

Endoscopic resection of giant colon lipomas: get rid of the roof!



To the Editor:

With great interest I have read the video case report by Tang and Naga,¹ “Endoclip-assisted giant colon lipoma resection,” published in the April issue of *VideoGIE*. The authors describe an alternative technique for resection of giant colon lipomas when classic snare resection or a loop-and-let-go approach is not feasible because of the sheer dimensions of the lesion. In their case, successful resection was performed by means of a needle-knife and clipping of the base. Mild per-procedural bleeding occurred, for which clipping was performed. We completely agree with the authors that snare resection or a “loop-and-let-go” approach was not a valid therapeutic option in this specific case. However, it is crucial for the reader to know that, compared with a dissection-based technique, there is a safer, more cost-effective, and less technically demanding alternative for endoscopic management of giant colon lipomas.

GI lipomas are benign lesions, which can be identified quite easily by several typical endoscopic features, such as the typical yellow hue, the naked fat sign, the typical subepithelial or submucosal location, and the pillow sign. Although generally asymptomatic, larger lesions can lead to obstructive symptoms, intussusception, ulceration, pain, diarrhea, and bleeding, which may necessitate endoscopic treatment. Several techniques have been reported in the context of large colon lipomas, where loop-assisted techniques or snare resections are deemed unfeasible. Endoscopic submucosal dissection (ESD),^{2,3} endoclip-assisted dissection techniques,⁴ and, most importantly, simple unroofing have been described.⁵⁻⁸

Documented for the first time in 1997, the unroofing technique relies on intraluminal expulsion of the residual submucosal content, following snare resection of the distal part of the subepithelial mass.⁹ Subsequent spontaneous evacuation of the underlying residual lipomatous tissue will lead to complete resolution of these lesions. Because only a snare resection is needed, little endoscopic experience is required, procedure time and costs are kept to a minimum, and possible dissection-related adverse events can be averted. Although no R0 resection will be obtained, relevance is limited in the context of these benign lesions. Moreover, tissue from partial resection can still be sent for pathologic evaluation in an effort to confirm the visual diagnosis. Regarding efficacy, there are reports of cases in which reintervention was required, presumably after insufficient unroofing, because re-epithelialization of a limited unroofing site may hamper expulsion of the submucosal content.^{10,11} Comparative studies

evaluating the different techniques for resection of giant colon lipomas are scarce. Only 1 retrospective analysis has compared unroofing, EMR, and ESD in resection of 28 giant colon lipomas, which showed complete resolution with all 3 techniques.¹²

Owing to the superior safety profile, cost effectiveness, and ease of resection, the unroofing technique should be considered the primary endoscopic technique for resection of giant colonic lipomas before resorting to dissection-based techniques. However, sufficient unroofing should be pursued in an effort to prevent incomplete clearance of the lesion.

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