Endoscopic submucosal dissection for residual rectal polyps embedded in tissue scar: a “rescue therapy” to prevent surgical intervention?

The authors report a case of a 48-year-old Caucasian woman with a 3.5 cm residual polyp embedded in tissue scar, as a result of three endoscopic piecemeal resection sessions of a 10 cm sessile polyp of the lower rectum, previously diagnosed from biopsy as tubulovillous adenoma with high-grade dysplasia.

The patient was then submitted to en bloc resection with endoscopic submucosal dissection (ESD) according to the technique of Yamamoto [1,2] (Fig. 1–3). The preparation of the patient consisted of mechanical bowel cleansing with polyethylene glycol solution and 5 days of oral antibiotic therapy with ciprofloxacin (500 mg twice daily) and metronidazole (500 mg three times daily).

The procedure was carried out using a single-channel upper gastrointestinal endoscope with a water-jet system (Olympus GIF 1T-160, Tokyo, Japan). A transparent cap (ST-HOOD, DH 15GR, Fujinon, Saitama, Japan) was attached to the tip of the endoscope in order to apply tension to the submucosal connective fibers during dissection (Fig. 4–5). The procedure time was 2 hours. The postoperative course was uneventful and the patient was discharged 2 days after the procedure.

The histological examination of the resected specimen described a residual adenomatous tissue with high-grade dysplasia; the excision margins were negative (R0 resection). The patient underwent control endoscopy 6 months later (Fig. 6), and multiple biopsies were...
taken of the resected area, which were negative at the histological examination.
In cases of large polyps the standard of care is endoscopic piecemeal resection
that, unfortunately, carries two disadvantages: the margins of resection may be
difficult to evaluate by the pathologist, and in 14%–50% of cases at least one ad-
ditional endoscopic session is required [3]. Notably, further endoscopic resection
is often difficult as a result of fibrosis. These concerns are emphasized in large
villous sessile rectal polyps because of their high potential for malignant trans-
formation. In the reported case, the en bloc resection of a residual polyp, not
amenable to standard endoscopic treatment (including endoscopic mucosal re-
section), was accomplished by ESD, avoiding a more invasive surgical proce-
dure. As reported for residual/recurrence of early gastric cancer after endoscopic
mucosal resection [4,5], ESD can be pro-
posed as an interesting endoscopic “res-
cue therapy” for residual rectal scar-em-
bedded polyps.

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