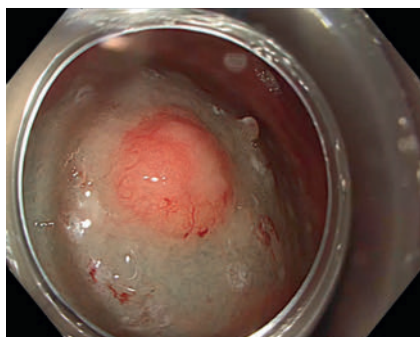


Traction-assisted endoscopic submucosal dissection of a neuroendocrine tumor in the gastric body of a patient with autoimmune gastritis

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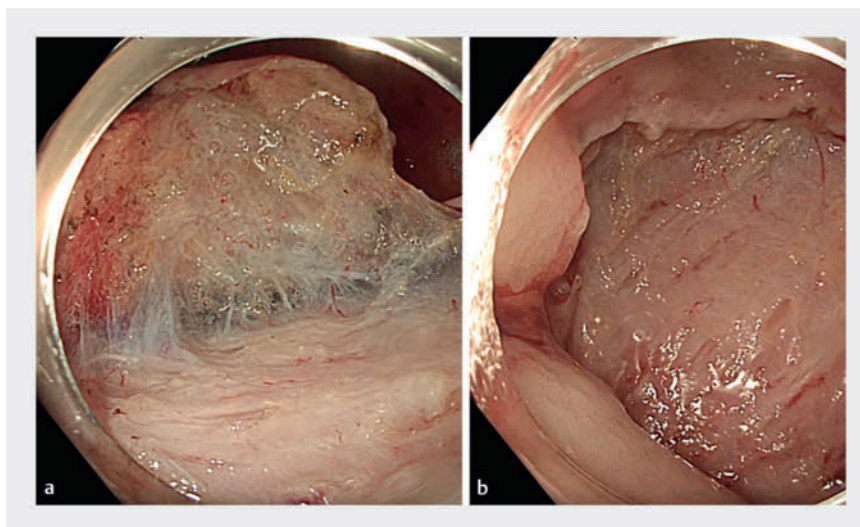


► **Fig. 1** Endoscopic appearance of the gastric neuroendocrine tumor. A subepithelial lesion on the greater curvature of the gastric body, identified in a patient with autoimmune atrophic gastritis.

A 75-year-old woman with known autoimmune atrophic gastritis (AAG) and previous resections of millimetric neuroendocrine tumors (NETs) presented for evaluation of a newly detected 25 × 20-mm lesion on the greater curvature of the gastric body. Vitamin B12 deficiency had also been documented in the context of AAG [1, 2].

A previous esophagogastroduodenoscopy (EGDS) confirmed the presence of a 25 × 20 mm suspected NET on the greater curvature of the gastric body. The lesion was marked, and an endoscopic submucosal dissection (ESD) was performed using a J-type hook-knife (Olympus Co. Ltd, Tokyo, Japan; ► **Fig. 1**). Traction was achieved through a double clip-and-band technique, which allowed for precise dissection of the lesion without significant intra-procedural bleeding (► **Fig. 2a**; ► **Video 1**). The lesion was resected en bloc, and the resection site was closed with clips to ensure hemostasis (► **Fig. 2b**).

Histopathology confirmed a R0 resection of a well-differentiated NET G1 (synaptophysin+, INSM1+, and gastrin-negative), which infiltrated the submucosa. Immunohistochemistry revealed strong expression of somatostatin receptor 2A



► **Fig. 2** Traction-assisted endoscopic submucosal dissection of the gastric NET. **a** The lesion is partially dissected, revealing the submucosal plane with visible fibrotic strands, facilitated by the double clip-and-band traction technique. **b** Post-resection appearance of the gastric muscular layer after en-bloc excision.

(SSTR2A, >95% membranous positivity) and weaker expression of SSTR5. The Ki-67 proliferation index was 2.9%, indicating low proliferative activity, without peritumoral lymphatic involvement.

A follow-up EGDS demonstrated a well-healed resection scar on the greater curvature with no signs of recurrence upon high-definition white light and narrow band imaging (Olympus Co. Ltd, Tokyo, Japan) evaluation. However, five new small lesions suspicious for NETs were identified in the body/fundus and deemed suitable for endoscopic resection, highlighting the propensity for multifocal NETs in AAG.

This video case underscores the feasibility of traction-assisted ESD for large gastric NETs in AAG [3,4]. By providing stable exposure of the submucosal plane, traction can enable precise dissection and secure margin clearance while preserving muscular integrity. Such an approach may be particularly valuable in patients with chronic inflammatory



► **Video 1** Traction-assisted endoscopic submucosal dissection (ESD) of a 25 mm × 20 mm gastric neuroendocrine tumor (NET) using a double clip-and-band technique in a patient with autoimmune atrophic gastritis.

conditions that predispose them to multiple or recurrent gastric lesions [5].

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Conflict of Interest

The authors declare that they have no conflict of interest.

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