Salvage hemostasis by scope compression during rectal endoscopic submucosal dissection

A 65-year-old man was referred for endoscopic submucosal dissection (ESD) of a large villous rectal lesion (lateral spreading tumor, granular type). Massive bleeding occurred during the procedure. A washing pump on the accessory channel of the scope was used to locate the source of the bleeding, however bleeding obscured the entire field of the procedure despite continuous use of the washing pump (Fig. 1). After 1 minute of intense bleeding with washing, a spurring arterial bleeding was noted (Fig. 2). Adrenaline injection was ineffective. Clips were inappropriate because they would interfere with the procedure preventing its completion, and it was impossible to use coagulation forceps because of the high rate of bleeding, which prevented precise visualization of the source of the bleeding. Compression with the distal cap attached to the head of the endoscope resulted in an initial decrease in the bleeding after 1 minute of compression (Fig. 3) and subsequently stopped it after 5 minutes of compression (Fig. 4) allowing partial coagulation of the artery responsible (Fig. 5). Then, before cutting it, the upstream part of the vessel was coagulated (Fig. 6, Video 1). Finally, the ESD was completed. Pathology revealed a tubulo-villous adenoma with in situ carcinoma with R0 margin.

Endoscopic submucosal dissection is the interventional endoscopic procedure with the greatest risk of bleeding. In ESD, hemostasis is considered part of the endoscopic therapy and not an adverse event. During the procedure, prophylactic coagulation is necessary using dissection knives or hemostatic forceps [1]. Oozing bleeding can usually be managed with a knife, while arterial bleeding requires hemostatic forceps [2]. Uncontrolled bleeding is problematic because clips are the most effective means of treatment, but can interfere with the ESD procedure, preventing its completion. For a rectal location, mechanical compression with a distal cap or a finger [3] is a useful alternative before attempting more radical treatment with coagulation forceps.

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References

Bibliography
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