Successful 2-channel cold snare polypectomy of a colorectal lesion involving the appendiceal orifice

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Colonic polypectomy is a common procedure with several approaches to remove small polyps.[1] However, there is no established endoscopic treatment for lesions on the appendiceal orifice that cannot be wholly observed; surgery is recommended for such lesions when endoscopic treatment is not feasible.[2]

A 70-year-old man was admitted to our hospital for polypectomy of a suspected sessile serrated adenoma/polyp, which was consistent with type II open-shape pit pattern with magnified endoscopy, about 10 mm, at the appendiceal orifice. The lesion involved the vermiform appendix (Figs. 1 and 2), so conventional cold snare polypectomy or EMR was not feasible. Therefore, we performed a cold snare polypectomy using a 2-channel gastroscope (2-channel method), GIF-2TQ260M (Olympus Medical Systems, Tokyo, Japan) (Video 1, available online at www.VideoGIE.org).

First, after local injection, we confirmed a distal border of the lesion by gripping it with forceps, FG-47L-1 (Olympus Medical Systems) (Fig. 3). We inserted a 10-mm snare, Captivator II (Boston Scientific, Natick, Mass, USA) from one channel and a pair of gripping forceps from the other channel to pass through the snare. We snared the polyp while gripping it with forceps and then performed a cold snare polypectomy (Fig. 4). En

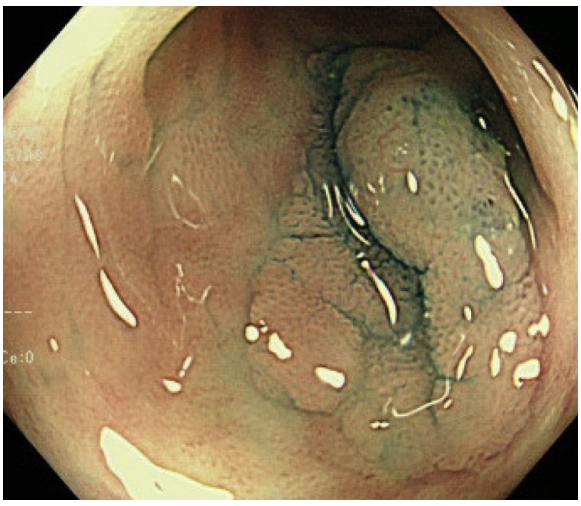

Figure 1. The polyp invaded the vermiform appendix, and the distal border could not be confirmed.

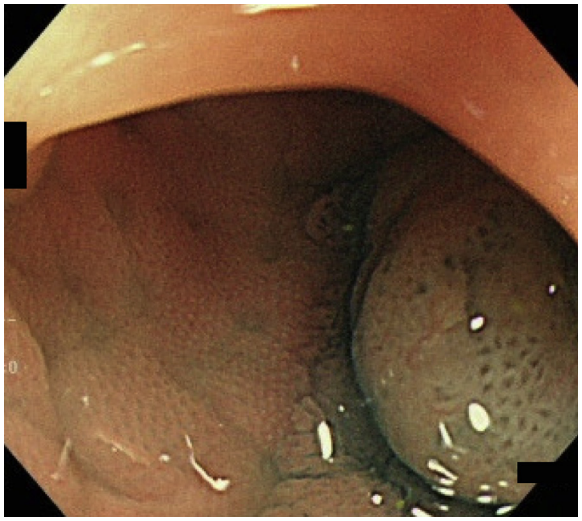

Figure 2. Magnifying image enabling diagnosis of the lesion as consistent with type II open-shape pit pattern.

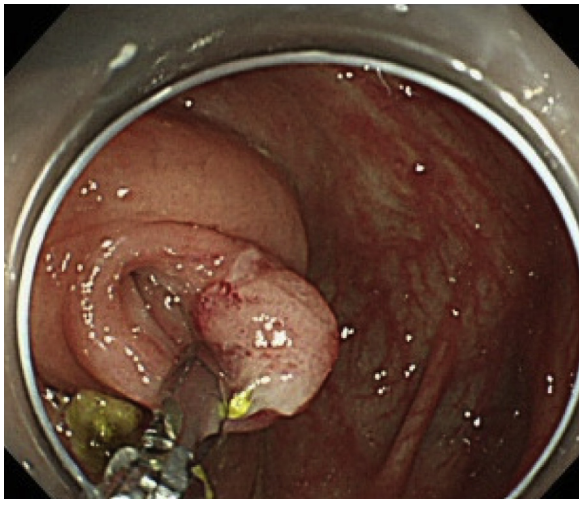

Figure 3. Gripping the polyp to confirm its distal border before snaring.

Written transcript of the video audio is available online at www.VideoGIE.org.

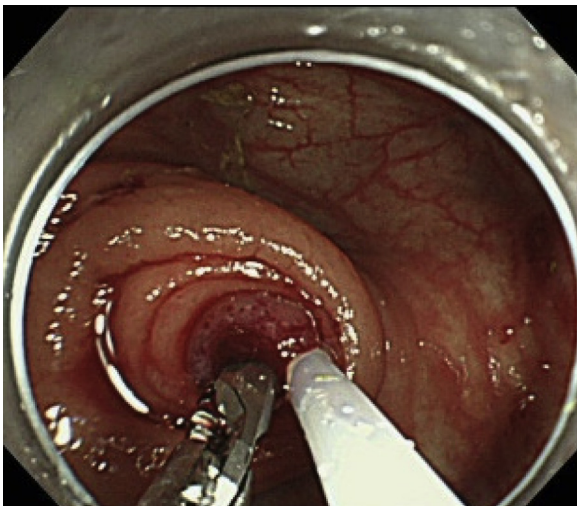

Figure 4. Snaring the polyp while gripping it with forceps.

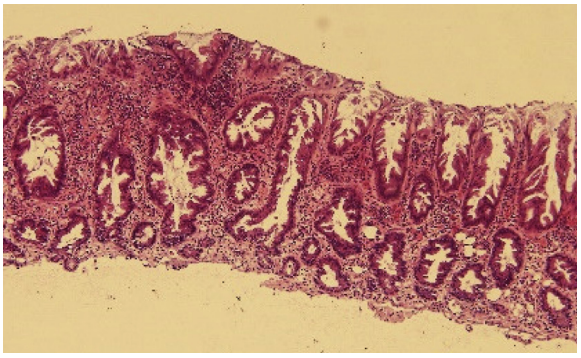

Figure 5. Pathologic view showing boot-shaped crypt; the polyp was diagnosed as a sessile serrated adenoma/polyp (H&E, orig. mag. ×100).

bloc resection was successfully performed without any adverse events. The polyp was 10 mm, and histologic examination confirmed the preliminary diagnosis of sessile serrated adenoma/polyp (Fig. 5). A follow-up total colonoscopy 3 months later revealed no remnant or recurrence. No neoplastic lesions were detected on scar biopsy.

The 2-channel method makes it possible to snare the lesion after confirmation of the distal border of the appendiceal orifice lesion; this confirmation is not possible by usual observation.[3] Although this 2-channel method is similar to strip biopsy[4] or underwater EMR,[5] its advantage over those procedures is that it is cold polypectomy, which does not require electrocautery. It, therefore, avoids the risks associated with the burning effects of cauterization,[6] decreasing the likelihood of appendix orifice perforation (given that this tissue has a thin submucosa). In addition, in this case, total colonoscopy was relatively easy, so we did not need to use any device for insertion.

When it is difficult to achieve total colonoscopy with a gastroscope, balloon-assisted endoscopy with a gastroscope will be useful.[7] Further examination of the efficacy and safety of this method is warranted.

DISCLOSURE

All authors disclosed no financial relationships relevant to this publication.

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https://doi.org/10.1016/j.vgie.2018.07.002