Response:

We appreciate Dr Bronswijk's interest and comments[1] on our published giant colon lipoma resection case.[2] Similar concerns were raised and published before.[3] We disagree with Dr Bronswijk's suggestion that the unroofing technique should be considered the primary endoscopic technique for all giant colon lipomas. Although unroofing management of GI submucosal neoplasms has been reported, in many cases, complete resection or resolution cannot be achieved. Of the reported cases of colon lipomas treated by the unroofing technique, most patients needed a second-look endoscopy to enable the resection base to be visualized. Even those patients' obstructive symptoms resolved from debulking therapy, and the only scar tissue was seen at the partial resection site; we do not know whether there was any residual lipomatous tissue below the scar. Because there are no long-term follow-up data, we do not know whether those giant lipomas will recur. Tomiki et al[4] reported one 2-cm colon lipoma and another 5-cm colon lipoma managed by unroofing. Additional endoscopic resection was required because the initial unroofing was incomplete. Those authors recommended that patients with abdominal pain and hemorrhage should be treated in consideration of complete resection, but not by unroofing, which could leave a residual tumor.

The management of symptomatic large and giant colon lipomas should be individualized based on local expertise, the patient's age, and comorbid conditions. If the endoscopists lack certain therapeutic skills and experience, or if the patient is quite senior with significant comorbid conditions, endoscopic unroofing for symptomatic relief is quite reasonable and should be considered the primary option along with a looping and let-go technique. If the endoscopists are skilled at EMR or submucosal dissection and the patient is quite young, endoscopic complete resection should be considered.

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Shou-jiang Tang, MD
Division of Gastroenterology
Department of Internal Medicine
University of Mississippi Medical Center
Jackson, Mississippi, USA

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