

## Challenging full-thickness resection of post endoscopic mucosectomy residual scar in right colon, accessed via a balloon-dilated stoma

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► **Fig. 1** The residual scar lesion after endoscopic mucosal resection of an intramucosal adenocarcinoma.



► **Video 1** Endoscopic full-thickness resection of a post-mucosectomy residual scar lesion in the right colon, with access through a cutaneous stoma.



► **Fig. 2** Pneumatic dilation of the stoma.



► **Fig. 3** The over-the-scope clip closing the defect in the colonic wall.

In recent years, the spectrum of endoscopic colorectal resection methods for mucosal carcinomas and scar lesions that show no lifting sign has been extended by the use of full-thickness resection (FTR) [1].

We report a case of resection of a right colon residual scar, using an FTR device (FTRD; Ovesco Endoscopy, Tübingen, Germany), with unconventional access through a cutaneous stoma.

An 81-year-old man had previously undergone a Hartmann resection for colorectal adenocarcinoma, with the creation of a definitive terminal stoma. He later underwent en bloc endoscopic mucosal resection (EMR) of a 7-mm polypoid sessile lesion (type 0-Is Paris classification) in the right ascending colon. The histological specimen showed intramucosal adenocarcinoma, but the vertical extension of the neoplastic verge was nonevaluable and consequently FTR of the residual scar was scheduled.

First, we accessed the scar through the stoma with a 13.2-mm caliber colonoscope and the lesion was marked with

an electrocautery probe (► **Fig. 1**). It was anticipated that it would not be possible to pass the scope fitted with the full-thickness resection device through the narrow opening of the stoma. Therefore pneumatic dilation of the stoma with an 20-mm esophageal balloon catheter was performed (► **Fig. 2**).

An 11.6-mm caliber gastroscope was required to obtain access through the stoma with the FTR device. When the marked lesion was reached, it was resected with the assistance of the grasper forceps (► **Video 1**).

The scope with the cap was withdrawn through the stoma without any problem. The subsequent evaluation showed correct placement of the clip and complete closure of the wall defect (► **Fig. 3**).

The lesion was later fixed in formaldehyde, oriented on a cork base for histological assessment.

To the best of our knowledge, this is the first case of a FTR procedure performed by means of access through a stoma, in a nonsurgical setting. The larger caliber of the FTR device and the nature of the

access point raise technical issues in this type of procedure that require adequate preparation and availability of resources.

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### Competing interests

S. Danese has served as a speaker, consultant, and advisory board member for Schering-Plough, AbbVie, Actelion, Alphawasserman, AstraZeneca, Cellerix, Cosmo Pharmaceuticals, Ferring, Genentech, Grunenthal, Johnson and Johnson, Millenium Takeda, MSD, Nikkiso Europe, Novo Nordisk, Nycomed, Pfizer, Pharmacosmos, UCB Pharma, and Vifor. F. Azzolini, A. Barchi, D. Esposito, L. Fanti, F.V. Mandarino, E. Viale declare no conflict of interest.

### The authors

**Francesco Azzolini, Francesco Vito Mandarino, Alberto Barchi, Lorella Fanti, Edi Viale, Dario Esposito, Silvio Danese**  
Division of Gastroenterology and Gastrointestinal Endoscopy, Department of Experimental Oncology, IRCCS San Raffaele Scientific Institute, Vita-Salute San Raffaele University, Milan, Italy

### Corresponding author

**Alberto Barchi, MD**

Division of Gastroenterology and Gastrointestinal Endoscopy, Department of Experimental Oncology, IRCCS San Raffaele Scientific Institute, Vita-Salute San Raffaele University, Via Olgettina, 60, 20136 Milan, Italy  
barchi.alberto@hsr.it

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