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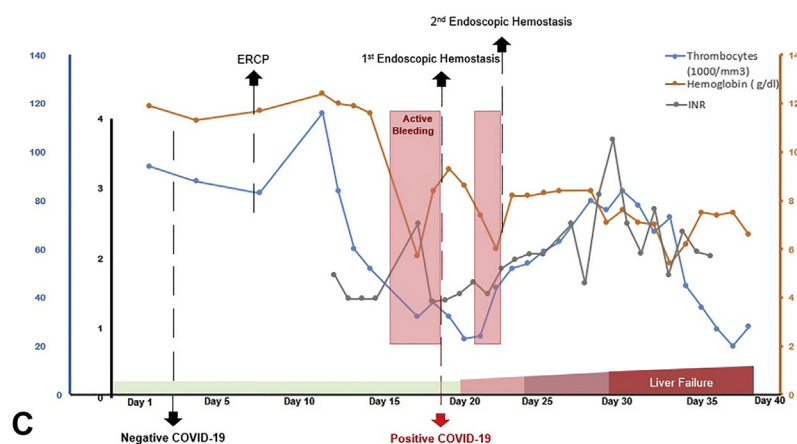
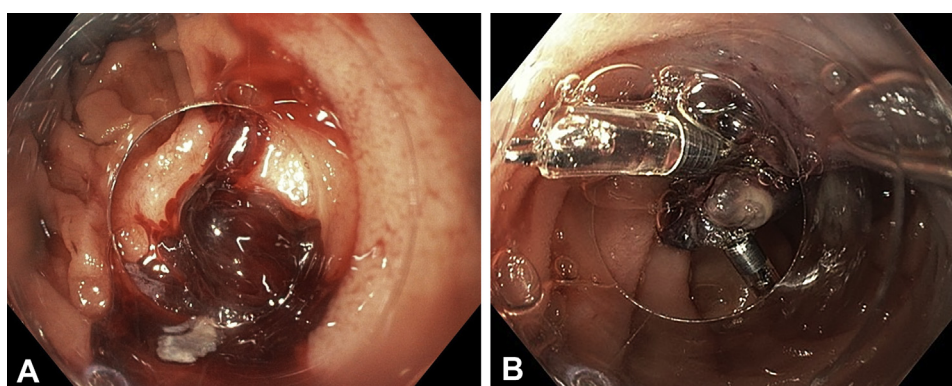
we are able to see it for ourselves. In the past, it was likely only surgeons and pathologists who had the opportunity to see this finding.

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Delayed postsphincterotomy bleeding induced by severe thrombocytopenia in a patient with COVID-19



A 67-year-old woman with Child A hepatitis C–related cirrhosis was transferred to our COVID unit because of upper GI bleeding. She had recently undergone ERCP with biliary stone extraction after an episode of acute pancreatitis. At that time she had normal liver function and a negative test result for COVID-19. Five days after the procedure she experienced melena and was readmitted with severe thrombocytopenia, posthemorrhagic anemia, and a positive test result for COVID-19.

We performed urgent cap-assisted endoscopy and found active bleeding (Forrest Ib) at the upper pole of the postsphincterotomy ulcer (**A**). Hemostasis with adrenaline injection and clipping was successful (**B**), but there was recurrent bleeding 5 days later, which was also stopped endoscopically. The patient experienced liver failure despite supportive measures and antiviral therapy, and she died 3 weeks after admission (**C**).

This case illustrates a surprising delayed postsphincterotomy bleeding probably triggered by the severe viral-induced thrombocytopenia. Reduced platelet counts are common in patients with COVID-19 and may be due to inhibition of hematopoiesis, an autoimmune response, disseminated intravascular coagulation, or altered platelet defragmentation. We recommend close follow-up of hematologic parameters after high-risk endoscopic procedures performed in patients with COVID-19 or other aggressive viral infections.

DISCLOSURE

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Commentary

The COVID-19 pandemic has changed the way we practice endoscopy. Patient prioritization schemes, enhanced personal protective equipment, and preprocedural viral testing are all commonplace features of today's endoscopy units. Clinical outcomes after standard endoscopy are also affected by COVID-19.

The authors describe a typical ERCP with sphincterotomy for gallstone pancreatitis. The patient's test result for COVID-19 was negative on preprocedural testing. Subsequently, the patient returned with delayed postsphincterotomy bleeding, and her test result was positive for COVID-19. The bleeding was difficult to control because of severe COVID-19-induced thrombocytopenia.

Thrombocytopenia of varying degrees occurs in 35% to 50% of patients with COVID-19. Mechanisms of viral-mediated thrombocytopenia include bone marrow suppression, immune-mediated platelet destruction, and platelet consumption via microthrombi. Thrombocytopenia may worsen during the course of the disease and parallel the severity of lung disease. Delayed bleeding adverse events from endoscopy in patients with COVID-19 should be anticipated, and in appropriate situations, prophylactic measures such as clips may be used. Who could imagine longing for a day when postsphincterotomy bleeding could just be blamed on poor technique!

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Unexpected cause of dilatation of the pancreatic duct



A 71-year-old man was admitted to our department because of dilatation of the main pancreatic duct. He had a medical history of recurrent cholecystitis, cholangiolithiasis, and cholangitis. His symptoms improved after endoscopic treatment, and a history of biliary stent implantation was reported during this period.

Abdominal CT revealed a 10 mm × 1 mm radiopaque lesion in the head of the pancreas and dilatation of the distal pancreatic duct (**A, B**). EUS revealed an irregular hypoechoic area with uneven internal echo and an unclear boundary at the head of the pancreas. The pancreatic duct was contorted and expanded to 1 cm, with a smooth inner wall. The wall of the lower bile duct was markedly thickened and slightly dilated (**C**).

On the basis of preoperative examination, potential diagnosis of early pancreatic cancer could not be ruled out; thus, surgical exploration was offered accordingly. Intraoperative exploration revealed a green foreign body measuring 10 mm × 1 mm × 1 mm in the main duct, together with a firm mass surrounding the foreign body at the neck of the pancreas. Analysis of a frozen section ruled out the diagnosis of pancreatic cancer. A central pancreatectomy was offered, and the tough mass with the foreign body was completely resected (**D**). Pathologic examination revealed that the foreign body was a fragment of bile duct stent, which had entered the pancreatic duct and resulted in stenosis.