Endoscopic submucosal dissection (ESD) of ampullary lesions is an alternative to endoscopic papillectomy [1], which has several drawbacks such as a significant perforation rate, bleeding, and a low curative resection rate [2–4]. ESD may overcome these drawbacks, except for the risk of perforation. The sphincter of Oddi often cannot be distinguished from the duodenal muscularis. We report a novel technique using miniprobe ultrasonography to identify the sphincter of Oddi, which facilitates appropriate dissection just above the muscularis propria.

A 51-year-old woman was found to have an ampullary lesion (> 2 cm) during screening esophagogastroduodenoscopy (▶ Fig. 1). Biopsy showed a high grade adenoma. Endoscopic ultrasonography revealed no findings suspicious for deep invasion. ESD was therefore attempted aiming to remove the lesion with negative margins (▶ Video 1).

A therapeutic endoscope (H-290T; Olympus, Tokyo, Japan) was used for the procedure and, after submucosal injection, an initial mucosal incision (approximately 15-mm long) was made 10 mm from the proximal side of the tumor using a needle-type knife (FlushKnife BT-S; 1.5 mm; Fujifilm, Tokyo, Japan). Submucosal pockets were created on both lateral sides of the ampulla (▶ Fig. 2). A miniprobe was inserted into the left-sided submucosal pocket. Ultrasonography clearly depicted the sphincter of Oddi and duodenal muscularis, and an appropriate dissection line was identified (▶ Fig. 3). The sphincter of Oddi was dissected from the muscularis using a scissor-type knife (SB Knife Jr. 2; SB KAWASUMI, Kanagawa, Japan) with Endocut I mode (VIO3; effect 1, duration 4, interval 1) to minimize thermal damage to the pancreaticobiliary ducts (▶ Fig. 4). The remaining area was dissected and an en bloc resection was achieved. A duodenoscope was then used during placement of bile and pancreatic duct stents, and the mucosal defect was closed using endoclips (▶ Fig. 5). There were no adverse events. The pathologic diagnosis was a high grade adenoma with a negative cut margin.

Miniprobe ultrasonography in the pocket was useful to identify the appropriate dissection line and avoid perforation.

Competing Interest

The authors declare that they have no conflict of interest.
The authors

Yuki Nakajima1,2, Daiki Nemoto1, Kohei Suzuki3, Ai Sato3, Goro Shibukawa2, Alan Kawarai Lefor4, Kazutomo Togashi1
1 Department of Coloproctology, Aizu Medical Center, Fukushima Medical University, Fukushima, Japan
2 Department of Gastroenterology, Aizu Medical Center, Fukushima Medical University, Fukushima, Japan
3 Department of Gastroenterology, Nikko Medical Center, Dokkyo Medical University, Mibu, Japan
4 Department of Surgery, Jichi Medical University, Shimotsuke, Japan

Corresponding author

Daiki Nemoto, MD, PhD
Department of Coloproctology, Aizu Medical Center, Aizu Medical Center, Fukushima University, 21-2 Maeda, Tanisawa, Kawaihigashi, Aizuwakamatsu-city, Fukushima 969-3492, Japan
nemotoda@fmu.ac.jp

References


Bibliography

Endoscopy
DOI 10.1055/a-1934-9641
ISSN 0013-726X
published online 2022
© 2022. The Author(s).
This is an open access article published by Thieme under the terms of the Creative Commons Attribution-NonDerivative-NonCommercial License, permitting copying and reproduction so long as the original work is given appropriate credit. Contents may not be used for commercial purposes, or adapted, remixed, transformed or built upon. (https://creativecommons.org/licenses/by-nc-nd/4.0/)
Georg Thieme Verlag KG, Rüdigerstraße 14, 70469 Stuttgart, Germany

ENDOSCOPY E-VIDEOS
https://eref.thieme.de/e-videos

Endoscopy E-Videos is an open access online section, reporting on interesting cases and new techniques in gastroenterological endoscopy. All papers include a high quality video and all contributions are freely accessible online. Processing charges apply (currently EUR 375), discounts and waivers acc. to HINARI are available.

This section has its own submission website at https://mc.manuscriptcentral.com/e-videos

Fig. 3 Miniprobe ultrasonography enabled differentiation of the sphincter of Oddi from the duodenal muscularis, and an appropriate dissection line was identified.

Fig. 4 Endoscopic view during dissection of the sphincter of Oddi using a scissors-type knife.

Fig. 5 Endoscopic image of the final appearance after placement of biliary and pancreatic stents and prophylactic closure of the mucosal defect using endoclips.