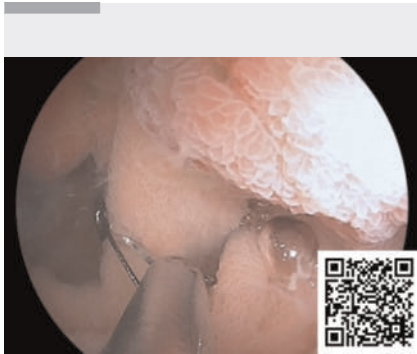
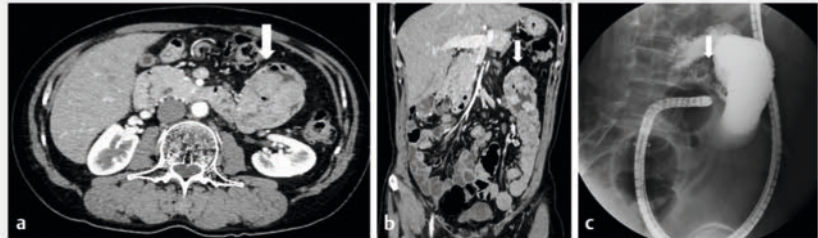


Endoscopic ischemic polypectomy using a large endoclip for Peutz–Jeghers polyps



▶ Video 1 Endoscopic ischemic polypectomy (EIP) for Peutz–Jeghers polyps (PJPs) using the longer-width SureClip.



▶ Fig. 1 Peutz–Jeghers polyps (PJPs) in a 51-year-old man previously treated for Peutz–Jeghers syndrome. **a,b** Abdominal computed tomography (CT) showed many PJPs (arrows) in the jejunum (**a**, axial view; **b**, coronal view). **c** Abdominal x-ray showed many polyps (arrow) in the jejunum and dilatation of the intestine proximal to the polyps.

Hamartomatous polyps seen in Peutz–Jeghers syndrome are called Peutz–Jeghers polyps (PJPs), and PJPs 15 mm or larger in size may cause intestinal intussusception that requires surgical treatment. The usefulness of balloon-assisted enteroscopy has been reported for PJPs in the small intestine [1]. Although endoscopic resection was the conventional treatment for PJP, endoscopic ischemic polypectomy (EIP), namely the strangulation of the polyps using endoclips without resection, is now preferred for PJPs because of the need to treat many PJPs at one endoscopic session [2]. For polyps with large stalks, conventional clips may not provide sufficient ischemia even with repeated clipping, resulting in the need for snare ischemia [3]. However, the snare technique takes a longer time and is challenging to perform because of the difficulty in obtaining adequate endoscopic images of large polyps and the limited maneuverability of the endoscope [2]. Moreover, if ligation with a snare fails, the snare cannot be reopened and must be discarded, representing a treatment failure. Recently, the SureClip (Micro-Tech) has been developed as a novel endoclip that rotates smoothly and can be reopened after grasping tissue. Although its usefulness in endo-

scopic treatment has been reported [4, 5], the utility of this device in EIP for PJPs is unclear. The SureClip has available a longer clip width (16 mm) than conventional clips and allows reopening and repositioning, making it easier to achieve strong clamping of the polyps. We report on EIP for PJPs, using the longer clip (**▶ Video 1**).

A 51-year-old man had been diagnosed with Peutz–Jeghers syndrome and treated for PJPs previously. A follow-up computed tomography revealed polyps larger than 15 mm in the small intestine for which treatment by balloon-assisted enteroscopy was required (**▶ Fig. 1**). Since numerous PJPs were observed in the jejunum, EIP using the clip with the longer opening was performed for polyps bigger than 30 mm. If a polyp with a thick stalk could not be adequately clamped, it was possible to reopen the clip and clamp the stalk appropriately (**▶ Fig. 2**). Underwater observation revealed floating polyps, and EIP was completed by clamping the stalks of the large polyps using the longer clip to ensure discoloration (**▶ Fig. 3**) as a sign of adequate ischemia. After treatment, no complications such as bleeding or bowel obstruction were observed.

Because patients with Peutz–Jeghers syndrome usually have multiple large polyps, the reopenable clip with the longer width is effective for secure EIP, and its use reduces procedure time.

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Conflict of Interest

The authors declare that they have no conflict of interest.

The authors

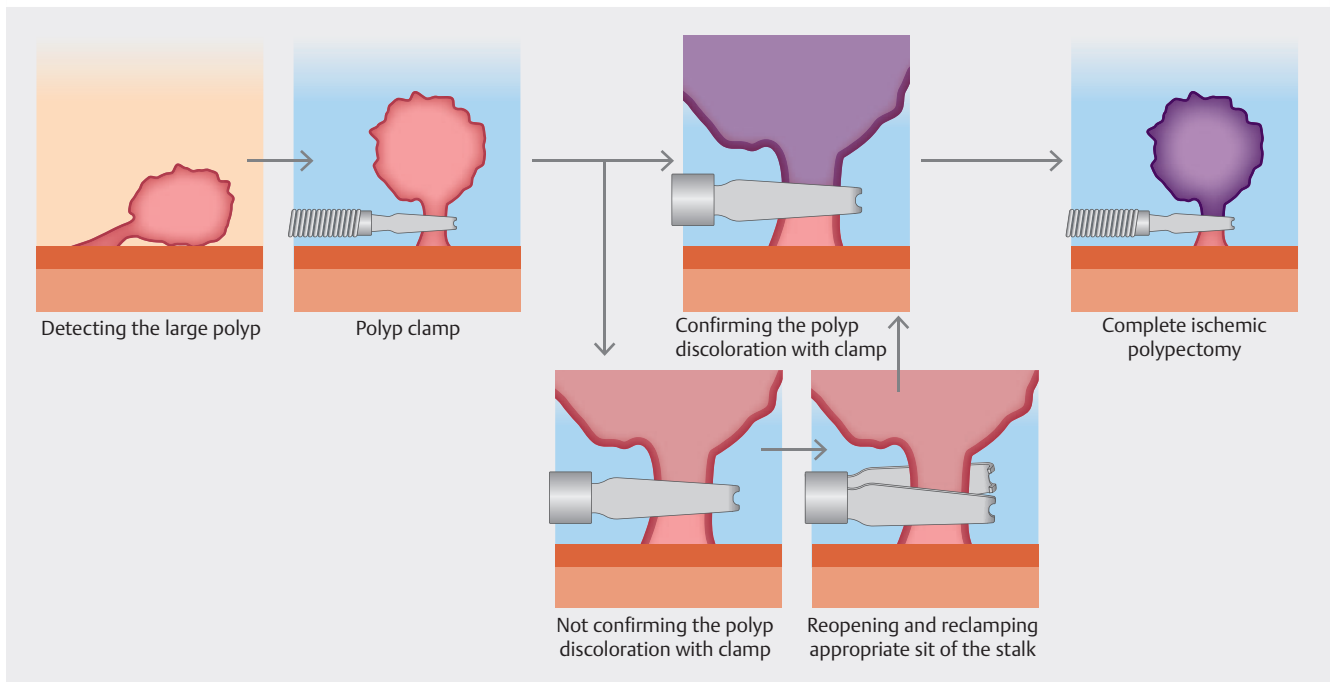
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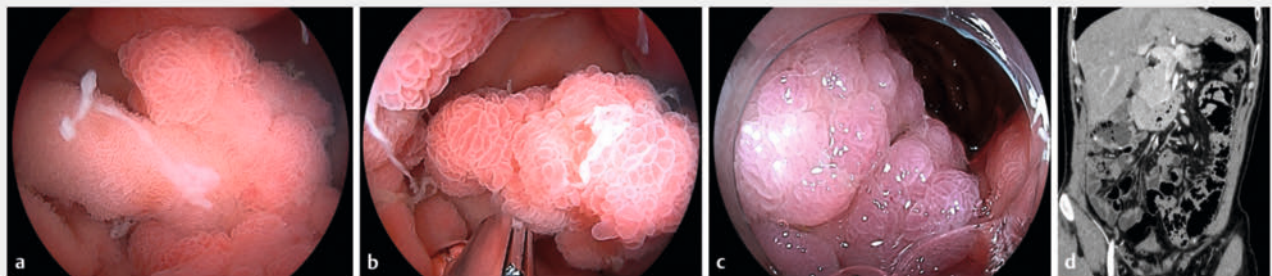
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► **Fig. 2** Endoscopic ischemic polypectomy (EIP) using the reopenable clip. The polyp is clamped. If polyp discoloration is confirmed, then EIP is completed. If discoloration cannot be confirmed, then the clip can be reopened and clamping done at another site on the stalk.



► **Fig. 3** Endoscopic ischemic polypectomy (EIP) for a Peutz–Jeghers polyp (PJP). **a** PJP with a thick stalk floating under water immersion. **b** The polyp stalk is clipped using the longer-width SureClip. **c** Discoloration of the PJP. **d** Abdominal computed tomography shows the decrease in PJP size in the jejunum after EIP.

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