A 73-year-old man underwent colonoscopy for recurrent diffuse abdominal pain. Previous colonoscopy, routine laboratory tests, and a fecal occult blood test had all shown normal results.

At retrograde ileoscopy, a 25-mm laterally spreading tumor, nongranular pseudodepressed type (LST-NG PD; type 0-IIa-IIc according to the Paris classification), was diagnosed 5 cm proximal to the ileocecal valve (Fig. 1). The lesion was characterized as noninvasive by chromoendoscopy and narrow-band imaging using colorectal classifications: it was not villous, the pit pattern was small tubular (type IIs by Kudo), and the capillary pattern showed thin no-uniform vessels surrounding the crypts (type 3A by Sano) (Fig. 2).

Endoscopic submucosal dissection (ESD) was performed using a pediatric colonoscope (PCF-Q180AI; Olympus, Japan) and a hood with a small-caliber tip (ST-hood; Fujifilm; Japan) under CO2 insufflation. The procedure started with the incision of the ileal mucosa at the oral side and then moved progressively from the anal to the oral side using a non-insulated knife (Dual knife; Olympus). Diffuse fibrosis (Fig. 3a) and a 2-mm translucent mucus-like nodule (Fig. 3b,c) were encountered in the submucosa beneath the lesion during dissection. The ESD was completed en bloc within 100 minutes (Fig. 4; Video 1). The resection site was closed using four clips (Resolution clip; Boston Scientific, USA), and no adverse events occurred.
Histology showed an adenoma with low grade dysplasia and negative lateral and vertical margins (Fig. 5). The submucosal nodule was interpreted as being a Peyer’s patch. Follow-up endoscopy after 6 months revealed no residual tumor and no evidence of a stricture.

Endoscopic resection of superficial neoplasms involving the ileocecal valve and the ileum is difficult and is relatively contraindicated: the conventional piece-meal snare approach is frequently incomplete and requires subsequent surgery even for adenomas and intramucosal cancers [1]. ESD is a new technique that achieves high rates of curative resection but is very rarely adopted in the small bowel, primarily in the duodenum, because of the high technical difficulty and risk of perforation [2–4]. This case reaffirms the need for routine retrograde ileoscopy [5] and indicates that ESD in the terminal ileum is feasible as in other parts of the gastrointestinal tract. However, specific technical skills are required to control the deeply inserted endoscope and safely resect a lesion in the narrow, tortuous, mobile and thin-walled small bowel.

Competing interests: None

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