Q13 Features of optimal snare placement, capture and closure

Answered: 12 Skipped: 0

#	RESPONSES	DATE
1	-Place appropriate sized snare on tissue laying it flat/horizontally -Be mindful of capturing 2-3 mm of normal tissue -Push down with big wheel dial and aspirate gas to seed tissue in snare -Assistant then asked to close to resistance -Snare handed to endoscopist to complete closure	1/13/2018 6:19 AM
2	Start at the edge of a lesion, aspirate while /just before closing, close until resistance Placing a marker on the handle may help to asses closure	12/7/2017 5:43 PM
3	- Appropriate size and type - Marking prior to deployment - Resistance corresponding to snare marking - Cut/coag appropriate to diathermy application and not inappropriately longer suggestive of large volume within the snare or factors causing increased resistance or leakage of current fro the snare - Working in contiguity for large piecemeal EMR	12/3/2017 9:40 PM
4	* don't take too much at once, preferably less than more and taking risks * oversee the far end of your snare (don't catch too much..) * press down the snare * desufflate * coordinate with nurse the velocity of closing * ask the nurse or feel yourself how much tissue is in snare (both can also be done by endoscopist)	11/18/2017 9:31 PM
5	Start at one edge Target at 6 o'clock Work systematically across Deflate to optimize capture MAtch snare to polyp size Close to the mark/finger tight PRoceduralist handles the snare during cutting	11/14/2017 6:02 AM
6	1. Snare placed distal to proximal ensuring normal mucosal margins 2, With piecemeal resection, ensure subsequent snare placement at resection edge to avoid islands 3. Limit 20 mm capture in the right colon and 30 mm in left colon to reduce perforation risk 4. Full snare closure prior to delivery of thermal energy	11/12/2017 2:03 PM
7	Competently ensures that the snare is placed over the lesion Ensures that an appropriate amount of tissue is trapped and that normal tissue is resected around the edge of the lesion Snare is close to the endoscope The endoscopist personally ensures that there is "no bounce" once the snare is closed to minimize the risk of grabbing the muscularis propria. It is good practice to release the snare by a few mm and then recapture the polyp to again minimize the risk of capturing the muscularis propria	11/5/2017 2:59 PM
8	1. Capture 1-2mm of normal colonic mucosa. 2. Close tightly, timing closure with assistant (use suction) 3. Re-inflate 4. 'Jiggle' by moving snare back and forth and observing opposite wall for movement. Release if concerns of too much tissue in snare 5. Inject and resect sequentially with careful snare placement at edge of defect	11/5/2017 3:03 AM
9	englobing a large rim of normal mucosa parallel to the colonic wall clean plane into submucosa avoiding superficial and deep plane. total control of the moment of closure	11/3/2017 1:40 PM
10	correct size and type of snare selection for each lesion, obtaining adequate lateral margins of normal mucosa, understanding principle of snare marking and getting "feel" of when too much tissue captured in snare. Endoscopist should do final snare closure after nurse has captured - I feel strongly about this - it is fundamental! Appreciating principle of release and recapture of tissue	11/3/2017 12:19 PM
11	Lesion at 6 o'clock, bringing snare down over lesion, determine left or right and border close to the endoscope. Make sure that lifting extends beyond tip of open snare. Once snare is in position, bring tip of the scope down, aspirate intraluminal gas en watch lateral and distal margin as long as possible before starting closure. View will be lost during closure.	11/1/2017 11:34 AM
12	Tip control. Plane parallel to polyp base (of piece resected). Placement of distal aspect under direct vision (if blind once snare closed). Remain close to lesion with polyp ideally in 5-6 o'clock position. Check no muscle in snare capture (wall movement etc) and partial release and re-closure if concern. Mark snare and close to mark.	10/31/2017 10:52 PM