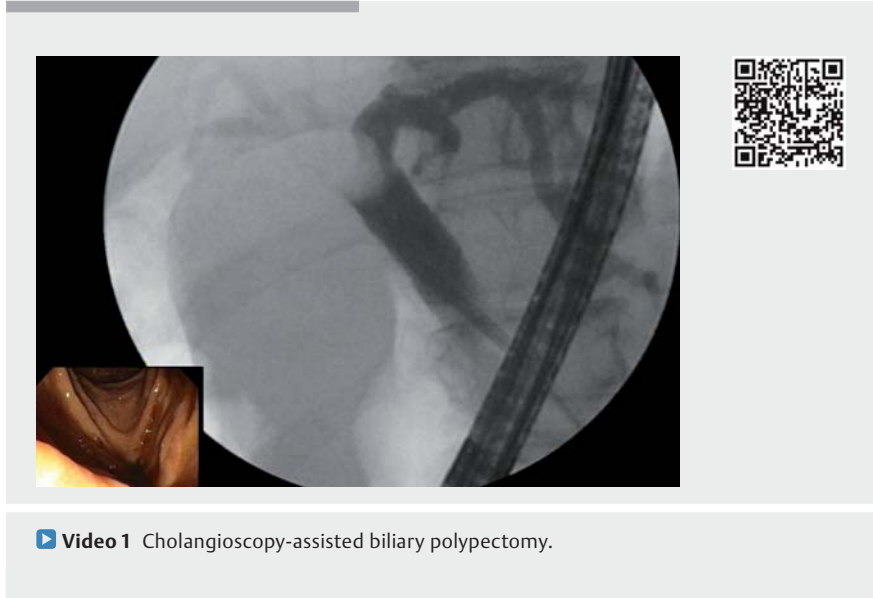


A novel technique for biliary polypectomy

We present a case of a 37-year-old man with known ulcerative colitis and primary sclerosing cholangitis. He had been diagnosed at the age of 17 years, but was lost to follow-up for about 15 years. He returned to an outpatient gastroenterologist and was found to have abnormal liver enzyme levels. As part of the work-up he had magnetic resonance cholangiopancreatography (MRCP) that showed a filling defect, measuring 10 mm × 7 mm, in the common hepatic duct. He underwent an endoscopic retrograde cholangiopancreatography (ERCP) with cholangioscopy which revealed a smooth benign-appearing polyp in the common hepatic duct that was causing obstruction of the right intrahepatic system. Biopsy of the mass was performed with a miniature biopsy forceps, and showed denuded fibrous tissue with acute and chronic inflammation without any evidence of carcinoma.

To obtain a better tissue sample for diagnosis and potentially a curative resection, a novel technique was employed in the subsequent ERCP. A 240 cm long 15-mm stiff hexagonal snare (from a Boston Scientific Captivator EMR kit) was used. The plastic sheath of the snare was removed and the naked snare was passed through a cholangioscope and advanced to the common hepatic duct. With this snare, using the cholangioscope catheter as the sheath, the polyp was resected in piecemeal fashion with a hot snare technique under direct and fluoroscopic visualization. The resected specimens were retrieved using a biliary basket. Some residual polyp was left behind; however good drainage was now appreciated from the biliary tree, including the right intrahepatic system. Histological exami-



Video 1 Cholangioscopy-assisted biliary polypectomy.

nation of the specimens showed well to poorly differentiated polypoid cholangiocarcinoma. The patient underwent an extended right hepatectomy, with the resected specimen revealing a 0.8-cm cholangiocarcinoma, perihilar type, involving the right hepatic duct with invasion into the periductal muscle layer/fibrous tissue without any positive lymph nodes (T1N0Mx). The patient is doing well.

We have described a novel cholangioscopic technique for biliary polyp resection. The technique may be helpful in select cases; however if it is employed, this should be done carefully. Possible complications to consider include bile duct injury/leak and hemobilia, and appropriate contingencies, be they biliary stenting or surgical back-up, should be pre-planned.

Endoscopy_UCTN_Code_TTT_1AR_2AD

Competing interests

D. L. Carr-Locke: Consultant for Boston Scientific and Olympus America.

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DOI <https://doi.org/10.1055/s-0043-114408>
Published online: 31.7.2017
Endoscopy 2017; 49: E244–E245
© Georg Thieme Verlag KG
Stuttgart · New York
ISSN 0013-726X

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