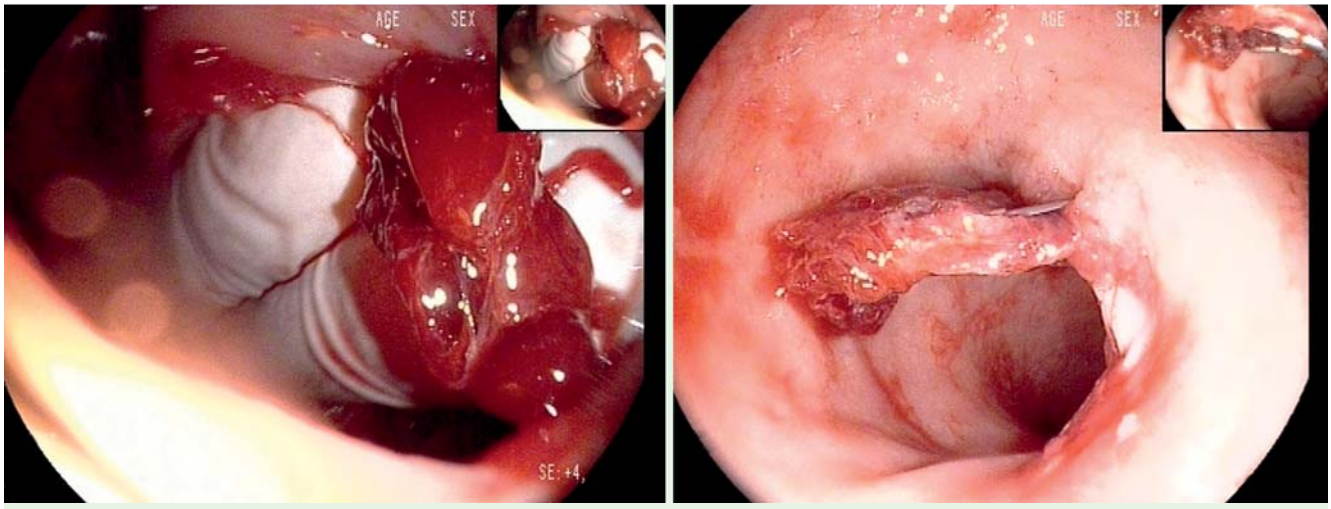

Fig. 4 Retroflexed view of two fingers pressing against the bleeding spot; when the fingers were removed, the bleeding had stopped.