

CASE REPORT

Modified endoscopic mucosal resection of gastric heterotopic pancreas: Report of two cases



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Summary Heterotopic pancreas is a congenital anomaly characterized by the presence of ectopic pancreatic tissue far from the pancreas. The treatment of heterotopic pancreas may include expectant observation, endoscopic resection, or surgery. The aim of this study was to describe the technique of cap-assisted endoscopic mucosal resection for the management of heterotopic pancreas of the stomach. Two patients, a 41-year-old woman and a 31-year-old man, were referred to us for the management of gastric subepithelial lesions. Endoscopic ultrasound was used in the female patient to disclose two small hypoechoic lesions arising from the submucosal layer. Cap-assisted endoscopic mucosal resection was performed in both patients without complications. Histopathological examination of the resected specimens showed heterotopic pancreatic tissue in the submucosal layer. Our technique is a suction, snaring, and cut method. This method does not need a special cap with a shallow circumferential lip on the inside and the snare does not need to be pre-looped. This technique allowed a histopathological confirmation of the suspected diagnosis in both patients.

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Introduction

Heterotopic pancreas (HP) is an uncommon congenital anomaly characterized by the presence of ectopic pancreatic tissue

far from the pancreas and without any anatomical or vascular communication with the pancreas. It occurs in around 2% of the general population [1] and is noted to be more common in men [2]. HP may occur throughout the gastrointestinal tract,

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but frequently involves the stomach and proximal small intestine. Most affected patients are asymptomatic, although a minority of patients may present with a variety of symptoms, such as epigastric pain [1]. Options for the treatment of HP in the stomach include surgery [1,2], endoscopic resection [3–6], or a “wait and see” strategy.

Endoscopic mucosal resection (EMR) is an important method that allows sessile lesions confined to the mucosa or with only minute submucosal invasion to be removed. However, it is often difficult to entrap a flat lesion with standard EMR. We describe here two cases of HP treated with cap-assisted EMR, a so-called “suction, snaring, and cut” method. This is a relatively simple approach for the management of HP.

Case reports

Case 1

A 41-year-old woman presented to our gastrointestinal outpatient department with a 1-month history of post-prandial abdominal fullness and early satiety. No significant abnormality was noted on physical examination and laboratory tests. Esophagogastroduodenoscopy (EGD) showed the presence of two small polypoid lesions (1.2 cm and 0.8 cm in size) with intact mucosa in the gastric antrum (Fig. 1). Endoscopic ultrasonography (EUS) indicated two oval, hypoechoic, and homogeneous lesions appearing to involve the muscularis mucosa and submucosa (Fig. 2). We suggested a “wait-and-see” strategy because a benign etiology was more favored. However, the patient was worried about the possibility of a malignant potential and decided, after discussion, to receive endoscopic resection. Informed consent was obtained and the patient was sedated with an intravenous administration of midazolam. We then performed cap-assisted EMR at our endoscopy unit.

Initially, we administered a submucosal injection of diluted epinephrine along the margin of the larger lesion; however, we were unable to loop the snare around the lesion. A translucent plastic cap (straight distal attachment, MH-462, outer diameter 12.6 mm; Olympus, Tokyo, Japan) was first fixed on

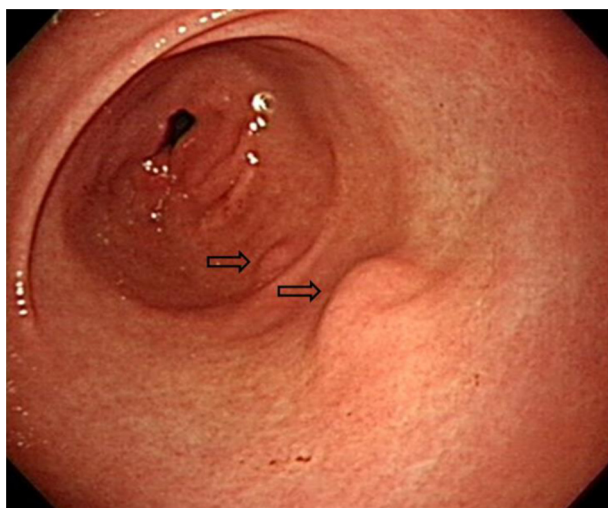


Figure 1 Esophagogastroduodenoscopy shows two polypoid lesions in the antrum (1.2 cm and 0.8 cm; arrows).

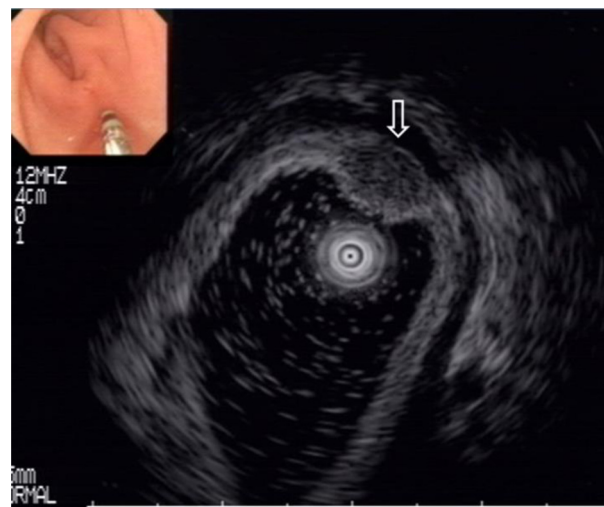


Figure 2 Endoscopic ultrasonography (Miniprobe 12 MHz, Olympus, Tokyo, Japan) shows an oval, well-defined, inhomogeneous hypoechoic tumor with an irregular outer margin involving the muscularis mucosa and submucosa layer (arrow).

the tip of the endoscope and the cap was positioned on the target lesion. Suction was then applied to draw the flat lesion into the cap and, when the suction was released, the flat lesion became a pseudopolyp (Fig. 3). Next, we used an electrosurgical snare (oval shape, SD-9L-1, Olympus) to strangle the pseudopolyp immediately before when it became flat (Fig. 4). We then resected it with an electrosurgical generator (ERBE VIO 200D, settings with ENDO CUT Q model effect 3, duration 1, interval 5; Elektromedizin, Tübingen, Germany), resulting in an artificial ulcer without active bleeding or perforation (Fig. 5). We removed the smaller lesion smoothly by the same method and the total procedure time was 19 minutes. The patient fasted for 1 day and an intravenous proton pump inhibitor was given. Her course after EMR was uneventful and she was discharged 2 days later.

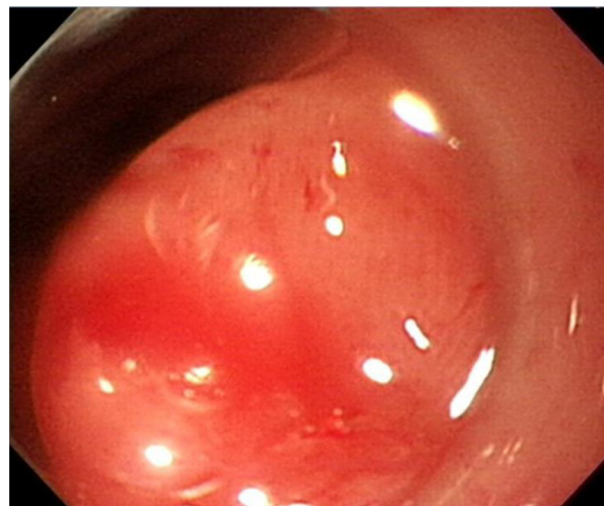


Figure 3 Suction is applied to draw the flat lesion into the cap and, on the release of suction, the flat lesion becomes a pseudopolyp.

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