

Cold Snare Papillectomy for Re-redo Endoscopic Resection of a Defiant Adenoma Recurrence with a Unique Growth Pattern

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ABSTRACT

Endoscopic papillectomy has become the mainstay treatment in early papillary neoplasia. However, local recurrence remains the Achilles heel of the procedure due to the complex anatomy and limited ductal involvement unappreciated on endoscopic ultrasound (EUS) and/or endoscopic retrograde cholangiopancreatography (ERCP). While re-do papillectomy is, in general, technically feasible and widely accepted to treat recurrent adenoma, re-redo procedures to this end have rarely been reported. Likewise, utilization of cold snare technology is rarely considered in papillectomy and has, in fact, only once been reported in the literature before. We present a unique clinical case with a highly atypical growth pattern with a bonnet-like pedunculated lesion with a small insertion point just at the pancreatic duct orifice treated by re-redo cold snare papillectomy.

Keywords: Ampullary adenoma, Cholangiopancreatography, Cold snare, Endoscopic resection, Endoscopic retrograde patient, Papillectomy.

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CLINICAL REPORT

An 83-year-old female patient presented for endoscopic follow-up after two uncomplicated *en bloc* papillectomies 24 and 12 months before using conventional diathermic snare resection with a macroscopic impression of R0 resection. However, histopathology described low-grade adenoma with uncertain margins in both specimens. Preinterventional endoscopic ultrasound (EUS) and endoscopic retrograde cholangiopancreatography (ERCP) examinations did not yield evidence for either biliary or pancreatic ductal invasion at the time. Unexpectedly, the recent duodenoscopy indicated repeat recurrence (Fig. 1A). However, manipulation with a Dormia basket catheter for biliary stone extraction detected on a preceding cholangiogram demonstrated an atypical growth pattern of the bonnet-like mobile, partly rotatable lesion estimated at 8 mm with a pedunculated appearance, while both duct orifices were to be cannulated freely (Suppl. Video). Given these uncommon findings and with a view to the most likely recurrence insertion point between the ductal openings, cold snare resection was chosen to limit delayed complications such as hemorrhage as well as transmural and/or pancreatic duct injury (Fig. 1B). After specimen retrieval, minor bleeding was noted (Fig. 1C), ceasing rapidly with a putative bleeding point or resection line at or just from within the pancreatic duct orifice (Fig. 1D). The procedure was terminated by gently flushing some more blood from the distal pancreatic duct and insertion of a 4-Fr prophylactic pancreatic stent (Fig. 1E) and biopsy taken from the suspicious area (Fig. 1F). The postinterventional course was unremarkable without postinterventional pain and/or pancreatic enzyme dynamics. Histopathology indicated low-grade adenoma of the papillectomy specimen and nonspecific findings from targeted biopsies. Closer surveillance with optional argon plasma coagulation around the pancreatic duct opening and/or limited ductal radiofrequency ablation treatment was scheduled three months later.¹ Recurrence remains the Achilles heel in endoscopic papillectomy due to the complex-related anatomy.² Cold snare papillectomy, albeit not systematically studied,

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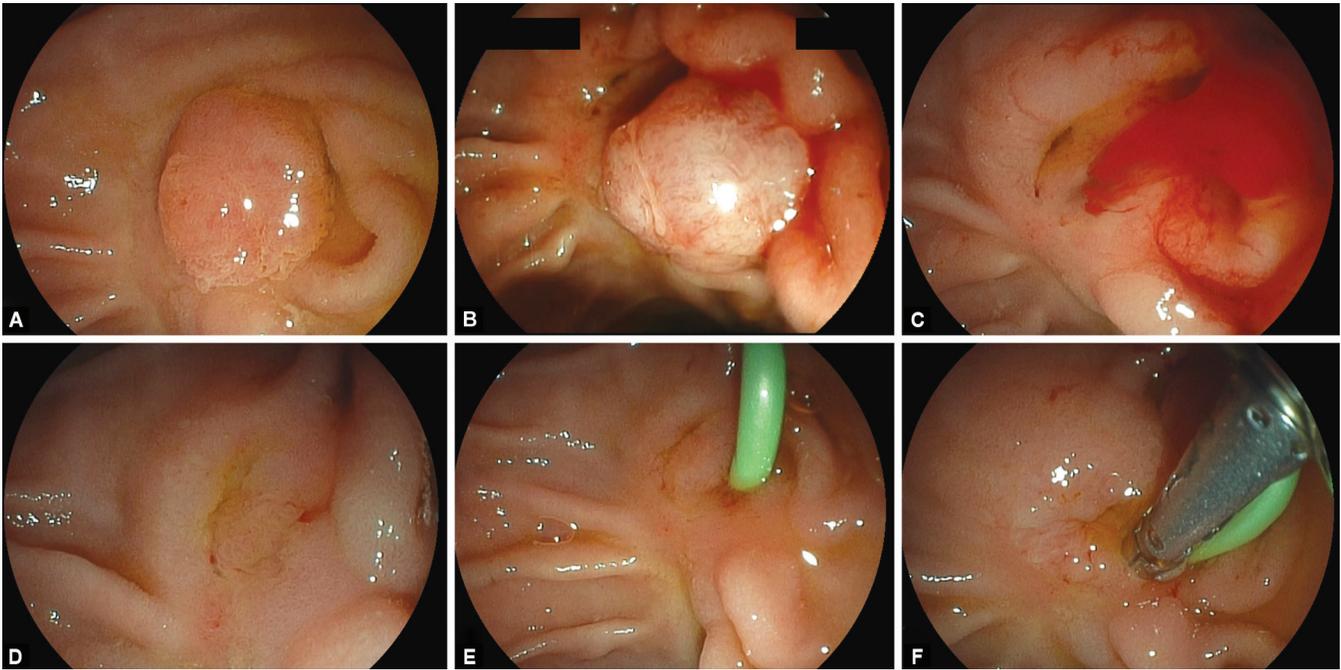
represents a novel principle and may have a role in selected lesions and clinical settings.³

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Figs. 1A to F: (A) Duodenoscopy indicating repeat adenoma recurrence after two conventional “hot” *en bloc* papillectomies. (B) Successful cold snare papillectomy (*compare Suppl. Video*) with histopathology confirming low-grade adenoma with unclear margins. (C) Discrete initial bleeding tendency that rapidly ceased spontaneously. (D) Putative bleeding point or recurrence insertion point at and putatively from within the pancreatic duct opening. (E) Insertion of prophylactic 4-Fr pancreatic duct pigtail stent after gently flushing blood from the distal pancreatic duct (*not shown*). (F) Targeted biopsies from the area without pathological proof of residual adenoma