

Long-term result of endoscopic treatment of an ampullary adenoma with extension into the common bile duct



► **Fig. 1** Endoscopic image showing a lesion at the major papilla.



► **Fig. 2** Cholangiogram performed 7 days after the initial therapy showing an irregular filling defect in the distal common bile duct.



► **Fig. 3** Radiographic image during cholangioscopy performed with a pediatric gastroscoposcope passed over a guidewire.

A 56-year-old man with chronic hepatic disease due to hepatitis C and esophageal varices was referred to our hospital with an elevated alpha-fetoprotein level and a solid lesion in the distal common bile duct (CBD) seen on computed tomography (CT) scanning. This lesion was protruding into the second part of the duodenum and causing dilatation of the biliary tree. An upper gastrointestinal endoscopy revealed a raised lesion at the major duodenal papilla (► **Fig. 1**). Biopsies showed a tubular adenoma with low grade dysplasia. Endoscopic ultrasound (EUS) revealed thickening that was restricted to the mucosal layer and choledocholithiasis.

The patient was not suitable for surgical treatment because of his portal hypertension. We therefore performed an endoscopic papillectomy, followed by a sphincterotomy and placement of a plastic pancreatic stent. A follow-up endoscopy 7 days later revealed a residual lesion with a filling defect in the distal CBD (► **Fig. 2**). After 30 days, a cholangioscopy was performed using CO₂ and a pediatric gastroscoposcope passed over a guidewire (► **Fig. 3**). Biopsies were taken and the residual lesion was treated with



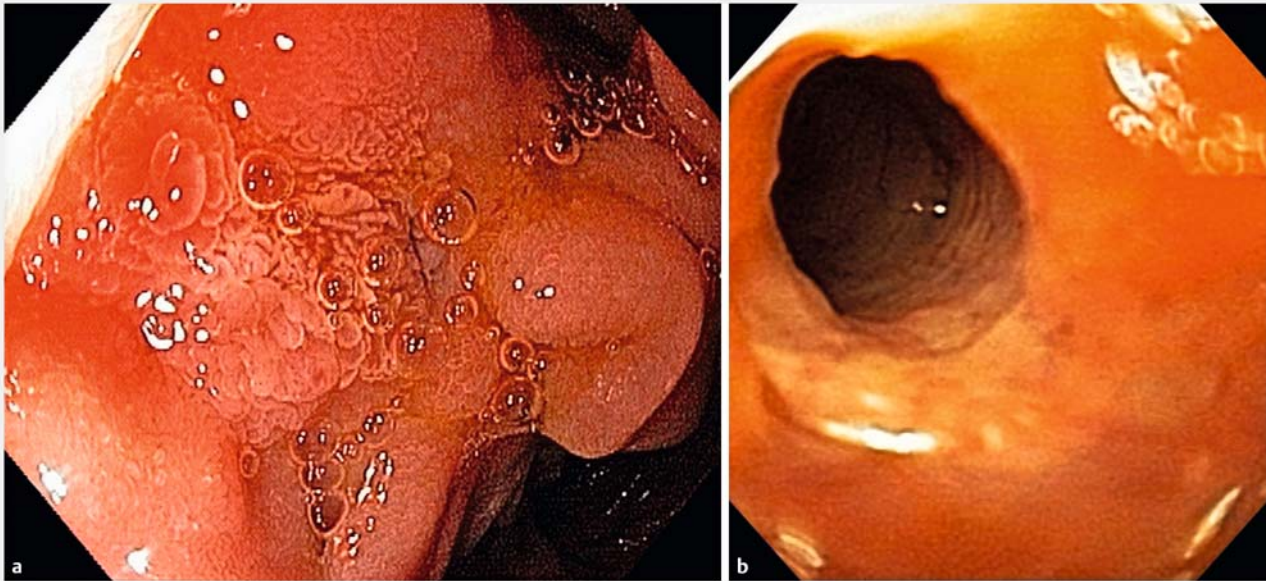
► **Video 1** Cholangioscopy performed after papillectomy with a pediatric slim gastroscoposcope revealed a residual lesion in the distal common bile duct. Biopsies were taken and the residual lesion was treated with argon plasma coagulation (APC).

argon plasma coagulation (APC) at 20W and 1.5L/min (► **Video 1**).

The patient remains completely asymptomatic 5 years later, receiving annual follow-up, and having no residual lesions (► **Fig. 4**).

Ampullary adenomas can be found incidentally on endoscopic screening exami-

nations and harbor a malignant potential [1]. In a retrospective study, 180 patients who had been treated for ampullary adenomas were followed up for a mean of 4.4 years [2]. There was no difference in endoscopic and operative resection of the ampullary adenomas in terms of local recurrence. However, intraductal



► **Fig. 4** Appearances 5 years after treatment on: **a** endoscopy of the ampullary region; **b** cholangioscopy.

extension of an adenoma is recognized as a limitation to endoscopic treatment [3]. In selected cases, intraductal adenomatous tissue can be endoscopically treated by ablation [1]. In our case, direct cholangioscopy with a slim scope and APC proved to be a valuable strategy for ablation of the intraductal adenomatous tissue.

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Competing interests

None

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