Overtube-assisted direct peroral pancreatoscopy using an ultraslim gastroscope in a patient suspected of having an intraductal papillary mucinous neoplasm

A 68-year-old man who had presented with abdominal discomfort and undergone a computed tomography (CT) scan that had revealed cystic lesions in the pancreatic head was referred to us for endoscopic ultrasound (EUS). The endoscopic view showed a fish-mouth opening to the ampulla with mucin content (Fig. 1).

EUS revealed a dilated pancreatic duct, approximately 1.7 cm in diameter, with a narrowing in the pancreatic head but with no mass seen. There were a few cystic lesions in the body of the pancreas and the pancreatic parenchyma showed evidence of chronic pancreatitis. The diagnosis of mixed-type intraductal papillary mucinous neoplasm was made (Fig. 2).

He was scheduled for pancreatoscopy to evaluate the pancreatic duct and biopsy any suspected malignant transformation. It was decided to perform overtube-assisted direct peroral pancreatoscopy with an ultraslim gastroscope because the pancreatic duct size was more than 1 cm and the image quality would be better than with a mother–baby scope system. Before the procedure, a hole was made in the overtube of a single-balloon enteroscope (ST-SB1; Olympus, Tokyo, Japan) at 70 cm from the distal tip of the overtube (Fig. 3).

First, pancreatic duct cannulation and sphincterotomy were performed through a duodenscope, and a 0.035-inch guide wire was left in the pancreatic duct. An ultraslim gastroscope (GIF-N260, scope diameter 5.9 mm, working channel 2.0 mm; Olympus) was then passed over the guide wire with the assistance of the overtube, without balloon inflation, to reduce stomach looping and maintain a straight position for the scope (Fig. 4). Once at the ampulla, the ultraslim gastroscope was advanced without the overtube further along the guide wire into the pancreatic duct.

Pancreatoscopy showed normal pancreatic duct mucosa; the stricture point was visualized, but there was no evidence of a...
mural nodule or mass (Fig. 5). The patient tolerated the procedure well without complications. He was referred for a Whipple operation a few weeks later. In this case, in contrast to the techniques described by other endoscopists [1, 2], we used the assistance of the overtube without balloon inflation. In our experience, direct peroral cholangiopancreatography with overtube assistance makes the procedure easier and shortens the ductal intubation time.

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References

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Fig. 4 Radiographic image during pancreatoscopy showing the position of the ultraslim gastroscope in the pancreatic duct.

Fig. 5 Endoscopic view of the pancreatic duct showing normal mucosa and openings of the side branches.