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Treatment of post-EMR duodenal adenoma: a case of unusual recurrence and novel approach

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was preferred because it provides better visualization than a cholangioscope. A 7-mm nodule in the distal duct was revealed (**C**). Although the leading diagnosis was cholangiocarcinoma, the surgical specimen pathology results revealed a benign neuroma of the distal common bile duct without evidence of malignancy (**D**). This demonstrates the first available cholangioscopic image of a bile duct neuroma. The possibility of a bile duct neuroma should remain on the differential diagnosis for soft-tissue lesions of the bile duct in patients who have had biliary surgery.

DISCLOSURE

All authors disclosed no financial relationships relevant to this publication.

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Commentary

Cholangioscopy, once often discussed but rarely performed, has now moved into the mainstream of pancreaticobiliary endoscopy. Early fragile cholangioscopes have been supplanted by modern instruments that are digital as well as durable and even disposable. In addition, many centers have significant experience with the use of ultrathin endoscopes or even standard upper endoscopes to perform even higher-resolution cholangiography. This case nicely demonstrates the power of cholangioscopy. The MRCP images are strongly suggestive of a common bile duct stone, whereas the EUS image shows a very concerning soft-tissue lesion. On cholangioscopy, performed with an upper endoscope, a solid mass lesion was seen. I agree with the authors that most biliary endoscopists would worry that this was a cholangiocarcinoma, and few among us would have considered the true diagnosis of a neuroma in our differential diagnosis. Biliary neuromas and schwannomas have been reported many times in the past and can occur in young and old patients. These lesions can arise de novo or can be secondary to surgical or even traumatic injury. The exact cause of this lesion remains unknown, but the history of surgery and ERCP may suggest that an iatrogenic injury led to this lesion.

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Treatment of post-EMR duodenal adenoma: a case of unusual recurrence and novel approach

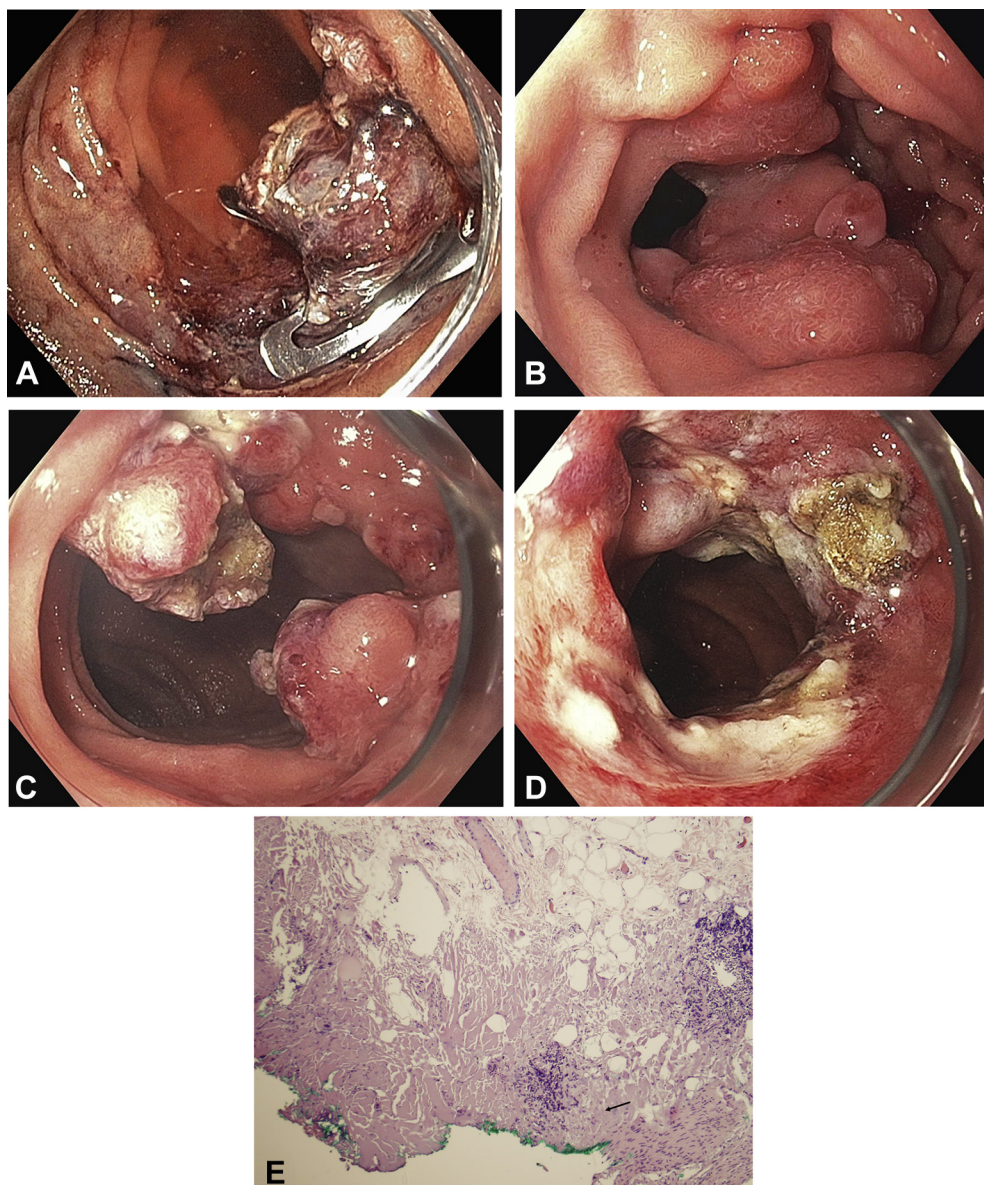


A 65-year-old man underwent EMR of a 3-cm duodenal polyp. Piecemeal EMR was performed, which was complicated by a perforation, but was successfully closed using the over-the-scope clip system (**A**). The patient remained asymptomatic and recovered uneventfully. Pathology showed tubular adenoma. Biopsy specimens from the post-EMR site at 4, 8, 12, and 24 months after the initial EMR were all negative for adenoma. EGD at 3 years after the initial EMR, however, demonstrated granulomatous growth around the clip, and biopsy specimens revealed tubulovillous adenoma with low-grade dysplasia. On repeat EGD 2 months later, the over-the-scope clip was gone, and the polypoid lesion was attached to opposite walls of the duodenum and bridged across the duodenal lumen (**B**). The bridging portion was first divided using a hook

knife (**C** and **D**), separating the lesion into 2 distinct mucosal polyps. These were then removed by standard piecemeal EMR (**D**). Pathology of the resected specimen revealed tubulovillous adenoma with low-grade dysplasia including some muscularis propria (**E**, *arrow*). The clip probably trapped the muscularis during closure, and, eventually, the entrapped tissue developed recurrent adenoma, forming this bridging lesion. EGD 9 months later showed no residual adenoma.

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Commentary

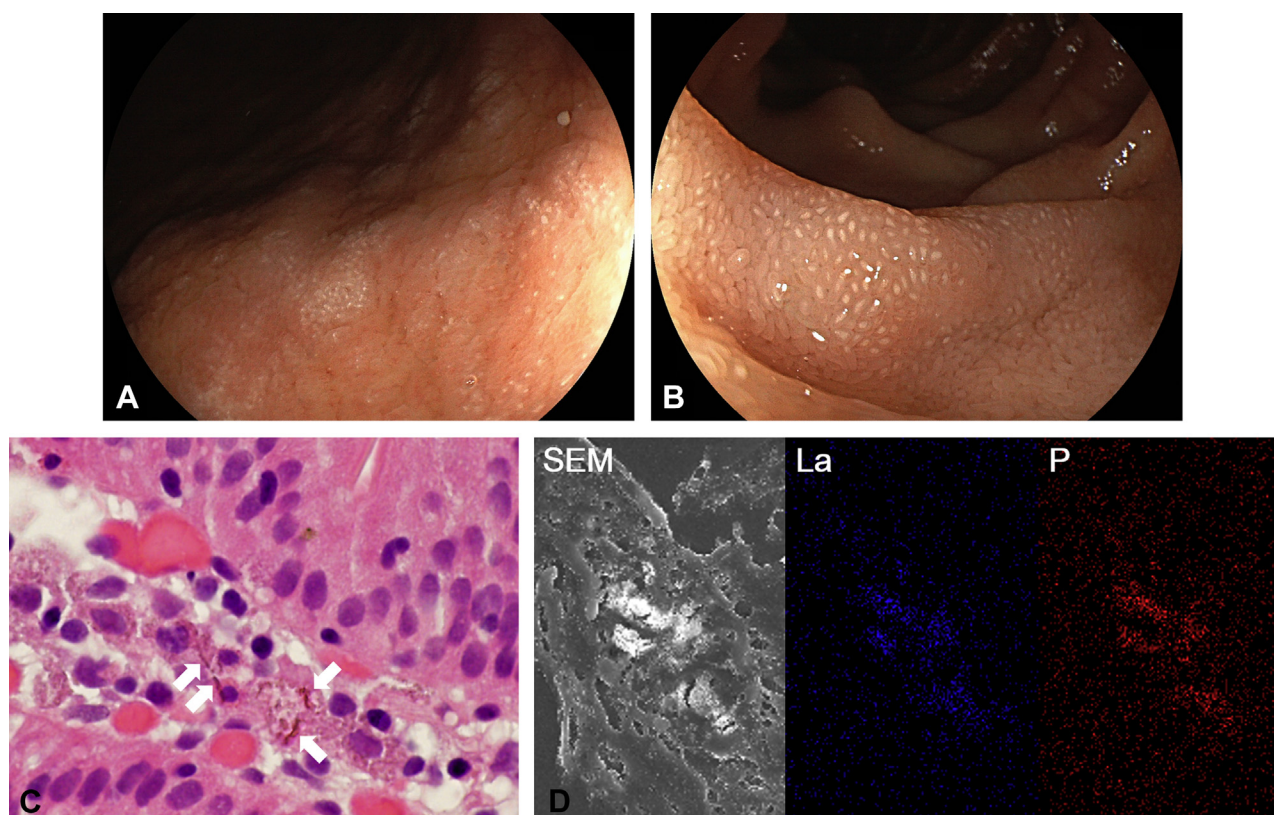
Bridging lesions are rare in endoscopy and can present special challenges for removal. In benign bridging lesions such as this one, the lesion may partially block the lumen and make endoscopic access and removal difficult or even impossible. Furthermore, bridging lesions may sometimes harbor vessels that can be of appreciable size, complicating attempts at resection even further. This case illustrates an atypical bridging lesion that formed out of recurrent tissue left behind after a duodenal polyp was removed by EMR. The authors speculate as to the cause of such a lesion, and it is possible that the over-the-scope clip itself helped to provide a lattice or bridge of sorts for adenomatous tissue to come into contact with the opposite wall and form the lesion. The case also highlights the need for close follow-up on adenomatous lesions of concern

because the recurrence in this case was very late (36 months after initial resection), showing that delayed recurrence even with close follow-up is a very real phenomenon.

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Lanthanum phosphate deposition in the duodenum



A 71-year-old Japanese man on hemodialysis for chronic renal failure underwent EGD screening. He had been taking lanthanum carbonate for 6 years to treat hyperphosphatemia. EGD showed diffuse deposition of white microgranules in the gastric body (**A**). In addition, white villi were observed in the duodenal second portion (**B**). Histologic examination of the duodenal biopsy specimen from the duodenal mucosa showed a fine, amorphous, eosinophilic material (**C**) that was also seen in the gastric mucosa. A diagnosis of lanthanum phosphate deposition in the duodenal and gastric mucosa was

made after analysis by scanning electron microscopy and elemental mapping showing the colocation of lanthanum and phosphate (**D**).

Lanthanum has been considered safe for ingestion because it is negligibly absorbed in the GI tract, and most of it is excreted with the feces. However, in recent years there have been several reported cases of lanthanum deposition in the GI mucosa, mainly in the stomach. To the best of our knowledge, this case is the first report showing endoscopic features of lanthanum phosphate deposition in the duodenum.