

► Less Invasive Treatment for Inflammatory Pancreatic Cysts

Acute or chronic pancreatitis—due to alcohol abuse, gallstones, or other causes—can block pancreatic ducts, causing a cyst-like, fluid-filled pocket to develop on the pancreas. While many such pseudocysts require only conservative care and are self-resolving, others can linger or continue to enlarge, with the potential to rupture or cause hemorrhage, obstruction, or infection. Conventionally, procedures to drain these pseudocysts have meant open or laparoscopic surgery. But new stenting technology is now making endoscopic treatment an easier and preferred approach to resolving pancreatic pseudocysts.

“This condition can become painful and dangerous,” said Virtua interventional gastroenterologist Punitha Shivaprasad, DO. “Using upper endoscopy with endoscopic ultrasound and an improved stent for draining the cyst into the GI tract, we are reducing the mortality and morbidity of treatment.”

Lumen-Apposing Metal Stent Creates Drainage

The large portion of pancreatic pseudocyst patients whose cyst has a proximity to the gastric wall of 1 cm or less are candidates for this less-invasive solution, in which an electrocautery tip on the endoscope creates a small opening in the stomach wall in order to penetrate and gain immediate access to the cyst. A wire-mesh stent placed through the pancreatic cyst wall drains the cyst into the stomach.

The team performs a fine-needle aspiration of the pseudocyst in advance to analyze its content. With the aid of endoscopic ultrasonography, the risk of hemorrhage due to trauma to local vessels is further minimized. Radiopaque markers aid positioning of the catheter that delivers the stent. Plastic stents used in the past often clogged or shifted. But the large flanges on each end of the new fully covered, MRI-compatible stents hold the two lumens in tissue apposition for transluminal drainage, reducing the risk of leakage and migration. Once placed, the stent functions as an access port that the team can dilate to allow passage of standard and therapeutic endoscopes to facilitate debridement, irrigation, and cystoscopy of the pancreatic lesion, if needed.

Simpler Procedure, Less Expense, Faster Recovery

The specialists can perform this cystogastrostomy by draining the cyst into the gastric lumen or small bowel, with either approach conserving pancreatic juices that would otherwise be lost. The stent typically remains in place for several weeks, until CT imaging confirms emptying and resolution of the pseudocyst. After endoscopic removal of the stent, the walls of the stomach and pancreas close on their own.

A burst pancreatic pseudocyst can be life-threatening. But specialized, advanced-therapeutic GI endoscopists can now use this approach to reduce and eliminate large, symptomatic pancreatic pseudocysts and walled-off pancreatic necrosis.

Endoscopy and improved stenting make treatment of these cysts easier to undergo.

“Guidelines now recommend a ‘step-up approach’ to treating pseudocysts. Endoscopic drainage is a first-line treatment for problematic cysts and potentially provides immediate relief with shorter hospital stays and prompter recovery,” said Virtua interventional gastroenterologist Raman Battish, MD.

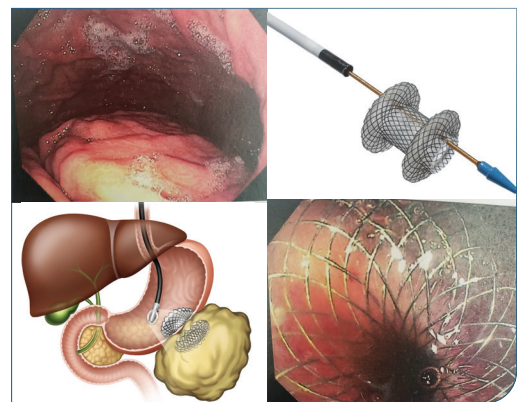


illustration courtesy giejournal.org

Left to right from top: pseudocyst compressing stomach; endoscopic electrocautery and AXIOS™ Stent (Boston Scientific) delivery system; illustration of lumen-apposing metal stent placement; stent draining cyst to stomach.

To reach Virtua GI and Digestive Health, call 856-237-8045

Case Illustrates Need for Esophageal CA Screening

“Providers should consider sending men over the age of 50 with an elevated body mass index (BMI) to GI to discuss the risks and benefits of screening for Barrett’s esophagus and esophageal cancer,” says Virtua gastroenterologist Charles Snyder, MD.

This recommendation by experienced gastroenterologists for this broad group of patients was brought home again recently in a Virtua patient case. The 57-year-old patient had come to see Dr. Snyder in December 2020 to discuss a colorectal screening. On his induction check list, he paused and decided to note some recent reflux.

The American Gastroenterological Association recommends that individuals with more than one of these risk factors be evaluated for Barrett’s esophagus: age 50 years or older, male sex, Caucasian, chronic GERD, hiatal hernia, elevated BMI, and intra-abdominal distribution of body fat. According to the standards, this means such individuals should undergo a preventive/diagnostic upper endoscopy.

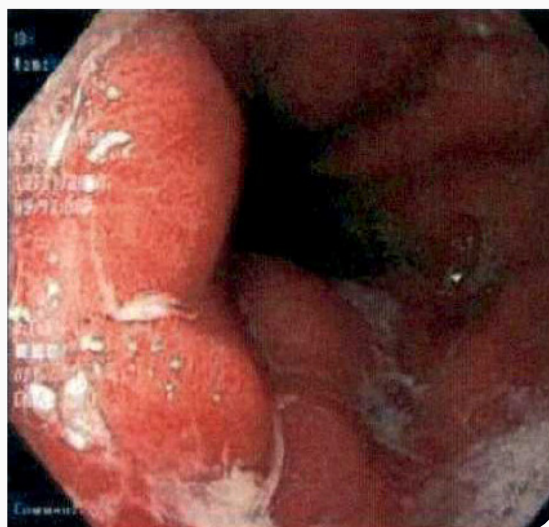
Using high-definition white light and narrow-band imaging for the patient’s endoscopy, Dr. Snyder observed a subtle inflammation in his distal esophagus. As a result, he performed a biopsy on a small nodule, the pathology of which revealed a high-grade dysplasia.

On referral of the patient, Virtua interventional gastroenterologist Punitha Shivaprasad, DO, performed a deeper endoscopic biopsy, which showed moderately differentiated adenocarcinoma. Endoscopic doppler information demonstrated the blood supply to the nodule, also helping to stage the cancer. A small, superficial lesion

might have been subject to removal of the nodule only or radioablation. However, the patient’s cancer was well below the mucosal level.

During an eight-hour surgery at Virtua Our Lady of Lourdes Hospital in February 2021, Virtua thoracic surgeon Christopher Derivaux, MD, performed a partial esophagectomy, followed by anastomosis of the GI tract. The patient has undergone several subsequent procedures to ease his ability to swallow.

“Thank God for Dr. Snyder and the Virtua team,” the patient said. “I didn’t think there was anything wrong with me.”



Endoscopic image of the patient's esophageal nodule