

Endoscopic resection of an unusual ampullary adenoma

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A 40-year-old woman with no comorbidities presented with episodic postprandial bilious vomiting of 6 months' duration and mild abdominal discomfort. Her liver function tests showed normal bilirubin with raised alkaline phosphatase and γ -glutamyltransferase. Abdominal US had shown dilatation of the common bile duct (CBD) and pancreatic duct (PD). She had previously undergone MRCP, which showed diffuse dilatation of the CBD, common hepatic duct, and intrahepatic biliary radicles with smooth tapering at the region of the ampulla, diffuse prominence of the main PD, and ectopic ampulla of Vater.

CT showed a polyp arising from the third part of the duodenum, with resultant duodenoduodenal intussusceptions (Fig. 1). In view of suspected ampullary adenoma, duodenoscopy was performed. A long pedunculated lesion with a very long stalk was noted in the second part of the duodenum, prolapsing deep into the duodenum. The ampulla itself could not be identified. Therefore, before performance of a polypectomy of the

unusually long-stalked polypoid lesion and to identify the position of the ampulla of Vater in relation to the polypoid lesion, EUS was performed (Fig. 2).

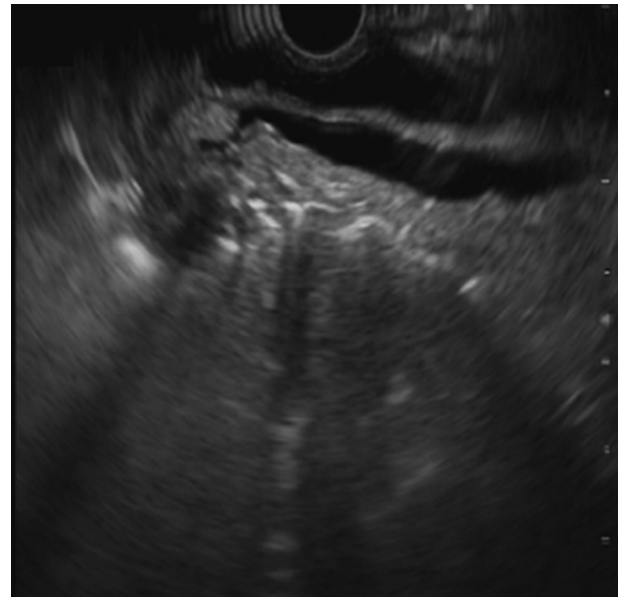


Figure 2. EUS image of ampulla with dilated common bile duct and pancreatic duct.



Figure 1. Duodenoscopic view of long stalk of ampullary adenoma.



Figure 3. Fluoroscopic image of rendezvous technique.



Figure 4. Endoscopic view of guidewire coming out of head of polyp after rendezvous.

At EUS, a dilated BD was visualized, which was then punctured with a 19-gauge needle, and a guidewire was passed across the ampulla into the duodenum (Video 1, available online at www.VideoGIE.org). A duodenoscope was reintroduced, and rendezvous was performed (Fig. 3). At this stage, it was noticed that the guidewire



Figure 6. Fluoroscopic image showing selective biliary cannulation.

had emerged out of the head of the long-stalked polypoid lesion, confirming it to be an unusual ampullary adenoma having a long stalk (Fig. 4). With the patient under general anesthesia, we proceeded with an ampullectomy (Fig. 5). Hemostasis was achieved with coagulation forceps and clips. After completion of the ampullectomy, the PD was cannulated (Fig. 6), a 5F stent was inserted into the PD through the cut edge of the ampullary stalk (Fig. 7), and a 10F stent was inserted into the BD.

After the procedure, the patient was in stable condition; on the second day she was discharged. The patient came for follow-up at 2 weeks. She was doing better and had no further complaints. Histopathologic examination of a



Figure 5. A, B, Performance of endoscopic ampullectomy.

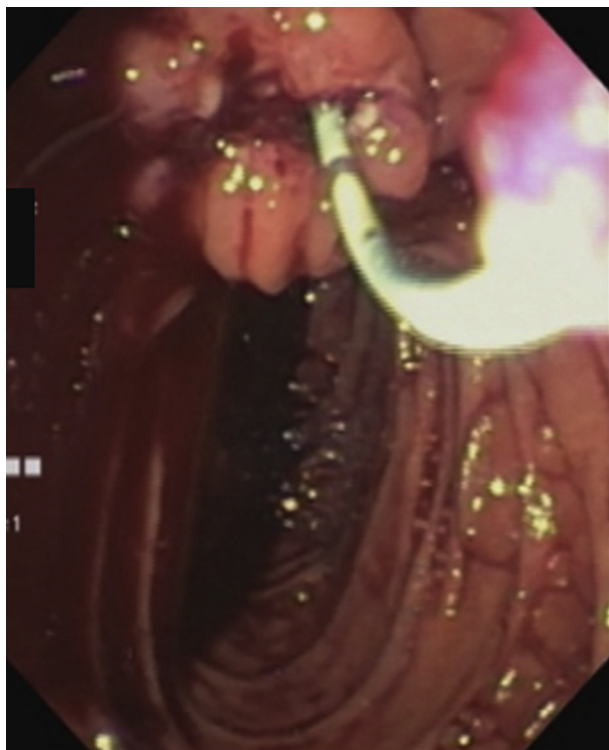


Figure 7. Pancreatic duct stent placement.

specimen, as expected, showed tubulovillous adenoma with low-grade dysplasia without invasion.

Endoscopic ampullectomy has gained popularity over surgical resection as curative therapy for large ampullary adenomas. Identification of the bile duct and PD opening at the ampulla before ampullectomy is essential. Endoscopists should be vigilant in identifying and distinguishing benign from malignant ampullary lesions.

DISCLOSURE

All authors disclosed no financial relationships relevant to this publication.

Abbreviations: CBD, common bile duct; PD, pancreatic duct.

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