SHORT REPORTS

Snare polypectomy by sigmoid-rectal intussusception

Appreciable bleeding or perforation after colonoscopic polypectomy is relatively unusual. Nevertheless, either may occur with broad-based sessile polyps owing to insufficient electrocoagulation of the base resulting from excessive current application, excessive snare-wire tightening, or a combination of both. If a polyp base is over about 2 cm in diameter the endoscopist has either to remove it "piecemeal" in several sessions or refer the patient for abdominal surgery.

Sigmoid colon polyps have been excised after deliberate intussusception to the anus using a conventional sigmoidoscope and surgical forceps.[1] On two occasions recently we have successfully used this approach at colonoscopy to remove polyps which would have been dangerous or impossible to remove endoscopically.

Case reports

Case 1—A 63-year-old man was admitted for colonoscopic snare removal of a sigmoid colon polyp diagnosed radiologically. He gave an eight-year history of recurrent colicky lower abdominal pain. On five occasions he had noticed a "lump" which had prolapsed to the anus but could be reduced by lying supine. Colonoscopy was performed with an Olympus CFMB-3 colonoscope. A 2·5-cm, broad-based polyp in the proximal sigmoid colon was snared and polypectomy attempted. The patient began to have pain from peritoneal irritation before visible electrocoagulation occurred. It was judged dangerous to continue and that the shape of the polyp was unsuitable for complete piecemeal removal. It was resnared with a handleless snare wire.[2] This was left in situ tightened on to the base of the polyp, and the colonoscope was withdrawn. The next day under general anaesthesia the polyp was intussuscepted to the anus by gentle traction on the snare wire and locally excised. The wound was sutured with absorbable sutures. The polyp histologically was a benign tubular adenoma and was completely excised. The patient was discharged two days later.

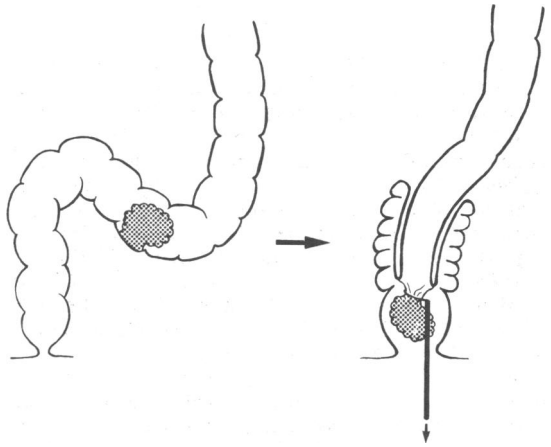

Diagram of broad-based mid-sigmoid colon polyp before and after snare loop intussusception.

Case 2—A 65-year-old man was admitted for colonoscopic removal of three polyps shown radiologically. Snare polypectomy of two 1-cm polyps in the mid-transverse colon was uneventful. The third polyp in the mid-sigmoid colon was broad based and 2·5 cm in diameter. Snare polypectomy was judged to be difficult and hazardous because of the configuration of the polyp base. The handleless snare loop was closed loosely at the base, the colonoscope withdrawn, and an artery forceps used to hold the loop closed. In the operating theatre and under general anaesthesia the polyp was intussuscepted to the anal verge by gentle traction on the snare wire. The base was grasped with sponge forceps, transfixed with a stay suture, and the polyp excised with scissors. The pedicle was then sutured with absorbable sutures. The polyp was a benign tubular adenoma, completely removed. The patient was discharged the next day.

Comment

Snare intussusception in these patients minimised the risks of bleeding and perforation, the latter possibility being signalled in the first case by pain from peritoneal heating. Probably the first patient had been having episodes of spontaneous sigmoid-rectal intussusception, with the polyp at the apex of the intussuscepted loop,[3] and this facilitated delivery per anus. The second case, however, shows that the technique is feasible even without such a history. Traction to the rectum should be enough to allow controlled surgical removal of large polyps with an operating proctoscope or rectal retractors.

In a few patients with broad-based polyps in the sigmoid colon the intussusception technique should be considered as a way of avoiding the risks of endoscopic polypectomy or the need to undertake abdominal surgery.

[1] Parks, A G, *Ergebnisse Der Angologie*, p 338. New York, F K Schattauer, Verlag-Stuttgart, 1976.
[2] Shinya, H, and Wolff, W, *Hospital Practice*, 1975, **10**, 71.
[3] Goligher, J C, *Surgery of the Anus, Rectum and Colon*, p 312. London, Baillière Tindall, 1975.

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Pulmonary oedema after propranolol therapy in two cases of phaeochromocytoma

There is little recorded evidence to support the assertion that beta-adrenergic blockade without concomitant alpha blockade may be harmful in patients with phaeochromocytoma.[1] Indeed, a recent case report suggested that beta blockade (without alpha blockade) was life-saving in a patient with adrenergic crisis due to phaeochromocytoma.[2] We describe two cases of phaeochromocytoma in which life-threatening pulmonary oedema followed soon after the introduction of beta-blocker treatment.

Case reports

Case 1—A 39-year-old man was referred to outpatients with hypertension. He complained of abdominal pain, headaches, night sweats, easy fatigability, and "shakiness." Treatment with propranolol 40 mg twice daily and chlorothiazide had been started eight days previously. The important clinical findings were obesity and a blood pressure of 160/110 mm Hg. Later the same day he collapsed with left-sided chest pain, dyspnoea, and haemoptysis. When examined in hospital one hour later he was ashen grey, his pulse rate was 120/min, and blood pressure 110 mm Hg systolic. He was in left ventricular failure with pronounced peripheral vasoconstriction. Electrocardiography showed ST segment elevation in anteroseptal leads. Over several days T wave inversion evolved in a similar distribution. Serum creatine phosphokinase and serum lactic dehydrogenase concentrations were slightly raised.

After admission he improved rapidly. His cardiac failure resolved without specific treatment and his blood pressure remained stable around 120/70 mm Hg. Urinary vanillylmandelic acid concentrations were consistently and urinary catecholamine concentrations intermittently raised. Right adrenal angiography showed a round mass in the gland. After preoperative treatment with phenoxybenzamine followed by propranolol a large, partly haemorrhagic phaeochromocytoma was removed. Subsequently he remained normotensive and urinary catecholamine and vanillylmandelic acid concentrations were normal.

Case 2—A 32-year-old woman had had pre-eclampsia when aged 22 and a left nephrectomy for hydronephrosis when aged 27. At that time her blood