Endoscopic resection and enucleation of gastric submucosal tumor facilitated by subsequent closure of incision using over-the-scope clip

A 73-year-old man with a history of diabetes mellitus, hypertension, coronary artery disease, and atrial fibrillation was found to have a 20-mm reddish elevated lesion of the lower gastric body (Fig. 1 a). Endoscopic ultrasound revealed a submucosal tumor originating from the muscularis propria. The patient preferred an endoscopic excision. An endoluminal resection was performed using the endoscopic submucosal dissection (ESD) technique with carbon dioxide insufflation. An indigo carmine-saline mixture was injected into the base of the lesion. After creation of incision with the tip of a snare, the IT-knife2 (Olympus, Melville, New York, United States) was then used to circumferentially cut the mucosa and submucosa around the tumor. Careful dissection was performed, exposing the entire capsulized round tumor, which was completely excavated from its base and enucleated (Fig. 1 b). The resection was deep exposing the muscle layer. Given the patient’s high risk cardiovascular status and continued need for antiplatelet agents, the wound was closed endoscopically using an over-the-scope clip (OTSC; 12/6 t, Ovesco, Tübingen, Germany). Air was suctioned from the stomach to decrease the surface area of the wound. Then the OTSC device was directed towards the wound and suction was applied to pull the lateral mucosa edges into the cap. The clip was released and the wound closed successfully (Fig. 1 c). The resected specimen confirmed enucleation of the gastric leiomyoma with hyperplastic epithelium on the surface (Fig. 1 d).

While ESD and excavation techniques are potential therapeutic options for the removal of a gastric submucosal tumor, they more frequently result in perforation than ESD for early gastric cancer [1, 2]. This case shows the utility of OTSC for full-wall closure during a one-step process, thus minimizing the risk of delayed bleeding and perforation. Although endoclips can be used, that is technically a more arduous and difficult procedure, usually necessitating several clips. Although the OTSC device is more expensive than a single clip, the use of more than three clips may exceed the price of an OTSC. In addition, the apposition forces of OTSC are much stronger and thus may result in a more secure closure [3, 4].

Competing interests: None

Seiichiro Abe1,3, Leona Council2, Xiaoyan Cui2, Yutaka Saito3, Klaus Mönkemüller1
1 Basil I. Hirschowitz Endoscopic Center of Excellence, Division of Gastroenterology and Hepatology, University of Alabama at Birmingham, Alabama, USA
2 Department of Pathology, University of Alabama at Birmingham, Alabama, USA
3 Endoscopy Division, National Cancer Center Hospital, Tokyo, Japan

Acknowledgments

Dr Seiichiro Abe is the recipient of the UAB Visiting Scientist/Professor Award and performed this work during his Boston Scientific Visiting Fellowship at the Basil I. Hirschowitz Center of Endoscopic Excellence, Division of Gastroenterology, University of Alabama at Birmingham, USA.

References

2 Li QL, Yao LQ, Zhou PH et al. Submucosal tumors of the esophago gastric junction originating from the muscularis propria layer: a large study of endoscopic submucosal dissection.