The management of ampullary adenomas includes surgical and endoscopic ampullectomy or pancreaticoduodenectomy. The latter is associated with prolonged hospital stay, increased morbidity, and increased costs. Mortality rates of up to 15% have been reported [1–4]. Because the surgical risks may outweigh the benefits and endoscopic ampullectomy is less radical, with recurrence or incomplete resection in up to 30% of cases [4,5], adjunctive minimally invasive endoscopic treatments are needed.

Endoscopic retrograde cholangiopancreatography (ERCP)-directed radiofrequency ablation (RFA) has the potential to fulfill this need. The technique, which induces local coagulative necrosis by delivering thermal energy from high frequency current via bipolar probes, has not previously been described in this setting. We report here the first three cases. (i) A 49-year-old woman with familial adenomatous polyposis refused pancreaticoduodenectomy when intraductal recurrence was noted at follow-up after endoscopic ampullectomy (Fig. 1). ERCP-directed RFA of both the common bile duct and main pancreatic duct with curative intent and double duct stenting were performed (Fig. 2, Video 1). (ii) A 63-year-old man with end-stage kidney disease, severe ischemic heart disease, recent stroke, obstructive jaundice due to common bile duct stones, and low grade dysplasia adenoma (12 mm) was treated with bile duct ERCP-guided RFA (Fig. 3). (iii) A 54-year-old man with alcoholic cirrhosis (Child–Pugh score of B), recent variceal bleeding, ischemic heart disease, and obstructive jaundice was treated for high grade dysplasia adenoma (20 mm) by bile duct ERCP-guided RFA and double duct stenting (Fig. 4). No major complications occurred.

The first patient is disease-free without histological recurrence of adenoma at 26 months’ follow-up. The second and third patients received successful prolonged palliation of jaundice at 12 and 36 months’ follow-up, respectively. The third patient died of complications of cirrhosis. In conclusion, ERCP-guided RFA is a safe and cost-effective alternative in patients who refuse or cannot undergo surgery and could be a long-term, palliative strategy in high risk patients (American Society of Anesthesiologists [ASA] class IV) whose 1-year life expectancy is not affected by their underlying co-morbidities.

Competing interests: None
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Insertion of the Habib EndoHPB probe into the main pancreatic duct with subsequent radiofrequency ablation and final appearance after treatment.

Fig. 4 Radiofrequency ablation treatment of 2-cm high grade dysplasia adenoma of the bile duct with the Habib EndoHPB probe set at 10W for 2 minutes. a Cholangiographic view. b Peroral cholangioscopic view (Spyglass; Boston Scientific, Natick, Massachusetts, USA).

Video 1

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