



Endoscopic Full-Thickness Resection of Proximal Ascending Colonic Intramucosal Carcinoma by FTRD Device: Saving the Colon

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Abstract

The full-thickness resection device (FTRD) allows for endoscopic full-thickness resection of gastrointestinal lesions up to 3 cm. This transluminal endoscopic minimally invasive technique allows safe closure after full-thickness resection, thereby providing an en-bloc specimen for histological examination and resection with minimal thermal damage. Using the device for lesions in the proximal ascending colon and cecum is technically challenging. Herein, we describe a case of JNET 2A/2B proximal ascending colonic polyp on both sides of the fold, which was resected safely by the FTRD device, and the en-bloc resected specimen turned out to be intramucosal carcinoma.

Keywords

- ▶ ascending colon
- ▶ FTRD
- ▶ intramucosal carcinoma

Brief History

A 73-year-old female with hypertension and dyslipidemia as comorbidities presented with loose stools and two episodes of bleeding per rectum in the last 2 months. A colonoscopy done elsewhere was suggestive of multiple colonic polyps; polypectomy was not done. A colonoscopy done at our center showed multiple polyps from the cecum to the descending colon. A 2-cm pedunculated polyp was noted in the transverse colon. Endoscopic mucosal resection (EMR) was done, and the polyp was removed. Another 2 cm flat polyp (Paris classification-Is-sessile) was noted in the proximal ascending colon, which was not lifting with submucosal injection, JNET 2A/2B classification by narrow-band imaging (NBI) (▶ Fig. 1A–C). The white light image and the NBI image has been shown in ▶ Fig. 1A and B, respectively, whereas ▶ Fig. 1C shows the image of the polyp on the oral side. Contrast-enhanced computed tomography abdomen showed no evidence of transmural invasion or significantly enlarged lymph nodes. The proximal ascending colonic polyp was resected by the colonic full-thickness resection device (FTRD) device (▶ Video 1). The alternative treatment options are endoscopic submucosal dissection (ESD) and EMR, both the procedures

are challenging considering the thin wall of the ascending colon. ESD is difficult in ascending colon and has got a steep learning curve. FTRD is an easier option and has a short learning curve but the challenge in this case was to negotiate the loaded colonoscope with the FTRD device to the right side of the colon. The histopathological examination of the flat polyp showed a tubulovillous adenoma with high-grade dysplasia and focal lamina propria invasion, s/o intramucosal carcinoma (▶ Fig. 2). The lamina propria invasion is shown by the green arrow in ▶ Fig. 2, magnification 10 ×. Lateral and deep margins were normal on histology. Follow-up colonoscopy was done after 6 months which showed the clip in place. The plan of management is to do surveillance colonoscopy every 1 year.

Video 1:

FTRD of right sided early colonic cancer. Online content including video sequences viewable at: <https://www.thieme-connect.com/products/ejournals/html/10.1055/s-0044-1787124>.

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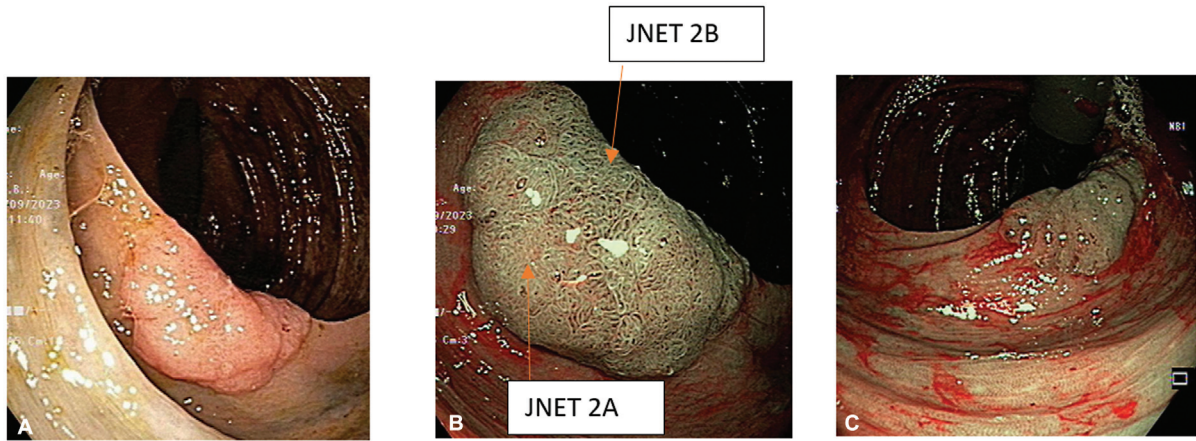


Fig. 1 A 2-cm flat polyp noted in proximal ascending colon, JNET 2A/2B by narrow-band imaging (NBI).

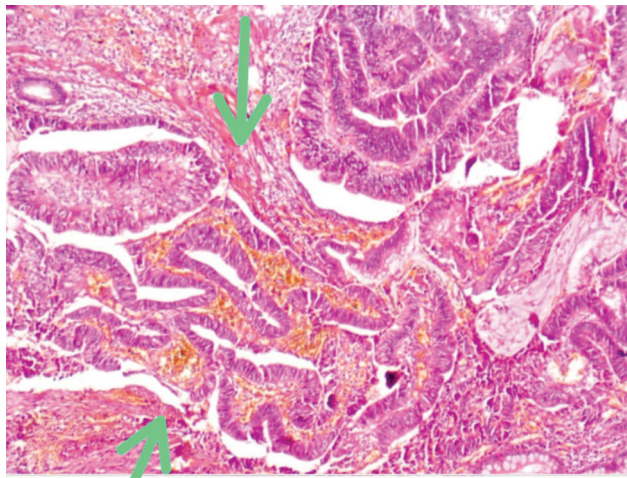


Fig. 2 Tubulovillous adenoma with high-grade dysplasia and focal lamina propria invasion (green arrow), s/o intramucosal carcinoma.

Conflict of Interest
None declared.