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**Snare traction-assisted method during endoscopic resection for gastric submucosal tumors: a single-center case series**

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*Dear Editor,*

From May 2021 to March 2023, 24 patients (12 male/12 female,  $54.5 \pm 12.4$  years) with 24 gastric submucosal tumors (G-SMTs) underwent snare-assisted endoscopic resection (ER) in our department. All patients had undergone pre-operative endoscopic ultrasonography (EUS) and abdominal computed tomography (CT) to detect tumor characteristics (13 located in the fundus, six in the lesser curvature or angle and five in other locations). Subsequently, the patients underwent snare-assisted ER. A transparent cap (D-201-13404, Olympus) was attached to the endoscope tip (GIF Q260J, Olympus). After submucosal injection, the mucosa was incised by a dual knife (KD-650L, Olympus) or an IT knife (KD-611L, Olympus) to expose the tumor. The endoscope was then removed, and a snare was fixed to the transparent cap before re-insertion into the stomach. The snare was then released

to grasp the tumor and was maneuvered externally by an assistant to provide traction, an IT knife or dual knife was used to completely resect the tumor. The EFTR technique was chosen to remove the SMTs and a small portion of the serosa if the SMT was closely adhered to the serosa. Coagulation was performed using the tip of the knife or a Coagrasper (FD-410LR, Olympus) in cases of bleeding. The defect was closed by hemoclips or endoscopic purse-string suture (HX-400U-30, Olympus) (Fig. 1). The tumor size was  $1.8 \pm 0.9$  cm, average surgery time was  $45.4 \pm 23.4$  minutes, intraoperative active bleeding rate was 0/24, 4/24 patients had abdominal pain, 2/24 had fever, 0/24 presented bleeding and 0/24 presented perforation within three days after the procedure. All patients achieved *en bloc* and R0 resection, and were discharged within 3-7 days after surgery. The postoperative pathology showed 17 gastrointestinal stromal tumors (GISTs), one leiomyoma, one heterotopic pancreas, one gastroblastoma, two polyps, one Schwannoma and one accessory spleen tissue. There were no reports of complications or recurrence during follow-up of three months.

Furthermore, we are expanding the sample size and comparing the snare traction-assisted method with the conventional procedure or other traction methods. Li et al. removed 101 duodenal subepithelial lesions (SELs) with endoscopic resection in combination with ligation (ER-L) (1). When limited to the duodenum, SELs originated from the submucosal layer and were less than 20 mm. We propose that the incorporation of traction methods could potentially broaden the applicability of ER-L. However, there appears to be a conceptual error in the article. It is important to note that “complete resection” is synonymous with “R0 resection”, while the article mistakenly confuses these two concepts (2).

## References

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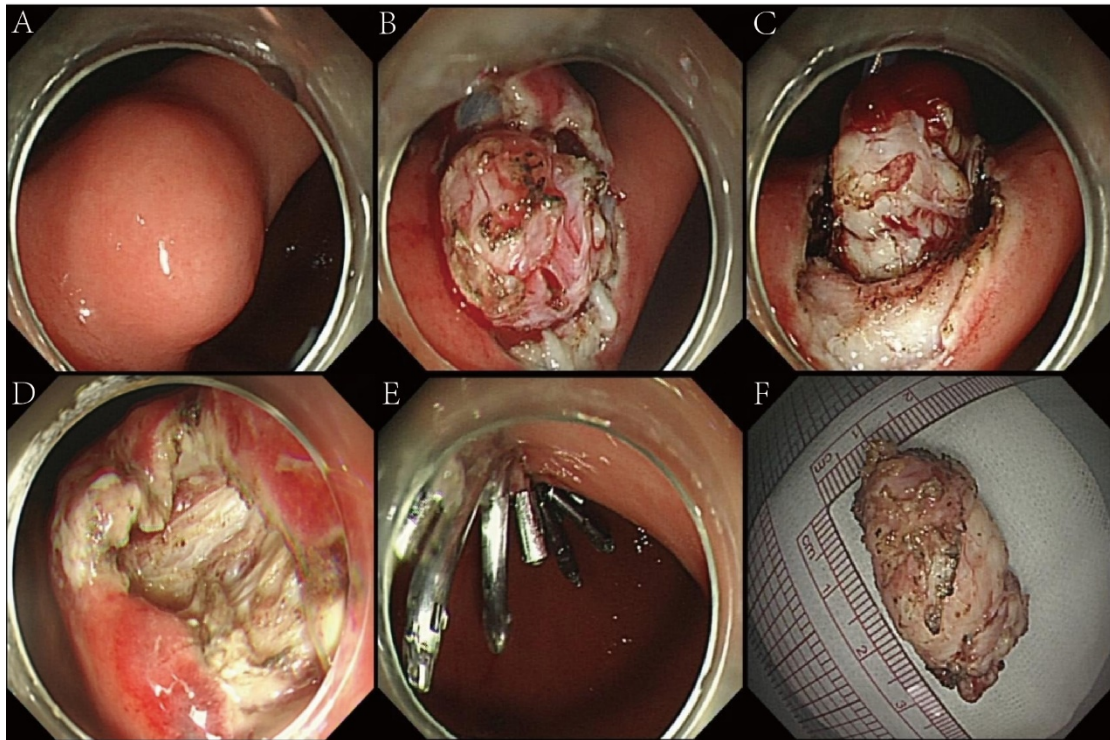


Fig. 1. The gastric submucosal tumor (G-SMT) resected by snare traction-assisted method. A. A SMT in the gastric angle. B. The surrounding mucosa was dissected in advance to expose the tumor. C. The tumor was grasped by a snare for countertraction and a clear dissection line was provided. D. A gastric wall defect after resection of the tumor. E. The gastric wall was closed by hemoclips. F. The resected G-SMT.