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 tubulous-villous 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

---

**Endoscopic submucosal dissection for residual rectal polyps embedded in tissue scar: a “rescue therapy” to prevent surgical intervention?**
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 additional 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 transformation. In the reported case, the en bloc resection of a residual polyp, not amenable to standard endoscopic treatment (including endoscopic mucosal resection), was accomplished by ESD, avoiding a more invasive surgical procedure. As reported for residual/recurrence of early gastric cancer after endoscopic mucosal resection [4,5], ESD can be proposed as an interesting endoscopic “rescue therapy” for residual rectal scar-embedded polyps.

References

Bibliography
Endoscopy 2008; 40: E222–E223
© Georg Thieme Verlag KG Stuttgart - New York - ISSN 0013-726X

Corresponding author
F. Azzolini, MD
Unit of Digestive and Biliopancreatic Endoscopy
Arcispedale Santa Maria Nuova
viale risorgimento 80
42200 Reggio Emilia
Italy
Fax: +39-0522-296129
francesco.azzolini@asmn.re.it