Although non-ampullary duodenal epithelial tumors (NADETs) are relatively rare in the general population, opportunities for endoscopic detection and treatment of them have been increasing due to advances in endoscopic equipment and awareness of the disease [1]. Because the prognosis for invasive duodenal carcinoma is dismal and surgical treatment with pancreatoduodenectomy can result in morbidity and death, less invasive prophylactic treatment of NADETs with endoscopic resection significantly benefits patients. Nevertheless, endoscopic treatment of NADETs is often difficult because the narrow and tortuous duodenal lumen restricts endoscopic maneuvers and thin duodenal walls and secretion of bile and pancreatic juice into the duodenal lumen induce severe delayed adverse events (AEs), such as bleeding and perforation [2]. Accordingly, it is important to establish practical indications for when NADETs should or should need be treated with endoscopic resection.

Recently, an association between the mucin phenotype and clinicopathological features of NADETs, particularly tumor location and histological grade, has been reported in several studies. First, gastric NADETs are likely to develop on the oral side, and especially the proximal half, of the ampulla of Vater. Brunner’s glands are compound submucosal glands that produce a mucus-rich alkaline secretion that contains bicarbonate and protects the duodenal mucosa from the acidic gastric content. The result is an alkaline condition that activates intestinal enzymes and lubricates the intestinal walls. Brunner’s glands are distributed in the duodenum on the oral side of the ampulla of Vater and may transform into metaplastic gastric epithelium as a result of chronic exposure to the gastric acid [3]. An association has been suggested between development of gastric NADETs and presence of Brunner’s gland hyperplasia, gastric foveolar metaplasia, and heterotopic gastric mucosa [4–6]. Recent studies have shown that gastric foveolar metaplasia and heterotopic gastric mucosa are more frequently observed in mucosa adjacent to gastric than intestinal NADETs, while Brunner’s gland hyperplasia is commonly found irrespective of tumor phenotype [7, 8]. Moreover, a significant proportion of gastric foveolar metaplasia and heterotopic gastric mucosa are more frequently observed in mucosa adjacent to gastric than intestinal NADETs, while Brunner’s gland hyperplasia is commonly found irrespective of tumor phenotype [7, 8]. More recently, an association between the mucin phenotype and clinicopathological features of NADETs, particularly tumor location and histological grade, has been reported in several studies. First, gastric NADETs are likely to develop on the oral side, and especially the proximal half, of the ampulla of Vater. 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Gastric NADETs appear to be a good indication for endoscopic resection; however, the diagnosis of mucin phenotype must be made before treatment. Recently, some studies have investigated the association between endoscopic appearance and mucin phenotypes of NADETs. Reddish color, polypoid appearance, and lobular or granular surface pattern in white-light endoscopy [13], oval-shaped marginal epithelium, dense pattern, and dilation of the intervening part on magnifying endoscopy with narrow-band imaging [13], and pinecone pattern on magnifying crystal violet chromoendoscopy [14] were more frequently seen with gastric than intestinal NADETs. Therefore, these findings can be used for prediction of gastric NADETs.

Mucin phenotype may be one useful indicator for decision-making about endoscopic resection of NADETs because gastric NADETs are associated with high malignant potential and low rates of AEs by pre-ampullary location. This concept warrants further verification in future large-scale studies, preferably cohorts.

Competing interests

The authors declare that they have no conflict of interest.

References


