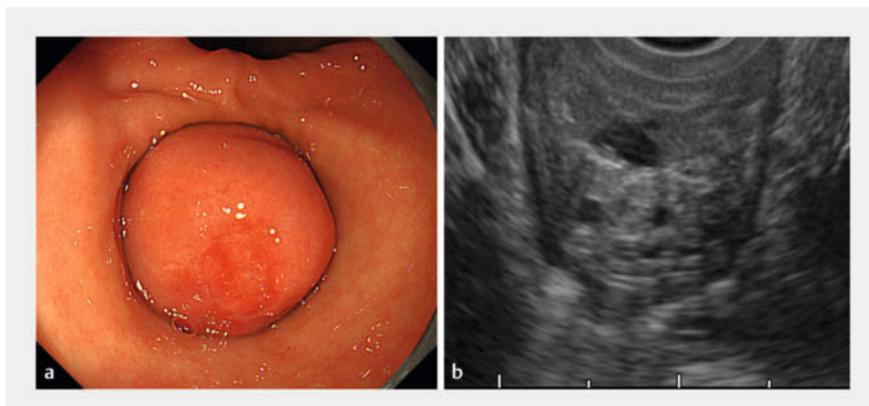




Successful ESD of a gastric hamartomatous inverted polyp intussuscepted into a pylorus ring using a clip with a line attachment prior to incision



▶ Fig. 1 Showing esophagogastroduodenoscopy and endoscopic ultrasonography. **a** A huge submucosal tumor arising from the greater curvature of the pylorus ring and duodenal bulb was intussuscepted into a pylorus ring, and the lesion was retracted into the stomach. **b** A heterogeneous lesion in the third layer of the gastric wall with variable cystic components.

Endoscopic ultrasonography showed a heterogeneous lesion in the third layer of the gastric wall with variable cystic components (▶ **Fig. 1b**). For a definitive diagnosis and treatment of this SMT, ESD was performed because distal gastrectomy is invasive.

The lesion was intussuscepted into a pylorus ring before starting ESD. First, a clip with a line was attached to the top of it, and powerful traction was applied to it prior to incision for ESD. Next, it was pulled back into the stomach using a clip with a line and grasping forceps (▶ **Fig. 2a**). Because it was kept in the stomach, a mucosal incision was easily made in the anal side of it in retroflex view of the duodenal bulb (▶ **Fig. 2b**). We easily made a mucosal incision and dissection was performed with the lesion kept in the stomach using a clip with a line in a forward view. Finally, it was removed. Histological examination revealed GHIP with negative resection margins (▶ **Fig. 2c**, ▶ **Video 1**). The patient's symptoms disappeared and her anemia improved after ESD. After about 3 months, her ulcer was completely cured and there was no stenosis at the pyloric ring (▶ **Fig. 3a**).

Although various endoscopic and surgical resections for a gastric hamartomatous inverted polyp (GHIP) have recently been reported [1,2,3], indications for the choice of resection method have not been established because it is a rare form of gastric polyp. The usefulness of a clip with a line attachment prior to incision for endoscopic submucosal dissection (ESD) has recently been reported [4,5]. Here we report successful endoscopic re-

section of a huge GHIP easily intussuscepted into a pylorus ring using a clip with a line attachment prior to incision. A 24-year-old woman presented for black stool (hemoglobin level of 9.9 g/dL). Esophagogastroduodenoscopy showed that a huge submucosal tumor (SMT) arising from the greater curvature of the pylorus ring and duodenal bulb was intussuscepted into a pylorus ring, and the lesion was retracted into the stomach (▶ **Fig. 1a**).

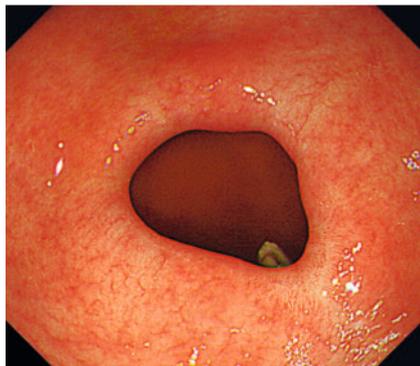


▶ Fig. 2 Successful endoscopic resection of a huge GHIP. **a** It was pulled back into the stomach using a clip with a line and grasping forceps. **b** Because it was kept in the stomach, a mucosal incision was easily made in the anal side of it in retroflex view of the duodenal bulb. **c** Histological examination revealed GHIP with negative resection margins.

VIDEO



► **Video 1** Successful endoscopic resection of a huge gastric hamartomatous inverted polyp easily intussuscepted into a pylorus ring using a clip with a line attachment prior to incision.



► **Fig. 3** Follow-up endoscopy. After about 3 months, the ulcer was completely cured and there was no stenosis at the pyloric ring.

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Conflict of Interest

The authors declare that they have no conflict of interest.

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