Purpose: The patient is a 68-year-old male with stage IV non-small cell lung cancer who presented with a 3-month history of progressive solid food dysphagia. Initial evaluation included a chest CT that showed an increase in subcarinal lymphadenopathy, a decrease in the left lower lobe adenocarcinoma and an EGD that showed a 5-cm mid esophageal stricture secondary to extrinsic compression. Palliative radiation therapy was administered to the subcarinal area. Two months later, the patient presented with productive cough and fevers. Chest CT revealed progression of disease and a 7.5-cm walled off necrotic mass with air and fluid levels in the posterior mediastinum. Per the patient's and his family's wishes, the patient was hospitalized for the abscess management with IV antibiotics and endoscopic therapy.

Methods: A diagnostic upper endoscope was inserted into the esophagus and a completely obstructing mass was encountered in the proximal esophagus. Mechanical debridement with a spiral snare was initiated and repeated multiple times. The continued debridement allowed for visualization of the second obstructing mass located at the gastroesophageal junction and a fistulous tract from the esophagus into the mediastinum. The endoscope was driven into the necrotic cavity through the fistulous tract. The same maneuvers used for debridement of the esophageal mass were again used for the debridement of infected walled-off mediastinal necrosis. A partially covered self-expandable stent was then deployed under direct fluoroscopic visualization across the first obstructing mass and fistula; contrast injected showed no leak. A second, bridging, partially covered self-expandable stent was then deployed to traverse a second tumor obstruction.

Results: An esophagram on post-procedure day one showed good position of the overlapping stents without contrast extravasation.

Conclusion: Direct endoscopic necrosectomy is most commonly used for debridement of walled-off pancreatic necrosis with good results. When possible, and in the right clinical setting, mediastinal direct endoscopic necrosectomy can be safely performed. This treatment modality is potentially a feasible therapeutic alternative to thoracoscopic or open surgical therapy in a right clinical setting. However, experience and published data are limited.
ABSTRACT BODY:

Purpose: Ingested Neodymium magnets are up to ten times as powerful as traditional magnets and have emerged as a serious health hazard in children leading to bowel perforation, volvulus and death. We described a novel use of the force of Neodymium magnets in the endoscopic removal of multiple ingested magnets in a two year old child who presented with a one month history of recurrent non bloody vomiting. Abdominal x-ray revealed bead like foreign bodies in stomach (figure 1). EGD demonstrated multiple Neodymium magnets in the lesser curvature of the stomach and gastric antrum. It was noted that the walls of the lesser curvature and antrum were attached due to the attractive forces. Several magnets had eroded through the gastric wall creating fistulae. A net retrieval device successfully removed some of the magnets; however, this device was unable to remove the additional embedded magnets. A multiprong forcep also failed to remove the embedded magnets. We therefore devised a novel technique to use the power of Neodymium magnets to remove the magnets that were embedded in the gastric wall. We used one of the magnets which was previously retrieved and front loaded in onto the Olympus video gastroscope using a net retrieval device (Roth net). The front loaded endoscope was then advanced under direct visualization to the embedded magnets which were then easily attracted by the magnetic force and removed en bloc. 25 magnets were thus removed using only three passes of the endoscope. The fistulae were then closed via application of clips. The child had an uneventful recovery and was discharged home the next day.

Methods: N/A

Results: N/A

Conclusion: N/A

AUTH DESIG: ACG Membership Status <font color="red">*</font>:

Stephen Nanton : ACG Member
Joelle Roskens : ACG Non-Member
David Strand : ACG Non-Member

(Figure 1) X-ray shows multiple beads/magnets in stomach.

(Figure 2) EGD shows multiple Neodymium magnets in stomach.
IMAGE CAPTION: (Figure 1) X-ray shows multiple beads/magnets in stomach. (Figure 2) EGD shows multiple Neodymium magnets in stomach.

(no table selected)

AVERAGE SCORE: 5

REVIEWER FLAGS: (none)

REVIEWER RECOMMENDATION CODE DESCRIPTION: None

REVIEWER COMMENTS:
Jonathan Buscaglia: [No Comments]
Christopher DiMaio: [No Comments]
Seth Gross: 6
John Saltzman: [No Comments]
Purpose: In this video, we demonstrate a novel technique for resection of a challenging subepithelial lesion arising from the muscularis propria layer of the stomach. Endoscopic ultrasound was used to inject hydroxypropylmethylcellulose mixed with indigo carmine and dilute epinephrine to expand the muscularis propria layer to create a large cushion to facilitate a safer endoscopic submucosal dissection. Finally, we demonstrate use of an endoscopic suturing device to successfully close a full-thickness gastric defect.

Methods: N/A - video submission

Results: N/A - video submission

Conclusion: N/A - video submission

AUTH DESIGN: ACG Membership Status <font color="red">*</font>:
Victoria Gomez: ACG Member
Larissa Fujii: ACG Member
Michael Levy: ACG Member
Louis Wong Kee Song: ACG Member

Script of the video narration (Page 1)

The small submucosal lesion attached to the capsule of the lesion was then resected in one piece using a snare. Shown here is the submucosal tissue of the submucosal lesion. The lesion was then inflated with fluid to facilitate the resection. The endoscopic suture device was then used to close the defect, creating a secure suture line. The stomach was then examined to ensure there were no leaks or perforations. The patient tolerated the procedure well and was discharged on post-operative day one.
Purpose: A 74-year old man underwent percutaneous trans-hepatic cholangiography (PTC) for a distal non-malignant common bile duct (CBD) stricture with internal and external drain placement in 2009. At a subsequent drain exchange, he developed significant bleeding from the drain, which necessitated coil embolization of the hepatic artery. He did well afterwards and drains were removed. Three years later, he developed jaundice and cholangitis. ERCP done at an outside facility revealed a foreign body, which was assumed to be jag wires from a prior ERCP. A plastic stent was placed for biliary drainage, and he was referred to us for further management.

A CT scan noted hardware within the porta-hepatis that caused streak artifact, along with dilation of intra-hepatic bile ducts. Review of the case suggested endovascular coils in the bile duct. It was assumed that some of the embolic material from the hepatic artery had eroded into CBD. It was decided to remove this embolic material by ERCP. Due to concern of hepatic artery rupture during retrieval, a catheter was positioned in the hepatic artery by Interventional Radiology (IR) to facilitate rapid re-embolization, should uncontrolled bleeding occur.

During ERCP balloon extraction of a vascular plug with sludge was performed, followed by removal of filamentous wires in distal CBD with rat-tooth forceps. The duct was then accessed with spyglass to extract the more proximal wires using spybite. A fluoroscopic video obtained at the end of the procedure demonstrated remaining coils in a different plane from the biliary system, most likely in the hepatic artery. There was a thin sliver of embolic material remaining in the CBD that will probably epithelialize. There was no GI bleeding during the procedure. The patient has been event-free for over seven months now.

Post-cholecystectomy clips, suture material and displaced stents are commonly discussed foreign bodies in CBD. There are limited reports on migration of vascular embolic material into duodenum; however, erosion of vascular coils into CBD is an extremely rare situation. Our case demonstrates successful use of various endoscopic techniques to manage this otherwise high-risk and presumably surgical condition. Adopting a multi-modality approach with IR backup may prevent need for surgical exploration of CBD in such intricate cases. Our method of management may serve as a teaching tool for endoscopists who may encounter a similar situation.

Methods: NA
Results: NA
Conclusion: NA

CONTACT ID: 1728798
PRESENTER: Mohit Girotra
PRESENTER (INSTITUTION ONLY): Division of Gastroenterology and Hepatology, Department of Medicine, University of Arkansas for Medical Sciences
PRESENTER (COUNTRY ONLY): United States

CONTACT BODY:

AUTH DESIG: ACG Membership Status: Investigator
Mohit Girotra : ACG Member
Shyam Dang : ACG Member
Sunbal Zafar : ACG Non-Member
Michael Beheshti : ACG Non-Member
Rayburn Rego : ACG Member
(No Image Selected)
(no table selected)

**AVERAGE SCORE:** 5.75

**REVIEWER FLAGS:** (none)

**REVIEWER RECOMMENDATION CODE DESCRIPTION:** None

**REVIEWER COMMENTS:**
Jonathan Buscaglia: [No Comments]
Christopher DiMaio: [No Comments]
Seth Gross: 5
John Saltzman: [No Comments]
Purpose: Case: A 39 year old Caucasian female presented with abdominal pain, nausea/vomiting, and jaundice. Abdominal CT scan revealed findings of type IVa choledochal cyst. There were enhancing lesions within the cyst suspicious for cholangiocarcinoma. An ERCP with cholangioscopy confirmed the presence of choledochal cyst, and showed finger like growth in the common hepatic and right hepatic ducts. Cholangioscopic biopsies showed papillary adenoma with high grade dysplasia (HGD). She underwent en-bloc extra hepatic bile duct resection, right hepatectomy, cholecystectomy, Roux-en-Y reconstruction with hepaticojejunostomy, and portal lymphadenectomy. Surgical pathology showed multifocal, moderately differentiated invasive adenocarcinoma, in a background of papillary adenoma and biliary dysplasia. The surgical margins, and the excised lymph nodes were negative for malignancy (pT1, pN0).

Patient returned for endoscopic surveillance 17 months after above surgery. A direct cholangioscopy was performed with a pediatric colonoscope. The hepaticojejunostomy anastomosis was reached and the scope was advanced into the left main intrahepatic duct and its first bifurcation. Careful endoscopic examination was performed with white light and narrow band imaging (NBI). An area of abnormal mucosa with tuft of papillary projections was seen in the left hepatic duct. Multiple targeted biopsies were obtained from this area. Exam of the abnormal mucosa with NBI highlighted the dark mucosa and prominent vasculature in the papillary projections. Although NBI exam did not show gross abnormalities in other areas of the bile ducts, the mucosa appeared speckled and blue, and there was prominent vascular pattern compared to the adjacent jejunal mucosa. Multiple random biopsies were also obtained from the hepatic ducts. Targeted biopsies from papillary projections showed high grade dysplasia (HGD). Random biopsies from areas without any obvious lesions also showed HGD in a background of intestinal metaplasia.

Discussion: This case highlights the risk of HGD and malignancy in unresected, but dilated biliary ducts in the setting of choledochal cyst. There are no specific guidelines regarding surveillance protocol for these patients. Continued endoscopic surveillance should be considered. Liver transplantation may be a curative option. Our patient is currently being evaluated for liver transplant. White light endoscopy is limited in recognizing dysplastic biliary epithelium. Random biopsies from normal appearing mucosa should be done in addition to targeted biopsies. Our case demonstrates NBI appearance of biopsy proven HGD in biliary system. We speculate that NBI may have a role in evaluating dysplastic biliary epithelium.
Lisa Yoo : ACG Non-Member
Niraj Gusani : ACG Non-Member
Eric Kimchi : ACG Non-Member
Charles Dye : ACG Member
Matt Moyer : ACG Member
Abraham Mathew : ACG Member
(No Image Selected)
(no table selected)

**AVERAGE SCORE:** 5.75

**REVIEWER FLAGS:** (none)

**REVIEWER RECOMMENDATION CODE DESCRIPTION:** None

**REVIEWER COMMENTS:**
ABSTRACT BODY:

**Purpose:** To demonstrate that metallic clips can successfully be used to close perforations in the GI tract secondary to endoscopic procedures in patients that are stable (in this case an ERCP-related iatrogenic perforation).

**Methods:** After passage of the side viewing endoscope into the duodenum, it was withdrawn to reduce the gastric loop and attain the short scope position of the endoscope and facilitate biliary cannulation. At that point fresh bleeding was seen coming from the opposite duodenal wall. Examination of this area revealed a 10 mm defect compatible with perforation likely caused by the shaft of the endoscope in the presence of a fixed duodenum related to her previous surgery. Fluoroscopy showed free air in the peritoneal cavity and peritoneal leakage of contrast injected into the duodenum confirmed a leak. The side viewing endoscope was exchanged for a gastroscope and the perforation was closed with 8 commercially available hemostatic endoclips. Subsequent contrast injection showed no leak.

**Results:** Subsequent contrast injection after the procedure showed no leak and the patient was placed on broad-spectrum antibiotics and a naso-gastric tube was placed. An upper GI series and CT of the abdomen showed free air in the peritoneum, which persisted for two weeks. Initiation of oral feeding precipitated an attack of acute relapsing pancreatitis treated with total parenteral nutrition and a jejunal feeding tube. Tube feeding was gradually escalated while weaning total parenteral nutrition and the patient was discharged pain free and stable on tube feeding. The patient subsequently followed in the clinic without noted complications.

**Conclusion:** When endoscopic sphincterotomy causes perforations endoscopic closure of the defect using metallic clips might be the first choice of intervention in patients who are stable. The deployment requires significant experience and an endoscopy team familiar to an endoclipping device. Moreover, these patients do need to be admitted for observation and placed on intravenous antibiotics with bowel rest and nasogastric drainage when necessary. This treatment modality therefore avoids possible surgical intervention.
Purpose: Dieulafoy disease is a rare cause of upper gastrointestinal bleeding and even rarer for colonic bleed. The dieulafoy lesion of the colon was first described by Barbier in 1985. We present a patient who had multiple dieulafoy lesions in the ascending colon, underwent endoscopic therapy and finally surgical resection with histopathologic confirmation of the dieulafoy lesion underneath endoscopically applied hemoclips.

Patient is a 71 year male with past medical history of Coronary artery disease, Stroke and pulmonary embolism on Coumadin presented with symptomatic anemia due to lower GI bleed in December 2011. His Hb was 9 with normal MCV. At that time he was found to have a Dieulafoy lesion of the ascending colon and underwent endoscopic ablation with endoscopic hemoclip placement. He presented with recurrent lower GI bleeding thrice in next 8 months needing colonoscopy each visit and underwent endoscopic placement of hemoclips and epinephrine injection of dieulafoy lesions with successful hemostasis. Videos and still images of the bleeding lesion were obtained as well as images of endoscopic metallic clip placement and injection therapy. Due to his history of pulmonary embolism requiring anticoagulation therapy, coronary artery disease and need for multiple blood transfusions of each episodes of GI bleeding, surgical consultation for colonic resection was obtained. Following resection of the ascending colon, the pathologist was able to perform cuts on gross specimen between the two endoclips applied during his last endoscopy and Histopathologic evaluation confirmed the presence of a colonic Dieulafoy lesion. The patient has remained clinically stable without the further signs of GI bleeding since his colon resection. Colonic Dieulafoy lesions are uncommon source for gi bleeding but confirmation with histopathologic proof of the clinical impression is exceedingly rare.

Methods: N/A
Results: N/A
Conclusion: N/A
REVIEWER RECOMMENDATION CODE DESCRIPTION: None

REVIEWER COMMENTS:
Purpose: In this video, we discuss the importance of recognizing and detecting sessile serrated polyps of the colon. We review the cytogenetic features of sessile serrated adenomas, the key endoscopic findings that can assist with their detection, and lastly, review important concepts for successful endoscopic mucosal resection (EMR) of these lesions. We emphasize that improvement in the detection of sessile serrated lesions can be accomplished by "re-training" the naked eye to detect subtle mucosal abnormalities. Finally, successful EMR of these lesions requires experience in polypectomy techniques.

Methods: N/A - video submission

Results: N/A - video submission

Conclusion: N/A - video submission

CURRENT CATEGORY: N. Endoscopy Video Forum

CURRENT SUB-CATEGORY: None

PRESENTER (INSTITUTION ONLY): Mayo Clinic

PRESENTER (COUNTRY ONLY): United States

ABSTRACT BODY:
AVERAGE SCORE: 4
REVIEWER FLAGS: (none)
REVIEWER RECOMMENDATION CODE DESCRIPTION: None
REVIEWER COMMENTS:
Purpose: Obesity is a worldwide epidemic affecting, one in every three Americans. Bariatric surgeries are on the rise, with many options available to the public. One of these options is the Fobi pouch gastric bypass, which was introduced in 1992 by Dr. Mal Fobi. This procedure uses the same type of pouch construction as a Roux-En-Y stomach bypass. What is different is the use of a fashioned silastic ring called the Fobi ring around the distal end of the pouch. The ring simulates a pyloric valve and prevents stretching of the opening between the pouch and section of small bowel, promoting more long-term weight-loss success. It is well known that adjustable gastric bands can migrate and erode through the stomach wall, and several case series have reported successful removal of these eroded bands endoscopically, but there is very limited reported data on the incidence of the erosion of Fobi rings, as well as its removal. Hence, we believe that our video, “Total Endoscopic Removal of an Eroded Gastric Bypass Fobi Ring,” is the first case of endoscopically removing such a ring using readily available endoscopic equipment. As more and more patients get bariatric procedures and possibly the Fobi ring, erosion of such rings may become more prevalent; therefore, offering an endoscopic approach is very important for these patients to avoid the morbidity of an additional abdominal surgery. We also feel that this endoscopic approach offers a safe and low morbidity procedure for patients who have this complication.

Methods: N/A
Results: N/A
Conclusion: N/A

AUTH DESIGN: ACG Membership Status <font color="red">*<font>
Susan Kais : ACG Member
Walter Coyle : ACG Member
Franklin Tsai : ACG Member
(No Image Selected)
(no table selected)

AVERAGE SCORE: 3.33
REVIEWER FLAGS: (none)
REVIEWER RECOMMENDATION CODE DESCRIPTION: None

REVIEWER COMMENTS:
Jonathan Buscaglia: [No Comments][Christopher DiMaio: [No Comments][Seth Gross: 2][John Saltzman: [No Comments]
Purpose: Gastric volvulus is characterized by rotation of the stomach upon itself on either its short or long axis. It is a rare entity that occurs later in life with 80 to 90 percent of cases occurring after the fifth decade. The etiology may be either primary or secondary to an anatomic defect such as a paraesophageal or diaphragmatic hernia. The symptoms may occur in a wide spectrum from minimal or intermittent discomfort to more severe abdominal pain and vomiting to gastric outlet obstruction and ischemia.

We present the case of an 82 year-old female with no significant medical history who presented as an outpatient with post-prandial coughing, nausea, and vomiting. Physical exam was unremarkable. Upper endoscopy was performed for further evaluation.

The endoscope was advanced into the stomach and upon initial inspection, the orientation of the stomach was abnormal and appeared twisted. Retroflexion revealed that the patient had a paraesophageal hiatal hernia with a mesenteroaxial type gastric volvulus. This was evident by inappropriate positioning of the antrum and duodenum in the patient's chest cavity. In order to advance the endoscope to the duodenum, slightly increased scope pressure was used. Once the endoscope reached the duodenal bulb, it was then advanced more distally into the duodenum. At that point, the small dial was locked forward and the endoscope was carefully withdrawn using right torque to straighten out the stomach. Once in the stomach, retroflexion as performed confirming that the stomach now appeared to have normal orientation.

Mesenteroaxial volvulus, as was present in our case, occurs when the rotation of the stomach is along the short axis through a line perpendicular to the greater and lesser curvatures. It is less commonly associated with an anatomic defect and it's usually a partial rotation, meaning less than 180 degrees. Organoaxial volvulus occurs when there is rotation along the long axis of the stomach through a line connecting the gastroesophageal junction and pylorus. This usually presents as a more acute process with a greater risk of strangulation and vascular compromise, which occurs in up to 30 percent of cases.

The management of gastric volvulus consists of gastric decompression and a method to derotate the stomach and fix anatomic defects if possible. Management may either be surgical or endoscopic depending on the etiology of the volvulus and whether the patient is a good surgical candidate or not.

Our patient subsequently underwent PEG tube placement for gastropexy after discussion in the office. Symptoms of dysphagia and chronic cough improved and completely resolved. PEG tube was eventually removed in the office three months after placement.

Methods: N/A
Results: N/A
Conclusion: N/A
AVERAGE SCORE: 7.5
REVIEWER FLAGS: (none)
REVIEWER RECOMMENDATION CODE DESCRIPTION: None
REVIEWER COMMENTS:
TITLE: Novel Use of Metal Stenting for an Esophageal Stricture after Radiofrequency Ablation Treatment of Barrett's Esophagus

PRESENTER: Traci Murakami
PRESENTER (INSTITUTION ONLY): University of Arizona Medical Center, Division of Gastroenterology
PRESENTER (COUNTRY ONLY): United States

ABSTRACT BODY:

Purpose: Radiofrequency ablation (RFA) is an effective, safe, and well-tolerated treatment of dysplastic and non-dysplastic Barrett's esophagus; however there is risk of post-ablative stricture formation. Stricture rates may be increased in those with long-segment Barrett's esophagus. These strictures are usually treated with endoscopic balloon or Savary dilators, however multiple dilations may be required to achieve stricture resolution. We report a case of a post RFA-stricture that was completely relieved by a self-expandable metal stent.

Case Description:
A 71-year old male with long segment Barrett's esophagus C7M7 had low grade dysplasia and underwent circumferential radiofrequency ablation. A month later, he experienced symptoms of dysphagia. Repeat endoscopy showed a tight stricture with circumferential ulceration at the proximal end of the RFA treated Barrett's epithelium. A 5.9 mm diameter gastroscope was advanced to the proximal end of the stricture. However, the distal end of the stricture could not be traversed. An 8.8 mm diameter gastroscope was reinserted and a 9-12 mm extraction balloon was introduced through the channel of the scope. Contrast revealed a 4 cm long stricture in the mid esophagus. A stent introducer was passed over a 0.035 inch guide wire which crossed the stricture under fluoroscopic and endoscopic guidance. A fully covered metal esophageal stent 23 mm X 105 mm was deployed. Repeat attempt at traversing the stricture was unsuccessful. The extraction balloon was reintroduced and injection of contrast showed a waist in the mid portion of the stent with free flow of contrast into the stomach.

The patient underwent repeat upper endoscopy 2-months later for removal of the stent. Six months later he had no symptoms of dysphagia post stent removal.

Discussion:
The incidence of strictures after RFA treatment of Barrett's esophagus ranges from 1% to 8% and happens more often after treatment of long segment Barrett's esophagus. Dilation of these strictures with active inflammation carries a risk of perforation. Placement of covered metal stents for management of this condition has not been reported to date. To our knowledge, this is the first case of an esophageal stricture post-RFA treatment of Barrett's esophagus that resolved with placement of a fully covered removable metal stent. Placement of a stent may also save multiple repeat dilations that might be required and may be cost-saving. It should be noted that this is not an FDA approved indication for placement of a fully covered metal stent.

Methods: N/A
Results: N/A
Conclusion: N/A

CURRENT CATEGORY: N. Endoscopy Video Forum
CURRENT SUB-CATEGORY: None
PRESENTATION TYPE: Video
ACG Research Grant Support: No
Supported by Industry Grant: No
Commercial Products or Services: No
Initiated Research: Investigator
Financial Relationships: No
FDA Approval: No
Designed Study: Investigator
Abstract Author: Investigator
AUTH DESIG: ACG Membership Status <font color="red">*</font>:
Traci Murakami : ACG Member
Hemanth Gavini : ACG Member
Nuri Ozden : ACG Member
Bhaskar Banerjee : ACG Member
(No Image Selected)
(no table selected)

AVERAGE SCORE: 6
REVIEWER FLAGS: (none)
REVIEWER RECOMMENDATION CODE DESCRIPTION: None
REVIEWER COMMENTS:
Purpose: Optimal diagnosis and surveillance of patients with Barrett’s esophagus (BE) is complex, given that few patients undergoing resection of esophageal adenocarcinoma have a prior diagnosis of Barrett’s esophagus (BE) and, among those who have been screened and diagnosed with BE, >90% never develop adenocarcinoma. Surveillance of patients with BE is further complicated by variability in the distribution of dysplasia and cancer within the esophagus. Random sampling of esophageal biopsies can result in missed regions of interest with pathology. Thus, a significant need exists for more accurate methods of identifying areas of dysplasia in the endoscopic screening and surveillance of BE. Volumetric laser endomicroscopy uses the principles of optical coherence tomography to generate high-resolution, cross-sectional, and longitudinal images of tissue microstructures simultaneously in real time.

Methods: The console generates the near infrared light and transmits the light into the VLE catheter. The Console includes the swept light source, optical receiver and interferometer, data acquisition computer and control electronics, and user interface and display. The Catheter is a long catheter (2.5m) plugs into the Console and has a polymer, noncompliant balloon with soft tip.

Results: In this case, a 64 year old man with long standing acid reflux and a family history esophageal carcinoma had undergone endoscopy documenting long segment BE with areas suspicious for HGD and/or carcinoma. At our institution, he underwent video endoscopy with VLE imaging documenting abnormal crypt formation and surface maturation consistent with BE HGD and focal mass treated with endoscopic resection.

Conclusion: Optical Coherence Tomography (OCT) is an imaging modality that has the ability to improve the current paradigm for endoscopic screening and surveillance. The benefit of OCT over ultrasound is that it is capable of generating cross-sectional images of tissues with an axial-resolution of up to 10 microns, which is comparable to low-power microscopy. Original OCT systems or time-domain OCT were limited to discrete locations or ‘point’ sampling due to slow acquisition rates. However, with the development of second-generation OCT, termed Optical Frequency Domain Imaging (OFDI) now called VLE, it is now possible to perform high-speed acquisition of large luminal surfaces in three-dimensions. Due to its high-resolution and high-acquisition rates, utilizing this technique for screening and surveillance of Barrett’s esophagus may provide a means to evaluate pathologic states of the esophageal lumen in real-time.

CURRENT CATEGORY: N. Endoscopy Video Forum
CURRENT SUB-CATEGORY: None
PRESENTATION TYPE: Video
ACG Research Grant Support: No
Supported by Industry Grant: Yes
Extra Info: Nine Point Medical, Cambridge MA
Commercial Products or Services: Yes
Initiated Research: Investigator
Financial Relationships: Yes
Extra Info: Leslie Blackshear, E Aranda-Michel, Mayo Clinic Florida: None
MB Wallace, HC Wolfsen, Mayo Clinic Florida and G Tearney
Massachusetts General Hospital: Grant/Research Support

FDA Approval: Yes
Designed Study: Investigator
Abstract Author: Investigator
AUTH DESIG: ACG Membership Status <font color="red">*</font>:
Purpose: We report a case outlining the technical aspects and outcome of percutaneous endoscopic sigmoidopexy with T-fasteners in a patient presenting with surgically inoperable sigmoid volvulus.

Case: A 68 year old male with a past medical history of CVA with L hemiplegia, seizure disorder, DM type II, HTN, and dementia presented from a nursing home with two days of constipation, increasing abdominal distension, and diffuse abdominal pain.

Workup revealed a sigmoid volvulus and the patient subsequently underwent flexible sigmoidoscopy with successful detorsion and decompression. The patient developed a recurrent volvulus on hospital day three and underwent repeat sigmoidoscopy for decompression of volvulus. He was deemed to be a very poor operative candidate. Due to his high risk for recurrent volvulus, he underwent endoscopically guided percutaneous sigmoidopexy using T-fasteners. The patient tolerated the procedure well without complications and was discharged in stable condition without recurrence of sigmoid volvulus after 6 months of follow-up.

Conclusion: Percutaneous endoscopic sigmoidopexy is a promising potential alternative to management of volvulus in carefully selected patients who are not surgical candidates. Long-term follow up with a larger treatment group is needed to assess the therapeutic potential and safety of this procedure.

Methods: N/A
Results: N/A
Conclusion: N/A
Endoscopic Mucosal Resection requires an adequate submucosal cushion to enable safe and effective polyp removal. The technique of submucosal injection, when used for epinephrine or sclerosant, required the needle to be stationary. Stationary injection, in turn, produces a flat cushion. In this video, we describe the dynamic injection technique for endoscopic mucosal resection, where the submucosal injection is generated by moving either the needle, the tip of the endoscope, or both, while suctioning the lumen so that the submucosa is tented and rapidly filled with saline.

Methods: We used dual viewing presentation showing the endoscopist, nurse, and endoscopic view to illustrate the proper technique. We included a number of cases. We used saline that was tinted with indigo carmine and 25G sclerotherapy needles. We showed how to maneuver the tip of the endoscope by pushing, pulling, or torquing the endoscope. We also showed how to generate generous submucosal injection by pulling the needle as the submucosa became filled. After the generous submucosal injection, we performed mucosal resection technique using standard stiff snares.

Results: The dynamic submucosal injection technique produces a large submucosal bulge facilitating endoscopic resection.

Conclusion: The dynamic submucosal injection technique is a valuable technique to facilitate safe and effective endoscopic mucosal resection.

AUTH DESIGN: ACG Membership Status <font color="red">*</font>:
Abby Conlin : ACG Non-Member
Roy Soetikno : ACG Member
Tonya Kaltenbach : ACG Member
(No Image Selected)
(no table selected)

AVERAGE SCORE: 5.5

REVIEWER COMMENTS:
Jonathan Buscaglia: [No Comments][Christopher DiMaio: [No Comments][Seth Gross: 5][John Saltzman: [No Comments]
A challenging case of large gastric polyp removal

Purpose: We present a challenging case of large gastric polyp removal, performed at the Center for Advanced Endoscopy, Beth Israel Deaconess Medical Center, Boston

Methods: N/A

Results: A 75-year-old female with persistent nausea and vomiting along with abdominal pain was referred from an outside hospital on an endoscopy finding of a large gastric polyp. Past medical history was significant for hypertension, coronary artery disease, hypothyroidism and hyperlipidemia. The medications included metoprolol, lisinopril, furosemide, levothyroxine and pravastatin.

We repeated an upper endoscopy at the Beth Israel Deaconess Medical Center and noticed a pedunculated polyp which appeared to be 9 cms in size and was prolapsed into the duodenum. We used a grasping forceps to pull the polyp into the stomach. We injected 4 cc of 1:10,000 epinephrine into the polyp. A 25 mm hard snare was used to resect the pedunculated polyp. The settings were zero cut and 18 coag. Three resolution clips were placed prophylactically on the base of the polyp. The resected polyp was retrieved using an endoscopic net. On pathology, the polyp was noted to be an inflammatory fibroid polyp. The patient did well. There were no complications and there was no recurrence of the polyp one year later.

Conclusion: N/A

AUTH DESIG: ACG Membership Status: Saurabh Sethi: ACG Member
Vaibhav Wadhwa: ACG Non-Member
Douglas Pleskow: ACG Member
(No Image Selected)
(Average Selected)

REVIEWER SCORE: 5.75
REVIEWER FLAGS: (none)
REVIEWER RECOMMENDATION CODE DESCRIPTION: None
REVIEWER COMMENTS:
Esophageal Mucosal Bridge In Young Male With Radiation Esophagitis

A 21 year old male with a history of Ewing’s sarcoma of the spine who had completed external beam radiation therapy and was currently receiving adjuvant chemotherapy was seen in the endoscopy suite for scheduled repeat therapeutic esophageal dilation. He had developed dysphagia and odynophagia with weight loss which persisted for months following completion of his radiation therapy. He had undergone TTS balloon dilation two weeks before his presentation. He presented with symptoms of worsening dysphagia and odynophagia which he had prior to his initial dilation. Esophagogastroduodenoscopy (EGD) was performed and showed a stricture 27 cm from the incisors approximately 7-8 mm in diameter. This could only be traversed with an ultra-slim scope. At 29 cm there was a bridge of mucosa extending across the lumen of the esophagus creating the appearance of a double lumen. There was esophagitis in the adjacent mucosa. The bridge was approximately 1 cm in depth. The mucosal bridge was dissected with argon plasma coagulation (APC) utilizing a bronchoscopic APC cannula at 0.3 liters/minute and 20 watts at the point of minimal tissue diameter. The bases of the bridge were then injected with 5 mL of saline mixed with 1 ml of 40 mg/mL triamcinolone in an attempt to reduce recurrence. The proximal stricture was then dilated up to 11 mm. The patient’s odynophagia and dysphagia improved, and he returned for repeat elective EGD 3 weeks days later. The bridge had resolved and the previously noted stricture was again dilated.

Esophageal mucosal bridges are rarely reported in the medical literature. Our limited experience suggests that these lesions can be successfully treated with APC followed by steroid injection at the bases. Other authors have reported success with this method as well.
AVERAGE SCORE: 6.5
REVIEWER FLAGS: (none)
REVIEWER RECOMMENDATION CODE DESCRIPTION: None
REVIEWER COMMENTS:
Jonathan Buscaglia: [No Comments]
Christopher DiMaio: [No Comments]
Seth Gross: 6
John Saltzman: [No Comments]
Purpose: Most upper GI SETs are gastrointestinal stromal tumors (GISTs), which are potentially malignant. Since risk stratification is dependent on size and mitotic rate, evaluation of SETs includes endoscopic sampling via EUS guided FNA or core biopsy, "well" biopsies or methods to remove the overlying mucosa followed by direct tumor sampling. These conventional methods only yield a definitive diagnosis in about 60-70% of cases and do not provide sufficient tissue for mitotic rate assessment. Therefore, NCCN and other guidelines recommend surgical resection of all SETs that are known or suspected GISTs ≥ 2 cm and lifelong endoscopic surveillance of those <2 cm. This approach generates a large burden of surgery and endoscopy for SETs <5 cm the majority of which are low risk. Furthermore, for SETs at the GE junction esophagus or cardia laparoscopic "wedge" resection may be challenging or impossible. Over the past decade enterprising endoscopists mostly from Asia have extended the technique of ESD (endoscopic submucosal dissection) to enucleation of SETs. However, the concern with using ESD to enucleate muscularis propria (MP) based SETs such as GISTs is that microscopic residual tumor may remain in the muscularis propria. Novel superior closure devices and methods have led to development of endoscopic full thickness resection techniques for SETs. Direct transmural endoscopic full thickness resection (EFTR) has been reported by groups in Asia over the past year. Unlike traditional ESD, EFTR can achieve complete en bloc resection of MP-based SETs along with the associated MP thus ensuring R0 curative resection.

Methods: We review the literature and present two cases of complete endoscopic removal of muscularis based SETs in the gastric fundus using EFTR. These two videos represent two cases from our series of EFTR for SETs, including the first such cases reported in the United States.

Results: Complete resection was achieved under deep sedation with short procedure times and no significant adverse events. Primary closure was achieved using an endoscopic suturing device. Histopathological examination revealed very low risk GISTs. No further endoscopic surveillance required.

Conclusion: These techniques represent a NOTES approach to resection of tumors <5 cm. Advantages include: 1. Incisionless approach 2. Wedge resection of SETs in areas that challenge laparoscopic "wedge" resection such as the GE junction, esophagus and gastric cardia. 3. Reliable diagnosis and mitotic rate assessment which along with complete resection obviates lifelong endoscopic surveillance for low risk tumors.
AVERAGE SCORE: 2.33
REVIEWER FLAGS: (none)
REVIEWER RECOMMENDATION CODE DESCRIPTION: None
REVIEWER COMMENTS:
Purpose: Gastrointestinal perforations are conventionally managed surgically. Advancements in endoscopic techniques and complexity of endoscopic procedures have increased the risk of luminal perforations. Co-morbidities and/or advancing age can potentially increase the risk of perforation for low risk procedures. A 61 year old female with history of diabetes mellitus, sarcoidosis on chronic oral steroids presented for esophago-gastro-duodenoscopy for evaluation of dysphagia. Patient was found to have four AVMs in the duodenum which were cauterized using a gold probe. On withdrawing the endoscope a linear 2 cm perforation was identified on the lesser curvature of stomach 5 cm below the gastroesophageal junction. An OTSC (Ovesco 12/6 gc) was applied endoscopically using suction technique to close the defect. Patient remained asymptomatic on recovery from sedation. Post endoscopy CT scan demonstrated large amount of free intraperitoneal air and OTSC on the lesser curvature of stomach. There was no leakage of gastrograffin into the peritoneum. The patient was admitted for observation and kept NPO. A barium upper gastrointestinal series at 48 hours showed OTSC in place without any leakage. Patient was started on regular diet and discharged home. OTSC is an easy to deploy and effective tool for endoscopic closure of selected gastric perforations.

Methods: NA

Results: NA

Conclusion: NA

AUTH DESIG: ACG Membership Status <font color="red">*</font>: 
Shashideep Singhal : ACG Member
Sreedevi Atluri : ACG Member
Kinesh Changela : ACG Member
Mahesh Krishnaiah : ACG Non-Member
Sury Anand : ACG Non-Member
(No Image Selected)

AVERAGE SCORE: 4.25

REVIEWER FLAGS: (none)

REVIEWER RECOMMENDATION CODE DESCRIPTION: None

REVIEWER COMMENTS:
Jonathan Buscaglia: [No Comments]
Christopher DiMaio: [No Comments]
Seth Gross: 5
John Saltzman: [No Comments]
Purpose: A 70 year old male, with history of hypertension, dyslipidemia, and gout presented to the ER for a 2 and ½ week history of dizziness, dyspnea on exertion, and melena. Vital signs were within normal limits, and physical exam was significant for a distended abdomen with a palpable liver edge, and melenic stool during rectal exam. Laboratory values revealed a hemoglobin of 4.9 (compared with a known baseline Hgb of 13.4 two months prior) and transaminitis. An EGD was performed which showed a normal esophagus. Trace blood was noted in the antrum, and blood was seen in the duodenum. However, no active bleeding was seen during endoscopy. CT imaging of the abdomen revealed hepatosplenomegaly with multiple focal and confluent hypodense lesions throughout the liver worrisome for metastatic disease. An MRI showed multiple areas of abnormal enhancement consistent with neoplasm. Further imaging did not reveal a primary lesion or any other evidence of metastasis. With persistent melena and daily blood transfusions, a second endoscopy was performed. Utilizing a side viewing duodenoscope, the second portion of the duodenum was found completely covered in fresh blood. The site of active bleeding was identified to be from the ampulla. The ampulla was irrigated and carefully watched, with fresh blood exiting the ampulla. Interventional radiology was immediately contacted and performed an angiogram with embolization. Angiogram revealed innumerable small hypervascular lesions arising within the mid and right hepatic lobes and a large dominant hypervascular conglomeration near the dome. Successful empiric embolization of the mid liver was performed. A liver biopsy revealed congested hepatic sinusoids filled with blood, but no metastatic carcinoma was identified.

This case represents an obscure cause for gastrointestinal bleeding. As metastatic workup was negative for our patient, our clinical suspicion was high for peliosis hepatis. This is a vascular condition characterized by multiple cystic blood filled lesions throughout the liver parenchyma. It can often be detected during evaluation for abnormal liver tests in an asymptomatic patient, but can also present with painful hepatomegaly, liver failure, jaundice, and hemorrhage. Pathogenesis remains unclear, but likely involves hepatocellular necrosis and injury to the sinusoidal epithelium with subsequent cyst formation. This condition has been associated with pulmonary tuberculosis, renal transplant, AIDS, oral contraceptives, anabolic steroids, and glucocorticoids. There is no specific treatment, however discontinuation of offending agents can lead to the regression of the cystic lesions.

Methods: n/a
Results: n/a
Conclusion: n/a
Michael Walter : ACG Member
(No Image Selected)
(no table selected)

**AVERAGE SCORE:** 5.33

**REVIEWER FLAGS:** (none)

**REVIEWER RECOMMENDATION CODE DESCRIPTION:** None

**REVIEWER COMMENTS:**
Jonathan Buscaglia: [No Comments]
Christopher DiMaio: [No Comments]
Seth Gross: 3
John Saltzman: [No Comments]
Image-guided radiotherapy is a recent technique that allows the delivery of precisely aimed radiation beams to tumors. This technique depends on reference points by which the target lesion can be identified and tracked. Implantation of fiducial markers into the target lesion enables targeting and tracking the location of the tumor. Endoscopic ultrasound (EUS) appears to be an excellent tool to implant fiducials for gastrointestinal (GI) malignancies. It is a minimally invasive approach with real-time visualization, Doppler imaging capability, and ability to access deeper structures within the GI tract. Currently available EUS guided fiducial delivery systems utilize a needle with a single fiducial marker thus requiring multiple needle passes for placement of multiple fiducials. We present a newly, dedicated EUS guided fiducial delivery system that allows for multi-fiducial deployment. We prospectively studied the performance characteristics of this new delivery system in a live porcine model, and found that the system allowed for quick, easy, and accurate fiducial deployment without adverse events. We now present our initial data on the performance characteristics of this novel system in pancreatic cancer patients who require image-guided radiotherapy.

Methods: N/A
Results: N/A
Conclusion: N/A
ABSTRACT BODY:
Purpose: In this video, we demonstrate the first reported case of a migrated cholecystectomy clip into the bile duct after Roux-en-Y gastric bypass. On its own, a migrated cholecystectomy clip is a rare complication after cholecystectomy. Its presentation after roux-en-y gastric bypass is even more unique. In this video, multimodality treatment is used to achieve clinical success.
Methods: N/A
Results: N/A
Conclusion: N/A
Purpose: We report a successful ampullectomy of a partially prolapsing intraductal ampullary adenoma using an improvised endoscopic technique of attaching an adjunctive tube to allow simultaneous passage of a balloon catheter and snare.

Methods: A 78-year-old woman with a history of hypothyroidism was involved in a motor vehicle collision and underwent a CT scan that, incidentally, revealed a 17x20-mm ampullary mass. On ERCP, the ampulla bulged with a soft polypoid tissue mass. FNA showed benign glandular cells. Respecting the patient’s wish to avoid Whipple procedure, we offered an endoscopic approach. The ERCP was performed in the operating room with the patient supine and surgeons on standby for a Whipple surgery. Intraductal tumor extension in the periampullary area was endoscopically seen. The ampulla was cannulated and sphincterotony was performed, taking the cut as high as possible. Segmental resection around the ampulla edges using the hot snare removed the intraduodenal part of the mass.

A sterile hollow accessory tube was then attached to the endoscope. A snare was passed through the endoscope and a balloon catheter through the accessory tube. The snare was looped around the balloon. The balloon catheter tip was manipulated with the snare to cannulate the bile duct, passed over a wire to above the lesion, and then retracted, completely prolapsing the tumor. The looped snare was advanced over the balloon catheter and the entire prolapsed ampullary adenoma, completely resecting it. The resection site was impressive for deep tissue exposure to the level of the muscle fibers with ductal mucosa widely separated from the duodenal mucosa. Pancreatic and bile duct stents were placed. Duodencholedochal clipping was done around the stents, mimicking anastomosis. With no post-procedural complications, she was discharged home after a 24-hour observation period. A three-month follow-up ERCP showed patent ducts and resolution of the previously-observed filling defect from the adenoma intraductal extension. EGD at six months revealed no residual adenomatous growth.

Results: N/A

Conclusion: The only definitive therapy for intraductal ampullary adenoma is complete excision, but they are suboptimal candidates for standard ampullectomy. A custom-added accessory channel allowed successful utilization of two devices to completely excise an intraductal ampullar adenoma without surgical intervention.

CURRENT CATEGORY: N. Endoscopy Video Forum
CURRENT SUB-CATEGORY: None
PRESENTATION TYPE: Video
ACG Research Grant Support: No
Supported by Industry Grant: No
Commercial Products or Services: Yes
Initiated Research: Investigator
Financial Relationships: No
FDA Approval: No
Designed Study: Investigator
Abstract Author: Investigator
AUTH DESIG: ACG Membership Status <font color="red">^</font>: 
Lisa Yoo : ACG Non-Member 
Animat Oluyemi : ACG Member 
Charles Dye : ACG Member 
Kevin Staveley-O'Carroll : ACG Non-Member 
Abraham Mathew : ACG Member
(No Image Selected)
AVERAGE SCORE: 5.75
REVIEWER FLAGS: (none)
REVIEWER RECOMMENDATION CODE DESCRIPTION: None
REVIEWER COMMENTS: