

jejunum. The surface of the tumor had an erosion with a red color sign. EUS during DBE revealed a hypoechoic mass originating from the second and third layers. Because the lesion was thought to be responsible for the bleeding, it was treated. Given its submucosal location, we attempted endoscopic mucosal resection (EMR). The lesion was fully elevated by submucosal injection and then removed with electrocautery (Fig. 1). No adverse events were observed (Video 1, available online at www.giejournal.org). Histopathologic examination revealed lymphangioma with complete resection. This case demonstrates that EMR can be an option for management of small SMTs in the small bowel.

Masanao Nakamura, MD, PhD, Department of Gastroenterology and Hepatology, Nagoya University Graduate School of Medicine, **Yoshiki Hirooka, MD, PhD**, Department of Endoscopy, Nagoya University Hospital, **Osamu Watanabe, MD, PhD**, Department of Gastroenterology and Hepatology, Nagoya University Graduate School of Medicine, **Takeshi Yamamura, MD, PhD**, **Asuka Nagura, MD**, Department of Endoscopy, Nagoya University Hospital, **Takafumi Ando, MD, PhD**, **Hidemi Goto, Professor**, Department of Gastroenterology and Hepatology, Nagoya University Graduate School of Medicine, Nagoya, Japan

DISCLOSURE

All authors disclosed no financial relationships relevant to this publication.

<http://dx.doi.org/10.1016/j.gie.2014.11.024>

Preclipping fixation EMR to achieve sufficient surgical margin and negative resection

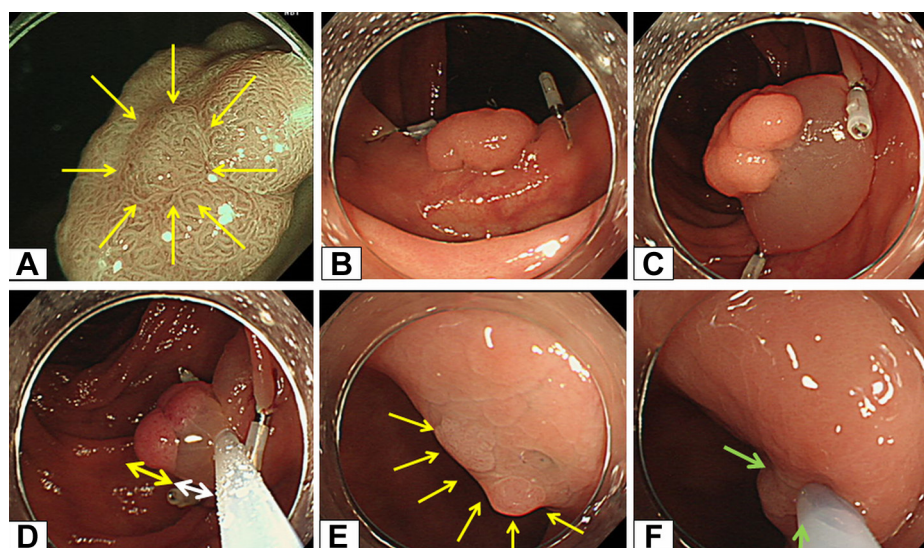


Figure 1. Comparison between pre-clipping fixation EMR and conventional EMR.

A 55-year-old man underwent 3-point pre-clipping around a 15-mm ascending colon polyp and conventional EMR for a 12-mm transverse colon polyp. Because magnified narrow-

band imaging revealed a slight irregular microvascular pattern at the center depressed area, this ascending colon polyp might have contained a malignant part with high risk for slight submucosal invasion (Fig. 1A) (Video 1, available online at www.giejournal.org). Preclipping to reach the muscular layer was performed (Fig. 1B), and 4 mL of saline solution was injected to ensure ample gripping (Fig. 1C). EUS to measure the distance of the bulging showed an 11.3-mm vertical bulging (Video 1). An ample safety margin allowing for easy and safe snare strangulation was



This video can be viewed directly from the GIE website or by using the QR code and your mobile device. Download a free QR code scanner by searching “QR Scanner” in your mobile device’s app store.

subsequently obtained (Fig. 1D). The transverse colon polyp was treated with conventional EMR (Fig. 1E). As local injection spread in the horizontal direction, EUS showed only 5.1 mm of bulging; the snaring was poorly performed with an inadequate safety margin and resulted in polyp contact (Fig. 1F). Placing the preclipping fixation before the local injection made it possible to create a more vertical mucosal bulging that enabled resection with an ample safety margin and minimal slippage without thermal denaturation.

DISCLOSURE

All authors disclosed no financial relationships relevant to this article.

Hirohito Mori, MD, PhD, Departments of Gastroenterology and Neurology, Faculty of Medicine, Kagawa University,

Department of Gastroenterological Surgery, Ehime Rosai Hospital, Japan, **Hideki Kobara, MD, PhD**, Departments of Gastroenterology and Neurology, Faculty of Medicine, Kagawa University, **Kazi Rafiq, MS, PhD**, Department of Pharmacology, Faculty of Medicine, Kagawa University, **Shintaro Fujihara, MD**, **Noriko Nishiyama, MD**, **Tae Matsunaga, MD**, **Maki Ayaki, MD**, **Tatsuo Yachida, MD**, **Taiga Chiyo, MD**, **Tsutomu Masaki, MD, PhD**, Departments of Gastroenterology and Neurology, Faculty of Medicine, Kagawa University, Kagawa, Japan

Copyright © 2015 The Authors. Published by Elsevier, Inc. on behalf of the American Society for Gastrointestinal Endoscopy. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/3.0/>).

<http://dx.doi.org/10.1016/j.gie.2014.10.022>

Abdominal necrotic abscess from colonic fistula treated endoscopically

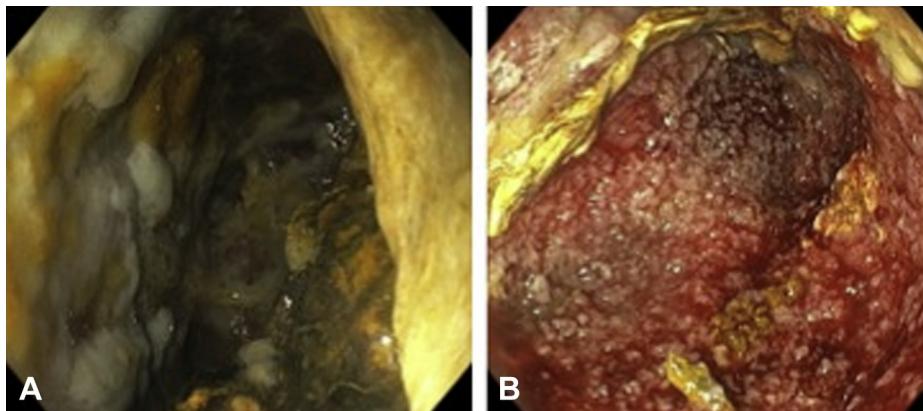


Figure 1. **A**, Necrotic tissue in the cavity into which Endo-SPONGEs were introduced. **B**, After treatment, the necrosis has disappeared and granulation tissue has filled the cavity, causing it to close up.

A patient underwent a partial colectomy for sigmoid diverticulitis, which was complicated by a colorectal anastomotic leaking fistula in communication with the ileum and an abdominal abscess, which induced a colonic fistula. A Redon's drainage and a jejunostomy diversion were performed. Nevertheless, the clinical condition of the patient had deteriorated to such an

extent that the surgeons decided to drain and wash the abdominal cavity by laparotomy. It was impossible for the surgeons to reach the anastomotic fistula and the peritoneal abscess because of extensive adhesions. With a gastroscope (Olympus, H180, Tokyo, Japan) inserted through the colorectal anastomosis leakage localized 7 cm from the pectineal line, we explored the ileal fistula and the peritoneal abscess through a colonic fistula 13 cm from the pectineal line. We introduced an Endo-SPONGE (B. Braun Melsungen AG, Melsungen, Germany) into the ileal fistula, and 2 EndoSPONGEs, then 1 Endo-SPONGE, into the necrotic cavity with a size of 17 cm (Fig. 1A).

The Endo-SPONGE is a polyurethane sponge into which a drainage tube is inserted. The tube is connected to a low-



This video can be viewed directly from the GIE website or by using the QR code and your mobile device. Download a free QR code scanner by searching "QR Scanner" in your mobile device's app store.