

Gastroscopic snare polypectomy for cystic duct adenoma: a rare occurrence



Fig. 1 Endoscopic ultrasound found a hyperechoic mass, floating at the upper common bile duct (CBD), not invading the CBD wall and with an intact endoluminal choledochal surface.



Fig. 2 Endoscopic retrograde cholangiopancreatography revealed the dilated intrahepatic and extrahepatic biliary tree, with no filling defects or stenosis. The arrow points to the balloon rather than a filling defect.

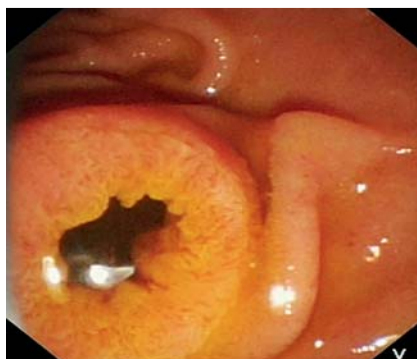


Fig. 3 Excessive mucinous discharge from the papilla of Vater.

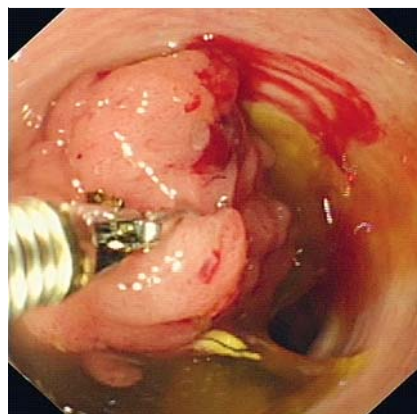


Fig. 4 A forward-viewing gastroscope showed much mucus and a 2-cm exophytic adenomatous lesion in the cystic duct and protruding into the hepatic and common bile ducts.

Cystic duct adenoma is an uncommon disease. Appropriate therapeutic strategies have not been clearly defined. Surgical resection is often recommended [1–4]. Recently, endoscopic procedures for biliary papillomatosis were reported, such as endoscopic papillary balloon dilation, argon plasma coagulation, photodynamic therapy, endoscopic retrograde biliary drainage, and intraluminal brachytherapy with iridium-192 [5–9]. However, it is difficult to achieve complete resection and the recurrence rate is high. We report on a patient diagnosed with cystic duct adenoma who presented with recurrent cholangitis and was treated with a snare polypectomy using a gastroscope.

A 61-year-old woman was admitted to our hospital with intermittent upper abdominal pain and fever. An abdominal computed tomography scan, magnetic resonance cholangiopancreatography, and endoscopic ultrasound showed a dilated intrahepatic biliary system and common bile duct (CBD), with a hyperechoic mass floating at the upper CBD (Fig. 1). Endoscopic retrograde cholangiopancreatography showed a CBD diameter of 2.5 cm (Fig. 2) and excessive mucinous discharge from the papilla of Vater (Fig. 3). It is interesting that the duodenoscope could access the CBD easily via the papilla. Subsequent examination using a forward-viewing gastroscope (GIF-H260; Olympus, Tokyo, Japan) demonstrated a 2-cm adenomatous lesion in the cystic duct and protruding into the CBD (Fig. 4). Histological examination revealed biliary tubulovillous adenoma with moderate-grade dysplasia.

The case was discussed by the multidisciplinary team who decided that surgical removal should be performed due to the potential for malignancy. However, the patient refused surgery and requested noninvasive endoscopic treatment. Therefore, endoscopic polypectomy was performed after written informed consent had been obtained from the patient. Piecemeal intraductal snare polypectomy was performed under gastroscopic visualization and the adenoma was completely resected without any remnant (Fig. 5, Video 1).

After the procedure, the patient experienced no further abdominal pain or fever.

Video 1

Gastroscopic snare polypectomy performed in a woman with a cystic adenoma.

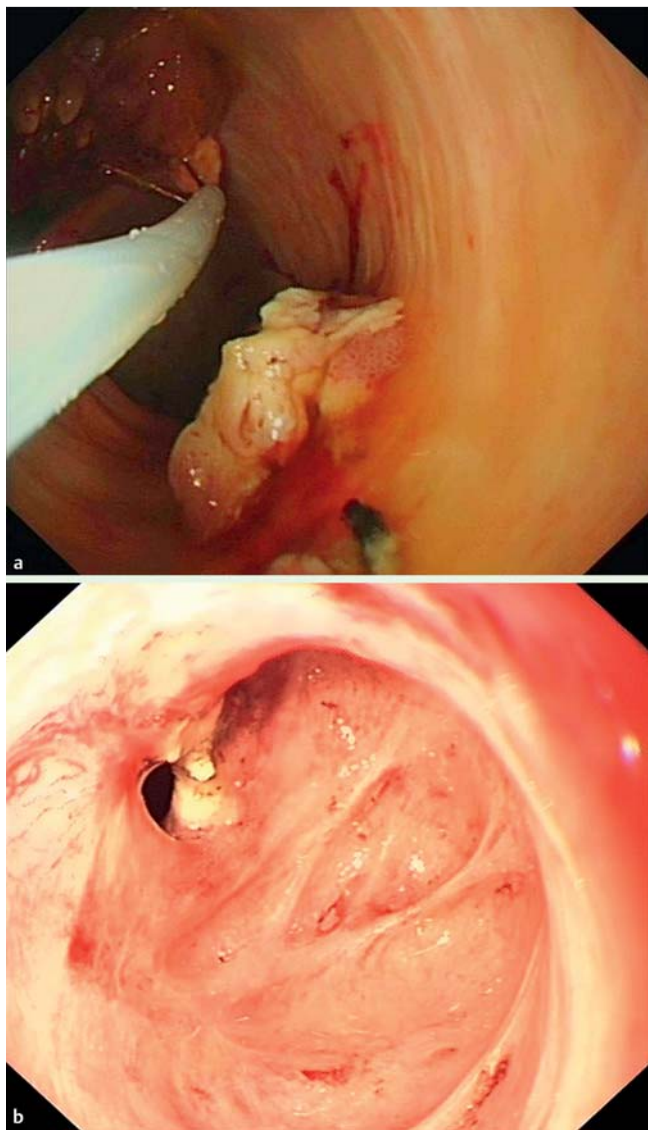


Fig. 5 Endoscopic removal of biliary tubulovillous adenoma. **a** Piecemeal intraductal snare polypectomy was performed under direct visualization. **b** The adenoma was resected completely, leaving a clean base.

During the 3-month follow-up period, the patient was asymptomatic with normal liver function test findings and no recurrent cholangitis.

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Competing interests: None

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