



Session 3. This is the Way to Deal with Adenoma of Ampulla of Vater

Endoscopic diagnosis & treatment with emphasis on EUS and endoscopic papillectomy

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Curriculum Vitae

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Ampulla of Vater Tumor has been recognized more frequently by increased use of screening UGI endoscopy, US, CT. Ampullary adenoma is most common ampullary tumor having Malignant potential. Diagnosis and evaluation can be done with endoscopic procedure, especially with EUS, or IDUS (intraductal US). Forceps biopsy should be done for the histologic confirmation of adenoma. Traditionally, surgical resection has been the standard method to complete removal of ampullary tumor. Endoscopic papillectomy for ampullary adenoma was introduced as an alternative to surgery. 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. 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 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.