

Efficacy and safety of the band and slough technique for endoscopic therapy of nonampullary duodenal adenomas: a case series

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Background: Endoscopic resection of nonampullary duodenal adenomas (NADAs) is effective but carries substantial procedural risks. Therapeutic banding for treatment of duodenal mucosal neoplasia has not been studied. We report a novel band and slough (BAS) technique for therapy of NADA without endoscopic resection.

Objective: Efficacy and safety of BAS.

Design: Retrospective review of a prospective database.

Setting: Community hospital.

Patients: Patients with sporadic and familial biopsy-proven NADA without invasive cancer undergoing BAS.

Intervention: Patients were treated with BAS without endoscopic resection on an outpatient basis. A follow-up telephone call was made by a nurse at 24 hours. Follow-up endoscopy was performed at 8 weeks, with further therapy of residual NADA. In patients with minimal residual NADA not amenable to banding, argon plasma coagulation (APC) “touch-up” was used. Subsequent endoscopic surveillance was performed.

Main Outcome Measurements: Complete histologic remission of NADA after successful BAS and postprocedure bleeding, perforation, and pain.

Results: Ten patients, average age 65 years, 6 male, with sporadic/familial adenomatous polyposis NADA 8 of 2 (6 tubular adenoma and 4 tubulovillous adenoma) were treated. Mean (largest) NADA was 12.5 mm (20 mm). Five patients achieved complete remission after a single session. Among 5 patients requiring further therapy, 3 were treated with repeat banding with or without APC and 2 with APC alone. The average number of bands per session was 4.4. Patients were followed up to 24 months without NADA recurrence. None of the patients had acute or delayed adverse events of bleeding, perforation, or postprocedure pain.

Limitations: Lack of polyp tissue retrieval.

Conclusion: BAS appears to be a safe and potentially effective endoscopic treatment for NADA. However, larger studies are needed to corroborate these findings.

Abbreviations: APC, argon plasma coagulation; BAS, band and slough; ER, endoscopic resection; NADA, nonampullary duodenal adenoma.

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Nonampullary duodenal adenomas (NADAs) are found incidentally in 0.3% to 4.6% of EGDs.¹ These lesions can occur sporadically (Fig. 1) or as part of a familial polyposis syndrome. Endoscopic resection (ER) is a very effective, minimally invasive approach to managing NADAs. However, electrocautery during ER is associated with a substantial risk of acute and delayed adverse events, including bleeding, perforation, and pain.² Further, ER is associated with incomplete resection and polyp recurrence, with rates as high as 37%.³ Successful repeat ER for polyp recurrence is challenging, given post-ER submucosal fibrosis.

Therapeutic banding has been performed for various lesions in the GI tract, including esophageal varices and small GI stromal tumors.⁴ In this study, we prospectively evaluated a novel therapeutic approach to effectively manage NADAs by a rubber band ligation and sloughing technique (band and slough [BAS]) (without use of electrocautery).

PATIENTS AND METHODS

Patients

The study was approved by the St. Joseph Mercy Hospital Institutional Review Board. All consecutive patients with an established diagnosis of NADA referred for therapy between 2011 and 2014 were included in the study. Endoscopic therapy of NADA was performed by single endoscopist (N.T.G.). Clinical data were prospectively recorded and reviewed retrospectively for purposes of analysis. Patients with ampullary or periampullary adenomas and invasive malignancy were excluded.

Methods

All procedures were performed on an outpatient basis, with the patients under conscious sedation. Intravenous glucagon was administered to decrease duodenal peristalsis. The polyps were assessed for absence of malignant invasion (eg, nonulcerated, elevation with submucosal injection, freely mobile). The mucosal pit pattern was carefully examined by N.T.G., who has extensive experience in narrow-band imaging.⁵ Polyp size was estimated.

The Speedband Superview Super 7 (Boston Scientific, Natick, Mass) banding kit was fitted onto a gastroscope in a standard fashion. The gastroscope was reinserted, the polyp was suctioned into the cap until "red out," and the rubber band was deployed at the base of the polyp (Fig. 2). No polyp site was treated with >2 bands. When patients had multiple polyps, 1 to 2 bands were placed per site per polyp. When >1 band was placed at a site, the second band was deployed deep to the first band. ER was not performed, and the polyp was allowed to slough off spontaneously. Location of the NADA after banding was marked with submucosal India ink injection.

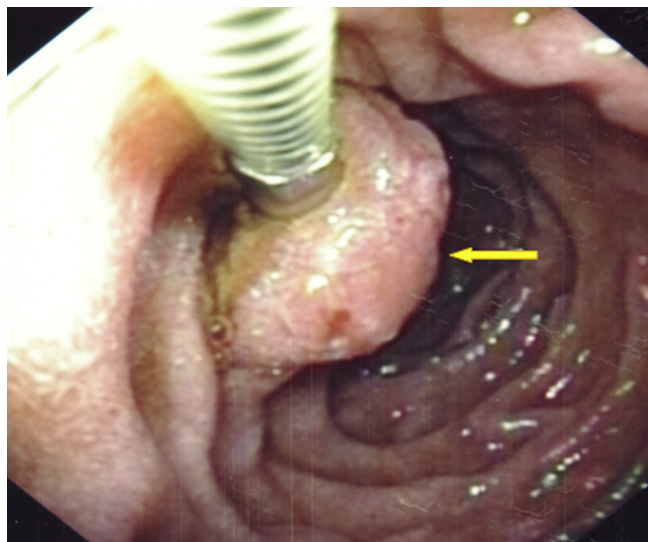


Figure 1. Endoscopic view of a sporadic nonampullary duodenal adenoma.

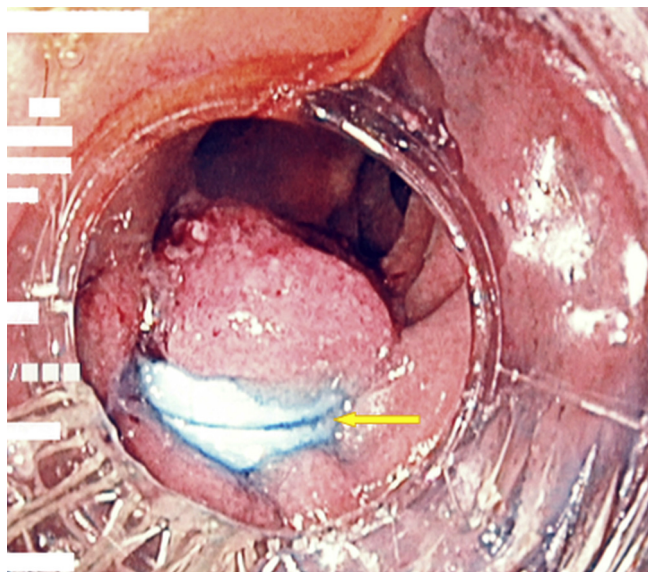


Figure 2. Pseudopolyp created by 2 bands.

Patients were observed for 60 minutes for acute post-procedure adverse events, in the absence of which they were discharged home. A follow-up telephone call was made by an endoscopy nurse after 24 hours to identify adverse events that were not apparent immediately after the procedure.

Follow-up endoscopic assessment was performed at 8 weeks with a repeat EGD. The treatment site was identified by tattoo and was examined carefully. If residual adenomatous tissue was identified, repeat banding was attempted. Argon plasma coagulation (APC) ablation was

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