A 69-year-old man with a history of carotid artery stenosis who was taking clopidogrel presented with dyspnea secondary to acute iron-deficiency anemia. His hemoglobin level was 6 g/dL. He underwent EGD at an outside center, which revealed a large bleeding gastric polypoid lesion. Histopathologic examination of a biopsy specimen revealed a hyperplastic polyp with superficial erosions but no dysplasia. He underwent 3 attempts at endoscopic resection over the next several months at the outside center, which were all unsuccessful. Because of his persistent severe symptomatic anemia, he was referred to our center for endoscopic management. After a detailed discussion regarding management options, the patient was offered a choice between a surgical consultation and EMR. The decision was made to proceed with EMR (Video 1, available online at www.VideoGIE.org).
On inspection, a large 7-cm to 8-cm very friable polypoid mass with a short broad stalk was found in the prepyloric antrum, initially prolapsing through the pylorus (Fig. 1). After a detailed examination, the decision was made to resect the lesion. Submucosal epinephrine/saline solution (1:100,000) was injected into the base of the polyp (Fig. 2); then a detachable endoloop was used to ensnare the base of the lesion, resulting in hemostasis and blanching of the polyp tissue (Fig. 3). A 20-mm braided snare was placed above the level of the endoloop (Fig. 4). Using pure endocut current (ERBE Q mode: Effect 3, Duration 1, Interval 6), the entire lesion was removed en-bloc.

The base was immediately inspected. The endoloop remained in place, with no perforation or significant bleeding noted at the EMR base (Fig. 5). Endoclips were placed at the site of the EMR defect prophylactically to reduce the risk of delayed post-EMR bleeding (Fig. 6). A large retrieval net was used to remove this gigantic polyp per-orally with gentle rotational movements through the esophagus (Fig. 7). A repeat endoscopy was performed to evaluate for any mucosal trauma, and this revealed a small superficial mucosal tear at the level of the upper esophagus but no significant bleeding or full-thickness perforation. The specimen underwent pathologic examination, which confirmed a hyperplastic polyp with no adenomatous changes (Fig. 8).

This patient had an uneventful postprocedure recovery and was discharged home that same evening. His anemia significantly improved within 2 weeks after the procedure. His hemoglobin subsequently normalized, and he has remained asymptomatic several months after the procedure.

This case demonstrates the technical aspects of safe, complete, and successful removal of a large foregut lesion and the principles of EMR in this setting. Successful use of endoloop for large colonic polyp resection has previously been demonstrated.1 Our case demonstrates that the endoloop technique can also be successfully used to manage large gastric polyps.
As described above, symptomatic anemia related to intermittent low-volume GI bleeding from a gastric polypoid mass can be managed by a minimally invasive endoscopic intervention with an excellent outcome.

DISCLOSURE

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