Endoscopic ultrasound-guided forceps biopsy from upper gastrointestinal subepithelial lesions using a forward-viewing echoendoscope

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Institutions are listed at the end of article.

Background and study aims: Endoscopic tissue acquisition techniques using needle-knife and biopsy forceps allow abundant tissue acquisition from upper gastrointestinal subepithelial lesions; however, these techniques cannot capture real-time intratumor information. The aim of this study was to evaluate the feasibility of endoscopic ultrasound-guided forceps biopsy (EUS-FB) from upper gastrointestinal subepithelial lesions using a forward-viewing echoendoscope.

Materials and methods
This prospective trial was conducted at the Nagoya University Hospital in Japan. Between January 2015 and April 2015, all 10 patients with upper gastrointestinal subepithelial lesions underwent EUS-FB. The overall rate of histological diagnosis by EUS-FB was 100% (10/10). The rate of diagnosable samples among all cases was 97.6% (41/42). The median procedure times for EUS-FB and complete closure were 28.5 and 4.5 minutes, respectively. No adverse events occurred.

Conclusions: This newly developed EUS-FB is feasible and allowed forceps biopsy from upper gastrointestinal subepithelial lesions. Study registration: UMIN000015364

Introduction
Endoscopic ultrasound-guided fine-needle aspiration (EUS-FNA) has become accepted as an accurate technique for tissue acquisition from upper gastrointestinal subepithelial lesions [1–3]. We have also reported the usefulness of a newly developed forward-viewing echoendoscope with regard to sample area [4]. On the other hand, endoscopic tissue acquisition techniques using snare, needle-knife and biopsy forceps allow abundant tissue acquisition; however, these techniques cannot capture real-time intratumor information [5–7]. We hypothesized that a forceps biopsy using a forward-viewing echoendoscope could be a useful new endoscopic tissue acquisition technique under EUS visualization. The aim of this study was to evaluate the feasibility of EUS-guided forceps biopsy (EUS-FB) from upper gastrointestinal subepithelial lesions.
who had performed both endoscopic submucosal dissection (ESD) and EUS on more than 200 upper gastrointestinal lesions. This echoendoscope provides a forward endoscopic view, allows device deployment along the axis of the scope, and has a larger tip angulation compared with the oblique-viewing echoendoscope.

EUS-FB procedure
All patients were placed in the left lateral position under conscious or deep sedation with intravenous anesthesia using midazolam and pentazocine. First, the lesion was observed and color flow mapping was applied to avoid thick vessels using a forward-viewing echoendoscope and an ultrasound processor with color Doppler function (EU-ME2; Olympus). Second, a mucosal cut was made by hot biopsy forceps (FD-210U; Olympus) with a PulseCut Fast mode setting of 40 W using an electrosurgical unit (ESG-100; Olympus) after injection of saline into the submucosa (Fig. 1). After mucosal and submucosal cuts, several specimens were taken within the lesion using this forceps without coagulation under real-time EUS visualization. The forceps biopsies were repeated until two whitish tissues were obtained macroscopically, with a maximum of six biopsies. On-site pathologists were not present to determine the adequacy of specimens in this study. Finally, the incision site was closed using hemoclips (HX-610-090L; Olympus) to achieve hemostasis and to avoid exposure of tumor. A broad-spectrum antibiotic and a proton pump inhibitor were administered for 5 days. Patients were hospitalized for 3 days.

Histological assessment
The collected specimens were immediately placed in formalin and embedded in paraffin for histological examination. The pathological diagnosis was made on the basis of hematoxylin-eosin staining and immunopathological stains by expert pathologists (Y.S., S.N).

Outcome measures
The primary end point was the diagnostic yield of the EUS-FB. The secondary end points were the number of mucosal cuts before biopsy of the lesion, the rates of diagnosable samples obtained under EUS visualization, and the procedure times for both EUS-FB and complete closure. Adverse events were defined as any deviation from the clinical course after EUS-FB. All patients were contacted within 1 month of the procedure to assess whether there had been any late adverse events.

Statistical analysis
Continuous variables such as patients’ age and tumor size were reported as median and range. Comparisons of proportions such as diagnostic yield, rates of diagnosable samples, and adverse events were expressed as frequencies and proportions.

Results
During this study period, 10 patients (7 males and 3 females; median age 63 years, range 31–77 years) underwent EUS-FB. Tumor locations were esophagus in two cases, stomach in five cases, and duodenum in three cases. The median tumor size was 16 mm (range 15–44 mm). Layers of origin were the submucosa in two cases and the muscularis propria in eight cases. Patterns of growth were intraluminal in seven cases, extraluminal in one case, and mixed in two cases (Table 1). The overall rate of histological diagnosis of EUS-FB was 100% (10/10). The median number of mucosal cut biopsies was 3.5 (range 1–11) and the rate of diagnosable samples among the 10 cases was 97.6% (41/42). Abundant tissue fragments without cautery artifact and without blood contamination were obtained from all cases. The histologic results of EUS-FB were gastrointestinal stromal tumor (GIST), mitotic index <5/50 (n = 1) (Fig. 2) (Video 1), leiomyoma (n = 4), schwannoma (n = 1), malignant lymphoma (n = 1), neuroendocrine tumor, Ki-67 3–5% (n = 1), ectopic pancreas (n = 1), and Brunner’s gland hyperplasia (n = 1). Median procedure times

<table>
<thead>
<tr>
<th>Case</th>
<th>Age, years/sex</th>
<th>Tumor location</th>
<th>Tumor size, mm</th>
<th>Wall layer of origin on EUS</th>
<th>Pattern of growth on EUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>33/M</td>
<td>Duodenum, bulb, PW</td>
<td>16</td>
<td>Muscularis propria</td>
<td>Intraluminal</td>
</tr>
<tr>
<td>2</td>
<td>77/F</td>
<td>Stomach, middle body, LC</td>
<td>21</td>
<td>Muscularis propria</td>
<td>Extraluminal</td>
</tr>
<tr>
<td>3</td>
<td>66/M</td>
<td>Duodenum, bulb, AW</td>
<td>15</td>
<td>Submucosa</td>
<td>Intraluminal</td>
</tr>
<tr>
<td>4</td>
<td>31/M</td>
<td>Stomach, upper body, GC</td>
<td>44</td>
<td>Muscularis propria</td>
<td>Intraluminal</td>
</tr>
<tr>
<td>5</td>
<td>72/M</td>
<td>Stomach, upper body, LC</td>
<td>15</td>
<td>Muscularis propria</td>
<td>Intraluminal</td>
</tr>
<tr>
<td>6</td>
<td>75/M</td>
<td>Duodenum, bulb, PW</td>
<td>15</td>
<td>Submucosa</td>
<td>Intraluminal</td>
</tr>
<tr>
<td>7</td>
<td>71/M</td>
<td>Stomach, middle body, GC</td>
<td>16</td>
<td>Muscularis propria</td>
<td>Mixed</td>
</tr>
<tr>
<td>8</td>
<td>35/M</td>
<td>Esophagus, middle, AW</td>
<td>31</td>
<td>Muscularis propria</td>
<td>Mixed</td>
</tr>
<tr>
<td>9</td>
<td>34/F</td>
<td>Stomach, lower body, GC</td>
<td>20</td>
<td>Muscularis propria</td>
<td>Intraluminal</td>
</tr>
<tr>
<td>10</td>
<td>60/F</td>
<td>Esophagus, cervical, AW</td>
<td>15</td>
<td>Muscularis propria</td>
<td>Intraluminal</td>
</tr>
</tbody>
</table>

PW, posterior wall; LC, lesser curvature; AW, anterior wall; GC, greater curvature.
for EUS-FB and complete closure were 28.5 minutes (range 9–46 minutes) and 4.5 minutes (range 3–32 minutes), respectively (Table 2). No adverse events occurred.

**Discussion**

EUS-FBs using the forward-viewing echoendoscope for upper gastrointestinal subepithelial lesions were successfully performed without adverse events. Histopathological diagnoses including immunopathological stains and mitotic index assessments were obtained in all cases. The prognostication of GISTs is based on the mitotic index, and gastrointestinal subepithelial lesions less than 2 cm have a low risk of malignant behavior [8,9]. Theoretically, early diagnosis and early treatment are promising means of obtaining a permanent cure. All six subepithelial lesions less than 2 cm were diagnosed in this study. A small tumor size was thought to be one of the factors related to a nondiagnostic result for EUS-FNA [2,4]. Therefore, the EUS-FB technique is thought to be suitable for all gastrointestinal subepithelial lesions including small tumor sizes. The diagnostic yield from EUS-FNA ranged from 83% to 93% [1–3]. Recently, we reported the usefulness of EUS-FNA using a forward-viewing echoendoscope with regard to sample area [4]. However, the mitotic and proliferative assessments using FNA are thought to be difficult. On the other hand, unroofing and cutting biopsy techniques allowed abundant tissue acquisition safely (Table 3) [5–7]; however, these reported techniques could not
capture real-time intratumor information using an echoendoscope. Recently, EUS-guided through-the-needle forceps biopsy was reported [10]. This technique allows tissue acquisition within the lesion using forceps under EUS guidance. However, this technique required 19 gauge needle puncture and miniforceps. Furthermore, the feasibility with regard to diagnosis of subepithelial lesions was not clarified. In this study, forward endoscopic view and device deployment along the axis of the scope could allow forceps biopsy from subepithelial lesions under real-time EUS guidance using the forward-viewing echoendoscope. The real-time intratumor information and the depth of forceps within the tumor could be confirmed using this echoendoscope. On the other hand, care should be taken not to burn the distal end of the echoendoscope when using hot biopsy forceps. This technique cannot be easily and safely performed using an oblique-viewing echoendoscope.

In this study, adequate tissues were obtained using hot biopsy forceps in all cases including eight subepithelial lesions originating from muscularis propria. Furthermore, the diagnostic yield of EUS-guided forceps biopsy may be higher than for conventional endoscopic tissue acquisition techniques including EUS-FNA; however, in some cases, several mucosal cutting biopsies were performed to insert the forceps into tumors because of slip. The improved prehensile hot biopsy forceps or needle-knife may be suitable for this technique.

Procedural blood oozing was common and was treated using unroofing and cutting biopsy techniques [5–7]. In our study, electrosurgical current using hot biopsy forceps and complete closure of the incision sites could prevent this adverse event. Furthermore, no infectious adverse events occurred. This technique may not require antibiotics and hospitalization. Theoretically, this EUS-FB technique is suitable for all subepithelial lesions. This may be especially advantageous for small lesions less than 2 cm and extraluminal growth lesions.

In conclusion, this study clearly demonstrated the feasibility of this newly developed EUS-FB using a forward-viewing echoendoscope for upper gastrointestinal subepithelial lesions. Stud-
ies with a larger sample size are needed to further evaluate this procedure.

**Competing interests:** None

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**Acknowledgments**

We thank Olympus Medical System for the loan of the forward-viewing echoendoscope to our unit.

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