Mapping international practice patterns in EUS-guided tissue sampling: outcome of a global survey

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Background and study aims: Although Endoscopic Ultrasound (EUS)-guided tissue sampling is widely used, the optimal sampling strategy remains subject of debate. We evaluated practice patterns within the international endosonographic community.

Patients and methods: An online questionnaire was sent to 400 endosonographers from the United States, Europe, and Asia.

Results: A total of 186 (47%) endosonographers participated: United States 54 (29%), Europe 85 (46%), and Asia 47 (25%). European (75%) and Asian (84%) respondents routinely check coagulation status, whereas US respondents only check on indication (64%, \( P=0.007 \)). While propofol is standard in the United States (83%), conscious sedation is still widely used in Europe (52%) and Asia (84%, \( P<0.001 \)). Overall, the 22-gauge needle is most commonly used (52%). For fine-needle aspiration (FNA) of solid pancreatic lesions, 22-gauge (45%) and 25-gauge (49%) needles are used equally. For fine-needle biopsy (FNB) of solid masses, the 25-gauge device is less favored than the 22-gauge FNA device (49% versus 21%). The 19-gauge needle is generally used for FNB of submucosal masses (62%). Rapid on-site pathological evaluation (ROSE) is utilized more often by US (98%) than by European and Asian respondents (51%, \( P<0.001 \)). Cytolyt (52%), formalin (15%) and alcohol (15%) are used for FNA specimen preservation in the United States and Europe, while saline (27%) and alcohol (38%) are widely used in Asia (\( P<0.001 \)).

Conclusions: EUS-guided tissue sampling practices vary substantially within the international endosonographic community and differ considerably from recommendations expressed in guidelines. Because the clinical relevance of these variations is largely unknown, the outcome of this survey suggests a need for further studies.
how available practice guidelines are implemented in current local sampling routines. The purpose of this study, therefore, was to: 1) map the practice patterns in EUS-guided tissue sampling in today’s endosonographic community; 2) identify differences and concordances between endosonographers from the United States, Europe and Asia; and 3) compare the current practice patterns to the guidelines of the ASGE and ESGE.

**Patients and methods**

**Selection of study subjects**

An online questionnaire was sent out per e-mail to endosonographers from the United States, Europe, and Asia. Registered endosonographers were selected by 1) using the personal network of the research team, which consists of national and international experts in the field, and 2) performing a PubMed literature search to identify authors who have published on the topic of EUS-guided tissue sampling in the last 10 years. Not only first authors but all listed authors were approached. Consent to participate in the study was inferred from voluntary completion of the survey.

**Questionnaire**

The survey consisted of a maximum of 65 multiple-choice questions and was designed to take less than 10 minutes to complete (Appendix 1) and was divided into four sections. The first part focused on demographics including gender, age, country of residence, type and size of current practice, years of experience, training and familiarity with EUS and EUS-guided tissue sampling. The second part included questions regarding peri-procedural use of anticoagulants, antibiotics, and sedation. The third part contained questions on preferred equipment and sampling techniques and whether these preferences depend upon target lesion type (pancreatic solid or cystic mass, lymph node or submucosal mass). The final part of the survey examined practice patterns regarding tissue processing and analysis.

**Questionnaire administration**

All endosonographers were approached by e-mail with a study invitation and were provided with a personal, direct link to the survey. This link was inactivated once the survey was completed. A reminder was sent by e-mail, after 2, 4, and 6 weeks. Subjects who did not respond within 4 weeks thereafter were considered to be non-respondents.

**Statistical analysis**

Only completed surveys were used for data analysis. For comparison between continents, the Chi-squared or Kruskal Wallis test was applied. All reported P values are two-sided and a value < 0.05 was considered to be significant. Data were analysed with SPSS 22, Statistical Package for the Social Sciences, SPSS Inc., Chicago, Illinois.

<table>
<thead>
<tr>
<th>ASGE</th>
<th>ESGE</th>
<th>Papanicolaou Society of Cytopathology</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anticoagulant use</strong></td>
<td>– Check coagulation status in patients with personal or family history suggesting bleeding disorder or with a clear clinical indication.</td>
<td>– EUS-FNA of solid lesions can be performed in patients on aspirin or NSAIDS, but not in patients on thienopyridines.</td>
</tr>
<tr>
<td><strong>Antibiotic prophylaxis</strong></td>
<td>– Recommended before sampling of cystic lesions.</td>
<td>– EUS-FNA of solid lesions can be performed in patients on aspirin or NSAIDS, but not in patients on thienopyridines.</td>
</tr>
<tr>
<td><strong>Sedation</strong></td>
<td>– Propofol provides more rapid onset of action and shorter recovery time. No proof of higher patient satisfaction or better safety. Cost-effectiveness for average-risk patients is not proven.</td>
<td>– Propofol provides higher post-procedural patient satisfaction, decreases time to sedation and recovery. No proof of cost-effectiveness.</td>
</tr>
<tr>
<td><strong>Needle size</strong></td>
<td>– 19-gauge, 22-gauge and 25-gauge needles have similar diagnostic yields and safety profiles. 19G should not be used for transduodenal puncturing.</td>
<td>– Generally: 22-gauge or 25-gauge</td>
</tr>
<tr>
<td><strong>Number of passes</strong></td>
<td>– Cysts: 1</td>
<td>– Solid pancreatic: ≥ 5</td>
</tr>
<tr>
<td><strong>Suction</strong></td>
<td>– Applying continuous suction with a syringe is recommended in solid masses but not in lymph nodes.</td>
<td>– Cysts: 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>– Lymph nodes: &lt;5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>– Stromal cell tumor: 3 – 5</td>
</tr>
</tbody>
</table>
Demographics

A total of 400 endosonographers were approached, of whom 197 responded (49%). Eleven responses were discarded because they were incomplete, which resulted in 186 participants (47%): 54 from the United States (29%), 85 from Europe (46%), and 47 from Asia (25%).

Preprocedural practice patterns

Coagulation status

In preparation for the procedure, most European (75%) and Asian (84%) respondents report that they “always check” coagulation status, while their US colleagues generally do so on indication (Table 3, P=0.007). Acetylsalicylic acid is generally continued (77%), but that differed between continents. US respondents always continue acetylsalicylic acid, as compared to 87% of European and 50% of Asian respondents (Table 3, P<0.001). Regarding the use of heparin, coumarin, and new oral anticoagulants (NOACs), there is little consensus. While heparin is discontinued by all US and most Asian respondents (94%), it is stopped by 75% of the Europeans (P=0.022). The opposite is true for coumarin, which is stopped more often in Europe (86%) than in the United States (46%) and Asia (59%, P=0.003). In analogy, European respondents less often perform tissue sampling in patients with an international normalized ratio (INR) >1.5 (11%), as compared to non-European respondents (33%, P=0.008). Lastly, NOACs are discontinued by virtually all US (91%) and European (88%) endosonographers, as compared to 66% of Asian respondents (P=0.029).

Antibiotic prophylaxis

In all continents, the majority of respondents use antibiotic prophylaxis for EUS-guided tissue sampling (77%); mostly depending on the indication (92%), but some use antibiotics routinely (8%). Of those endosonographers who report prescribing antibiotics on indication, virtually all use it when sampling a cystic...
lesion (95%) [12]. A minority prescribes antibiotics for other indications, such as a prosthetic cardiac valve, vascular graft, previous infective endocarditis, or congenital heart disease (<39%, Table 4). US physicians reported the lowest use of antibiotic prophylaxis.

Sedation and anesthesia
Almost all endosonographers sedate their patients during EUS-guided tissue sampling (98%). Propofol is generally used in the United States (83%), whereas conscious sedation is still used by 52% of European and 84% of Asian respondents ($P<0.001$). All US respondents who use propofol have anesthesia personnel in the endoscopy room (100%), compared to only 66% in Europe and 50% in Asia ($P<0.001$).

Sampling techniques and equipment
Target lesion size
While half of the respondents perform EUS-FNA, regardless of the lesion diameter, the other half has a preferred minimum size of 0.5 cm (32%), 1 cm (17%), or 2 cm (1%). For EUS-FNB, most respondents confine to a minimum size of 1 cm (59%). European respondents perform EUS-FNB of lesions <1 cm more often (51%) than non-European respondents (34%, $P=0.014$).

Needle size
The gross of respondents prefers a specific needle size for FNA (84%) and FNB (75%), depending on the position of the scope or the location of the target lesion (66%). Overall, the 22-gauge needle is most popular (Table 5). However, for FNA of solid pancreatic lesions, 22-gauge (45%) and 25-gauge (49%) needles are used equally, and for FNA of submucosal lesions, besides the 22-gauge (44%), the 19-gauge needle (49%) is frequently used. For FNB of submucosal masses, most respondents use the 19-gauge needle (62%). Responses did not differ between continents.

Number of passes
Generally, respondents perform two to three needle passes for FNA (49%) and FNB (57%). Most respondents adjust the number of passes according to the target lesion. In pancreatic cysts, a single pass is performed for FNA (81%) and FNB (76%). For FNA of solid pancreatic masses, two to three (46%) or more than three needle passes are performed (50%). For FNB of solid pancreatic masses, most respondents report carrying out only two to three passes (70%). A minority report doing more than three passes (26%). Asian respondents vary their number of needle passes less often (47%) than European (69%) and US respondents (63%, $P=0.037$).

Sampling technique
Fanning is the preferred needle motion technique for FNA (64%). For FNB, fanning (44%) and only moving “to and fro” (46%) are favored equally. To increase the yield of EUS-FNA, most endosonographers apply suction with a syringe (47%) or use the slow-pull technique (42%). Most respondents use dry instead of wet suction (93%). Also for FNB, most endosonogra-

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**Table 4** Antibiotic prophylaxis for EUS-guided tissue sampling; the United States as compared to Europe and Asia.

<table>
<thead>
<tr>
<th>Antibiotic prophylaxis</th>
<th>All n=132 (%)</th>
<th>US n=38 (%)</th>
<th>Europe + Asia n=94 (%)</th>
<th>P value$^1$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prosthetic valve</td>
<td>41 (31)</td>
<td>6 (16)</td>
<td>35 (37)</td>
<td>0.012</td>
</tr>
<tr>
<td>Vascular graft</td>
<td>17 (13)</td>
<td>1 (3)</td>
<td>16 (17)</td>
<td>0.018</td>
</tr>
<tr>
<td>History of IE</td>
<td>52 (39)</td>
<td>5 (13)</td>
<td>47 (50)</td>
<td>$&lt;0.001$</td>
</tr>
<tr>
<td>History of CHD</td>
<td>19 (14)</td>
<td>2 (5)</td>
<td>17 (18)</td>
<td>0.045</td>
</tr>
<tr>
<td>Lesion lower gastrointestinal tract</td>
<td>44 (33)</td>
<td>13 (34)</td>
<td>31 (33)</td>
<td>0.523</td>
</tr>
</tbody>
</table>

Abbreviations: US, United States; IE, infectious endocarditis; CHD, congenital heart disease

$^1$ A chi square test was used to compare Europe and Asia with the US.

**Table 5** Reported use of needle size for EUS-guided tissue sampling.

<table>
<thead>
<tr>
<th></th>
<th>FNA All n=88 (%)</th>
<th>FNB All n=72 (%)</th>
<th>Overall</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>25-gauge 86 (24)</td>
<td>25-gauge 34 (12)</td>
<td>25-gauge 86 (24)</td>
<td>25-gauge 34 (12)</td>
</tr>
<tr>
<td></td>
<td>22-gauge 192 (55)</td>
<td>22-gauge 150 (52)</td>
<td>22-gauge 192 (55)</td>
<td>22-gauge 150 (52)</td>
</tr>
<tr>
<td></td>
<td>19-gauge 74 (21)</td>
<td>19-gauge 104 (36)</td>
<td>19-gauge 74 (21)</td>
<td>19-gauge 104 (36)</td>
</tr>
<tr>
<td></td>
<td>22-gauge 61 (69)</td>
<td>22-gauge 49 (68)</td>
<td>22-gauge 61 (69)</td>
<td>22-gauge 49 (68)</td>
</tr>
<tr>
<td></td>
<td>19-gauge 33 (26)</td>
<td>19-gauge 19 (26)</td>
<td>19-gauge 33 (26)</td>
<td>19-gauge 19 (26)</td>
</tr>
<tr>
<td>Pancreatic solid lesion</td>
<td>25-gauge 43 (49)</td>
<td>25-gauge 15 (21)</td>
<td>25-gauge 43 (49)</td>
<td>25-gauge 15 (21)</td>
</tr>
<tr>
<td></td>
<td>22-gauge 40 (46)</td>
<td>22-gauge 35 (49)</td>
<td>22-gauge 40 (46)</td>
<td>22-gauge 35 (49)</td>
</tr>
<tr>
<td></td>
<td>19-gauge 5 (5)</td>
<td>19-gauge 22 (31)</td>
<td>19-gauge 5 (5)</td>
<td>19-gauge 22 (31)</td>
</tr>
<tr>
<td>Lymph node</td>
<td>25-gauge 33 (38)</td>
<td>25-gauge 13 (18)</td>
<td>25-gauge 33 (38)</td>
<td>25-gauge 13 (18)</td>
</tr>
<tr>
<td></td>
<td>22-gauge 48 (54)</td>
<td>22-gauge 41 (57)</td>
<td>22-gauge 48 (54)</td>
<td>22-gauge 41 (57)</td>
</tr>
<tr>
<td></td>
<td>19-gauge 7 (8)</td>
<td>19-gauge 18 (25)</td>
<td>19-gauge 7 (8)</td>
<td>19-gauge 18 (25)</td>
</tr>
<tr>
<td>Submucosal mass</td>
<td>25-gauge 6 (7)</td>
<td>25-gauge 2 (2)</td>
<td>25-gauge 6 (7)</td>
<td>25-gauge 2 (2)</td>
</tr>
<tr>
<td></td>
<td>22-gauge 43 (49)</td>
<td>22-gauge 25 (35)</td>
<td>22-gauge 43 (49)</td>
<td>22-gauge 25 (35)</td>
</tr>
<tr>
<td></td>
<td>19-gauge 39 (44)</td>
<td>19-gauge 45 (63)</td>
<td>19-gauge 39 (44)</td>
<td>19-gauge 45 (63)</td>
</tr>
</tbody>
</table>

Abbreviations: FNA, fine-needle aspiration; FNB, fine-needle biopsy
The second interesting finding involves differences in anticoagulation and antiplatelet management. While respondents from the United States generally check coagulation status on indication only, European and Asian respondents do this more routinely. Interestingly, the practice of the US respondents, rather than that of the Europeans, seems to follow the ESGE guidelines, which recommend checking coagulation status only in selected patients, that is, those using anticoagulant or antiplatelet therapy or who have a (family) history of a bleeding disorder. Both the ASGE and ESGE recommend not discontinuing acetylsalicylic acid, while all other anticoagulation and antiplatelet therapy should be stopped [12,23]. In contrast to US respondents, not all European and Asian respondents adhere to this recommendation. One explanation might be that US physicians adhere to guidelines more promptly, possibly as a consequence of an increased chance for malpractice claims in the United States [24,25]. The relatively high number of Asian respondents who discontinue acetylsalicylic acid may be a reflection of the fact that bleeding risks are weighted more heavily in Asia. It has been suggested that Asians are more susceptible to bleeding complications, while whites are more at risk for thromboembolic events [26]. However, the Japan Gastroenterological Endoscopy Society has recently revised their guidelines, emphasizing the thromboembolism risks of discontinuation of antithrombotic agents [27]. Therefore, a shift toward continuance of acetylsalicylic acid is to be expected.

Another interesting finding of this survey is that for solid pancreatic masses, endosonographers report performing fewer needle passes with FNB than with FNA. This finding is line with recently published data about using FNB to establish a diagnosis in solid pancreatic masses [28–31]. The ESGE recommends performing at least five passes for FNA of solid pancreatic masses, in the absence of ROSE. Neither the ASGE nor the ESGE recommend a minimum number of passes for FNB.

Also noteworthy is that, overall, most respondents reported using the 22-gauge needle more often than the 25-gauge needle. This finding is especially interesting, since two recent meta-analyses found no differences between the two needles, with regard to diagnostic accuracy, the number of needle passes, or complications [8,32]. In fact, a trend towards better performance of the 25-gauge needle for FNA of solid pancreatic masses was observed in these studies. The ESGE guideline states that, although there is no difference in diagnostic yield and safety profiles, the 25-gauge needle performs somewhat better with regard to number of required needle passes, presumably due to its higher flexibility [12]. The Papanicolaou Society of Cytopathology (PSC), recommends adapting the needle size to the target lesion. For highly vascular lesions and lymph nodes they recommend a 25-gauge needle, for mucinous cysts a 22-gauge needle, and for fibrotic or stromal-rich lesions, a 19-gauge needle [17].

Another important outcome of this survey is the intercontinental variation in use of rapid on-site pathological evaluation. Whereas virtually all US respondents use ROSE, only half of the European and Asian respondents do. Respondents who refrain from using ROSE state that they consider it too time consuming and that reimbursement for pathology services is too low. However, more than two-thirds of our respondents also mention that they have doubts with regard to the added benefit of ROSE, which might be influenced by ESGE recommendations of the ESGE stating that ROSE should only be implemented at sites where specimen adequacy rates are below 90% or during the learning curve of EUS-FNA [12,33]. In contrast, the PSC recommends the use of ROSE whenever possible [17].
The last, but certainly not least remarkable finding concerns the preservation of the tissue samples. After procurement, EUS-FNA specimens are susceptible to damage by colonizing bacteria and to autolysis by enzyme activity. To halt these processes, it must be placed in a fixative (e.g., formalin, CytoRich Red, Cytolyt) or physiologic solution (e.g., saline, Hanks’ salt solution). Although most of the respondents use formalin to preserve histologic samples, there is no consensus regarding preservation of cytological samples. While a majority of the Asian respondents store cytology in alcohol or saline, their European and US colleagues store it in Cytolyt. Although there are currently no guidelines on this topic, we did not expect to find such striking differences among the three continents. It would be interesting to investigate the influence of preservation methods on the specimen’s quality and diagnostic accuracy, as this aspect is under-investigated so far.

Our survey has some potential limitations. First, it seems conceivable that our results have been subject to a response bias, given our response rate of 47%. Although our response rate still falls at the high end of the spectrum for online surveys amongst physicians (1–10), it might have caused a selection towards the more active, academic endosonographers. Although most respondents indeed reported to work in high-volume academic centers, only 61% had participated in a formal EUS training program. This could have accounted for the low adherence to the practice guidelines. Currently, the ESGE and ASGE advise that a dedicated fellowship should last 6 to 24 months [12,34]. However, they also acknowledge that there is a lack of sufficient EUS-training and training capacity in Europe and the United States [35, 36]. Because most respondents in the current study are EUS experts, the number of formally trained endosonographers and the adherence to the guidelines is likely to be even lower in non-academic, low-volume centers. Last, a reporting or goodwill bias is likely to exist, since that is inevitable for retrospective surveys that are based on self-reporting. If respondents indeed gave an expected answer rather than a true answer, that would only strengthen our main conclusion that practice patterns for EUS-guided tissue sampling differ and are not congruent with the guidelines.

In conclusion, this survey shows that there is considerable intercontinental variation in the practice of EUS-guided tissue sampling. Despite of the growing number of studies in the field of EUS-guided tissue sampling, the optimal sampling strategy remains subject to debate. Moreover, some routines vary considerably from recommendations stated in existing guidelines. Further studies are required to determine the relevance and impact of various practices on outcome and safety. Pending these outcomes, cost-effectiveness studies may be required to support the implementation of a certain sampling strategies.

Appendix 1 International EUS Survey

Background Information

1. What is your gender?
   □ Female
   □ Male

2. What is your age?
   Please write your answer here: _________

3. What is your specialty?
   □ Gastroenterologist
   □ Surgeon
   □ Other

4. In which year did you finish your training?
   Please write your answer here: ___________________________

5. In what country are you currently working?
   Please write your answer here: ___________________________

6. In what kind of hospital are you currently working?
   (More than one option possible)
   Please choose all that apply:
   □ Community hospital
   □ Academic/University hospital
   □ Private hospital or independent endoscopy unit
   □ Other, please specify: ______________________________

7. How many EUS procedures do you perform each year?
   Please choose only one of the following:
   □ <100
   □ 100–200
   □ 200–300
   □ >300

8. How many EUS-guided tissue-sampling procedures do you perform each year?
   Please choose only one of the following:
   □ <50
   □ 50–100
   □ 100–200
   □ >200

9. Did you have formal training in performing EUS guided tissue sampling? (Formal training is defined as a fellowship in a dedicated EUS training center for at least 3 months)
   Please choose only one of the following:
   □ Yes
   □ No

Preparation for EUS guided tissue sampling

10. Do you use any type of sedation when performing EUS-guided tissue sampling?
    Please choose only one of the following:
    □ Yes, conscious sedation, continue to 12
    □ Yes, propofol
    □ No, not as standard practice, continue to 12
11. Is anesthesia personnel routinely present during the procedure?  
Please choose only one of the following:  
☐ Yes  
☐ No  

12. Do you use antibiotic prophylaxis when performing EUS-guided tissue sampling?  
Please choose only one of the following:  
☐ Yes, always, continue to 14  
☐ Yes, depending on the indication  
☐ No, continue to 14  

13. Please specify for which indication you use AB prophylaxis?  
(More than 1 answer possible)  
Please choose all that apply:  
☐ Cystic lesions  
☐ Prosthetic cardiac valve  
☐ Vascular graft  
☐ History of previous infective endocarditis  
☐ Congenital heart disease  
☐ Solid lesions of lower gastrointestinal tract  
☐ Other, please specify: ______________________________  

14. Do you routinely check the coagulation parameters before EUS-guided tissue sampling?  
Please choose only one of the following:  
☐ Yes  
☐ No, continue to 18  

15. Please specify when you check coagulation status?  
(More than one answer possible)  
Please choose only one of the following:  
☐ Always  
☐ In patients on anticoagulants  
☐ In patients with a (family) history of bleeding disorder  
☐ In both, patients on anticoagulants and patients with a (family) history of bleeding disorder  

16. Which of the following anticoagulants do you generally discontinue, prior to a puncture procedure?  
(More than one answers possible)  
Please choose all that apply:  
☐ Acetylsalicylic acid (Aspirin, Carbasalate calcium [Ascal], Dipyridamole [Persantin])  
☐ Thienopyridines (Clopidogrel [Plavix, Grepid, Iscover, Viatrud], Prasugrel [Effient])  
☐ Coumarin derivatives (Aacenocoumarol [Sintrom], Phenprocoumon [Marcoumar, Marcumar, Falithrom])  
☐ Heparin or derivatives (Warfarin [Coomadin], Dalteparin [Fragmin], Nadroparin [Fraxiparin], Tinzaparin [Innohep])  
☐ New Oral Anticoagulant drugs (NOAC) (Rivaroxaban [Xarelto], Apixaban [Eliquis], Dabigatran [Pradax])  
☐ Other, please specify: ______________________________  

17. Up to which INR value would you consider it safe to perform EUS-guided tissue sampling?  
Please choose only one of the following:  
☐ INR 1.0  
☐ INR 1.1 – 1.5  
☐ INR 1.6 – 2.0  
☐ INR > 2.0  

This section contains questions about Fine Needle Aspiration  

18. What is the minimum lesion diameter for you to consider FNA?  
Please choose only one of the following:  
☐ No minimum  
☐ 0.5 cm  
☐ 1 cm  
☐ 2 cm  

19. Do you have a preferred needle size for FNA?  
Please choose only one of the following:  
☐ Yes  
☐ No, continue to 21  

20. Does your preferred needle size depend on scope position and/or location of target lesion?  
Please choose only one of the following:  
☐ Yes, continue to 22  
☐ No  

21. Which needle size do you generally prefer?  
Please choose only one of the following:  
☐ 19G  
☐ 22G  
☐ 25G  

22. Specify if your preferred needle size depends on:  
(More than one answer possible)  
Please choose all that apply:  
☐ Location of target lesion,  
☐ Scope position, continue to 24  

23. Please specify your preferred needle size for the following indications:  
Please choose the appropriate response for each item:  

<table>
<thead>
<tr>
<th>Indication</th>
<th>Needle Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pancreatic solid mass</td>
<td>19G 22G 25G</td>
</tr>
<tr>
<td>Pancreatic cystic mass</td>
<td>19G 22G 25G</td>
</tr>
<tr>
<td>Lymph node</td>
<td>19G 22G 25G</td>
</tr>
<tr>
<td>Submucosal mass</td>
<td>19G 22G 25G</td>
</tr>
</tbody>
</table>

24. Please specify your preferred needle size for the following scope positions:  
Please choose the appropriate response for each item:  

<table>
<thead>
<tr>
<th>Scope Position</th>
<th>Needle Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transgastric</td>
<td>19G 22G 25G</td>
</tr>
<tr>
<td>Transduodenal D1 (Superior part/Duodenal bulb)</td>
<td>19G 22G 25G</td>
</tr>
<tr>
<td>Transduodenal D2 (Descending part)</td>
<td>19G 22G 25G</td>
</tr>
<tr>
<td>Transduodenal D3 (Horizontal part)</td>
<td>19G 22G 25G</td>
</tr>
</tbody>
</table>
25. Does your number of needle passes depend on the indication for FNA?
   Please choose only one of the following:
   - Yes
   - No, continue to 27

26. Please specify the number of needle passes per indication.
   Please choose the appropriate response for each item:
   - Pancreatic solid mass
   - Pancreatic cystic mass
   - Lymph node
   - Submucosal mass
   - 1
   - 2 – 3
   - > 3

27. Please specify the number of needle passes you generally perform.
   Please choose only one of the following:
   - 1
   - 2 – 3
   - > 3

28. What is your preferred needle movement technique during FNA?
   Please choose only one of the following:
   - To & Fro
   - Fanning
   - No preferred technique

29. Which additional techniques do you employ to increase the yield of tissue sampling during FNA?
   Please choose only one of the following:
   - Slow pull
   - Syringe
   - Wet suction
   - Capillary technique
   - None
   - Other, please specify _________________________________

30. How do you expel sampling material from the FNA needle? (More than one answer possible)
    Please choose all that apply:
    - Flushing with air
    - Flushing with saline
    - With stylet

31. Do you use on-site pathological evaluation of the specimen?
    Please choose only one of the following:
    - Yes, always
    - Yes, sometimes
    - No, continue to 33

32. Please specify who performs on-site pathological evaluation.
    Please choose only one of the following:
    - Pathologist
    - Cytotechnician
    - Myself

33. Why are you not using on-site pathological evaluation? (More than one answer possible)
    Please choose all that apply:
    - No added benefit with regard to yield
    - Costs
    - Time
    - Expertise
    - No pathological personnel available
    - Other, please specify _________________________________

34. Do you prepare glass slides after you performed FNA?
    Please choose only one of the following:
    - Yes
    - No, continue to 37

35. How do you fixate these smears?
    Please choose only one of the following:
    - Air dry
    - Direct fixation with alcohol
    - Other, please specify _________________________________

36. Which preservation medium do you use to collect cytology, obtained with FNA?
    Please choose only one of the following:
    - Saline
    - Cytolyt
    - A fixative (formalin)
    - Hanks
    - Alcohol
    - Other, please specify _________________________________

37. Is the cell block technique applied in your center?
    Please choose only one of the following:
    - Yes
    - No

38. Do you or your pathologist routinely look for tissue cores after FNA?
    Please choose only one of the following:
    - Yes, always, continue to 40
    - Yes, depending on the target lesion
    - No, continue to 44

39. Please specify for which indication(s) you look for tissue cores after FNA? (More than one answer possible)
    Please choose all that apply:
    - Cystic pancreatic lesions (from solid components or cyst wall)
    - Solid pancreatic lesions
    - Lymph nodes
    - Submucosal lesion

40. Are these tissue cores processed differently compared to the cytological tissue sample?
    Please choose only one of the following:
    - Yes
    - No, continue to 44
41. They are collected in a separate vial?
   Please choose only one of the following:
   □ Yes
   □ No

42. They are collected in a different medium?
   Please choose only one of the following:
   □ Yes
   □ No

43. In what medium?
   Please choose only one of the following:
   □ Saline
   □ Cytolyt
   □ A fixative (formalin)
   □ Hanks
   □ Alcohol

This section contains questions about Fine Needle Biopsy

44. What is the minimum lesion diameter for you to consider FNB?
   Please choose only one of the following:
   □ No minimum
   □ 0.5 cm
   □ 1 cm
   □ 2 cm

45. Do you have a preferred needle size for FNB?
   Please choose only one of the following:
   □ Yes, continue to 47
   □ No

46. Which needle size do you generally prefer?
   Please choose only one of the following:
   □ 19G
   □ 22G
   □ 25G

47. Does your preferred needle size depend on scope position and/or location of target lesion?
   Please choose only one of the following:
   □ Yes, continue to 49
   □ No

48. Which needle size do you generally prefer?
   Please choose only one of the following:
   □ 19G
   □ 22G
   □ 25G

49. Specify if your preferred needle size depends on:
   (More than one answer possible)
   Please choose all that apply:
   □ Location of target lesion
   □ Scope position, continue to 51

50. Please specify your preferred needle size for the following indications:
   Please choose the appropriate response for each item:
<table>
<thead>
<tr>
<th>Indication</th>
<th>19G</th>
<th>22G</th>
<th>25G</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pancreatic solid mass</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pancreatic cystic mass</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymph node</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Submucosal mass</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

51. Please specify your preferred needle size for the following scope positions:
   Please choose the appropriate response for each item:
<table>
<thead>
<tr>
<th>Scope Position</th>
<th>19G</th>
<th>22G</th>
<th>25G</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transgastric</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transduodenal D1 (Superior part/Duodenal bulb)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transduodenal D2 (Descending part)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transduodenal D3 (Horizontal part)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

52. Does your number of needle passes depend on the indication for FNB?
   Please choose only one of the following:
   □ Yes
   □ No, continue to 54

53. Please specify the number of needle passes per indication.
   Please choose the appropriate response for each item:
<table>
<thead>
<tr>
<th>Indication</th>
<th>1</th>
<th>2 – 3</th>
<th>&gt; 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pancreatic solid mass</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pancreatic cystic mass</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymph node</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Submucosal mass</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

54. Please specify the number of needle passes you generally perform.
   Please choose only one of the following:
   □ 1
   □ 2 – 3
   □ > 3

55. What is your preferred needle movement technique during FNB?
   Please choose only one of the following:
   □ To & Fro
   □ Fanning
   □ No preferred technique

56. Do you use a special technique (slow pull or syringe) to acquire tissue with the FNB needle?
   Please choose only one of the following:
   □ Yes, this depends on the indication
   □ Yes, independent of the indication, continue to 58
   □ No, continue to 59
57. Please specify per indication
Please choose the appropriate response for each item:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Slow pull</th>
<th>Syringe</th>
<th>Wet suction</th>
<th>Capillary technique</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pancreatic solid mass</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pancreatic cystic mass</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymph node</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Submucosal mass</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

58. Please specify
Please choose only one of the following:
- Slow pull
- Syringe
- Wet suction
- Capillary technique
- Other, please specify ______________________________

59. How do you expel sampling material from the FNB needle?
(More than one answer possible)
Please choose all that apply:
- Flushing with air
- Flushing with saline
- With stylet

60. Which preservation medium do you use to collect the FNB specimen?
Please choose only one of the following:
- Saline
- Cytolyt
- A fixative (formalin)
- Hanks
- Alcohol
- Other, please specify __________

61. Is immunohistochemical analysis performed in your center?
(when sufficient sampling material is available)
Please choose only one of the following:
- Yes, depending on the indication
- Yes, independent of the indication, continue to 63
- No, continue to 63

62. Please specify (More than one answer possible)
Please choose all that apply:
- Solid pancreatic mass
- Lymph node
- Submucosal mass

63. Is a cytological sample also prepared and evaluated (i.e. glass slide, cyto spin), in addition to the histological tissue core specimen?
Please choose only one of the following:
- Yes
- No, end of survey

64. Does this depend on the needle size?
Please choose only one of the following:
- Yes
- No, end of survey

65. Please specify for which needle size you look for additional cytological sample?
Please choose all that apply:
- 19G
- 22G
- 25G

Appendix 2 List of countries of respondents

<table>
<thead>
<tr>
<th>Countries</th>
<th>Number of respondents</th>
<th>Percentage of total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Europe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finland</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Israel</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Latvia</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Scotland</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Belgium</td>
<td>2</td>
<td>1.1</td>
</tr>
<tr>
<td>Ireland</td>
<td>2</td>
<td>1.1</td>
</tr>
<tr>
<td>Norway</td>
<td>2</td>
<td>1.1</td>
</tr>
<tr>
<td>Switzerland</td>
<td>2</td>
<td>1.1</td>
</tr>
<tr>
<td>Sweden</td>
<td>3</td>
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<tr>
<td>Germany</td>
<td>7</td>
<td>3.8</td>
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<td>Italy</td>
<td>18</td>
<td>9.7</td>
</tr>
<tr>
<td>Asia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Korea</td>
<td>1</td>
<td>1.6</td>
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<tr>
<td>India</td>
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<td>3.8</td>
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<td>Singapore</td>
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<td>10.2</td>
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<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>United States</td>
<td>54</td>
<td>29</td>
</tr>
<tr>
<td>TOTAL</td>
<td>186</td>
<td>100</td>
</tr>
</tbody>
</table>

Competing interests: None

References
4 Erickson RA, Sayage-Rabie L, Beissner RS. Factors predicting the number of EUS-guided fine-needle passes for diagnosis of pancreatic