Symposium V

Endoscopic Papillectomy (Ampullectomy)

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Adenoma involving the major duodenal papilla is being recognized more frequently as a result of the increased use of diagnostic upper endoscopy. These adenomas are considered premalignant, and should be resected completely. Patients with papillary adenoma can be divided into those with a sporadic lesion and those with an FAP-associated lesion. Papillary adenomas will continue to develop in patients with FAP. FAP may be less suitable as candidates for endoscopic resection of a papillary adenoma than those with sporadic adenoma, because of the relatively high recurrence rate and the development of adenomas elsewhere in the duodenum. However, adenoma involving the papilla is being diagnosed increasingly at upper endoscopy in patients who do not have FAP. The standard of management for papillary adenoma is local surgical excision or pancreaticoduodenectomy, but these procedures are associated with significant morbidity. Endoscopic papillectomy for ampullary adenoma was introduced as an alternative to surgery. Endoscopic papillectomy is relatively safe and reliable for complete resection of adenomas of the major duodenal papilla. To prevent tumor recurrence, the technique should ensure complete resection with a low rate of complications. However, there is no standardized procedure for snare resection of ampullary tumor. En bloc resection is fundamental in the treatment of adenomatous lesion and allows precise histopathologic evaluation of the resected specimen. Sphincterotomy and the injection of an epinephrine solution were not required for successful en bloc resection of papillary tumors. This may reduce the time required for endoscopic papillectomy and thereby decrease the chance of complications.

Complications related to endoscopic papillectomy occur in up to 25% of patients. These include pancreatitis, bleeding, duodenal perforation, cholangitis, and papillary stenosis. The two most common complications are bleeding and pancreatitis. Most bleeding can be managed by conservative management and endoscopic hemostasis. The common problematic complication is post-procedure pancreatitis. Prophylactic placement of a pancreatic duct stent is a possible supportive measure to prevent severe pancreatitis after endoscopic papillectomy. Pancreatic stenting also reduces the risk of papillary stenosis after papillectomy. In some patients, a stent cannot be placed after snare resection when pancreatic cannulation is impossible. Wire-guided endoscopic snare papillectomy in selected patients is one of useful techniques to maintain pancreatic access for stenting. This procedure simplifies endoscopic papillectomy: the snare for endoscopic resection is merely inserted over a guidewire already in place in the pancreatic duct. This procedure also improves the accuracy of endoscopic resection of a papillary tumor. Therefore, another important advantage of an indwelling guidewire is that it increases the probability of complete resection. This appears to prevent pancreatitis and improve the outcome in endoscopic resection of ampullary tumor. However, prospective, randomized studies are needed to determine whether the prophylactic placement of a pancreatic stent should be used routinely in all cases. Study for consensus among endoscopists is needed to more effective techniques with minimal complication.