UT Southwestern Medical Center

Advanced Endoscopy Case Discussion
The Do and Don’t

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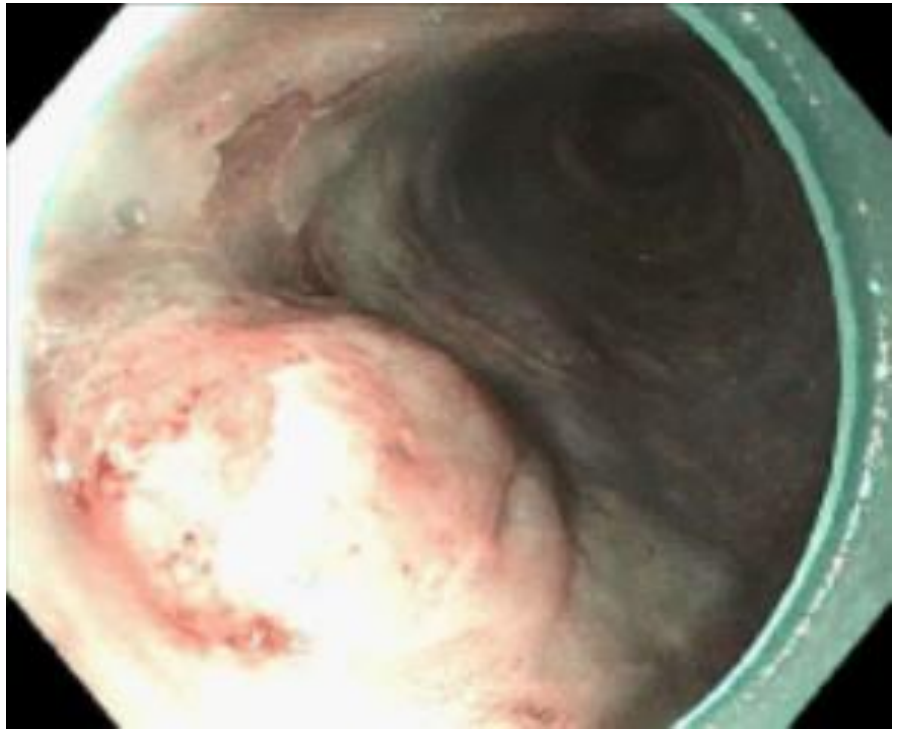
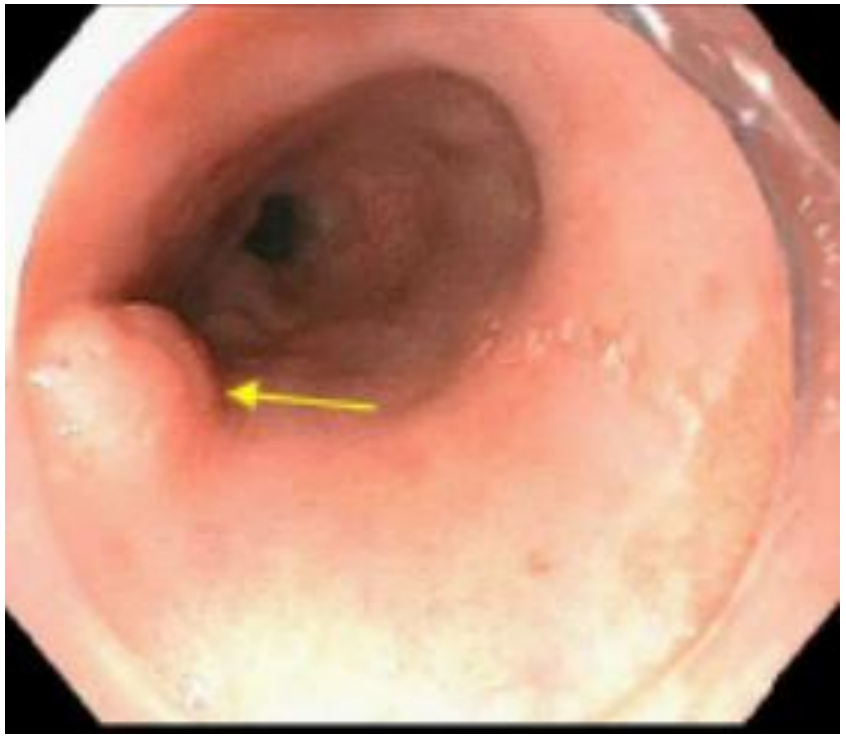
Disclosures

- None

Case # 1

- 60 y/o man with history of obesity who was referred for RFA for BE. He denies any heartburn of dysphagia
- He takes PPI once daily
- Last EGD showed C7M9 segment of BE
- Biopsy showed high-grade dysplasia





3. In individuals with non-dysplastic BE, AGA suggests against the routine use of EET.

4. In patients undergoing EET, AGA suggests resection of visible lesions followed by ablation of the remaining BE segment over resection of the entire BE segment.

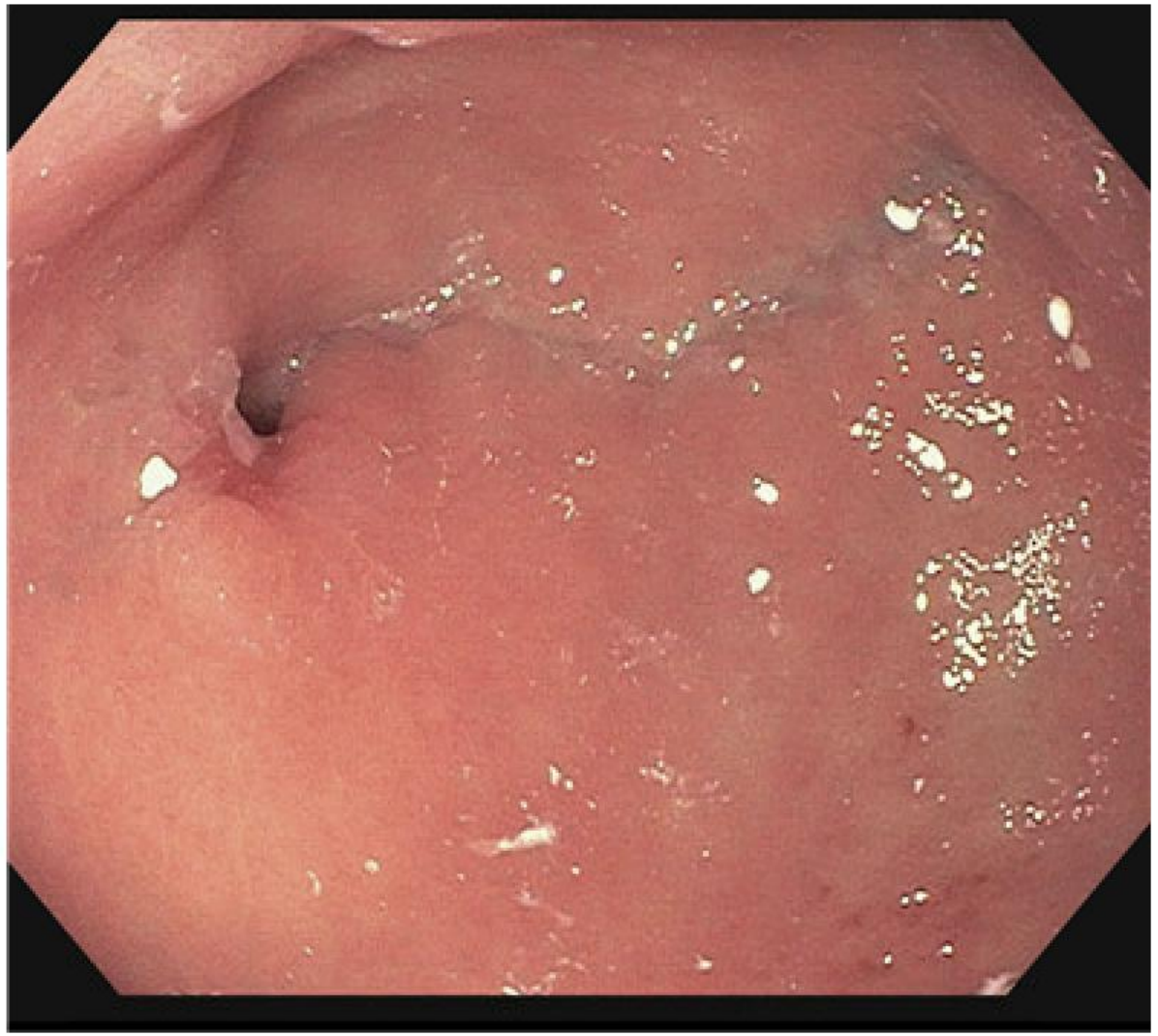
5. In individuals with BE with visible neoplastic lesions that are undergoing endoscopic resection, AGA suggests the use of either endoscopic mucosal resection (EMR) or endoscopic submucosal dissection (ESD) based on lesion characteristics.

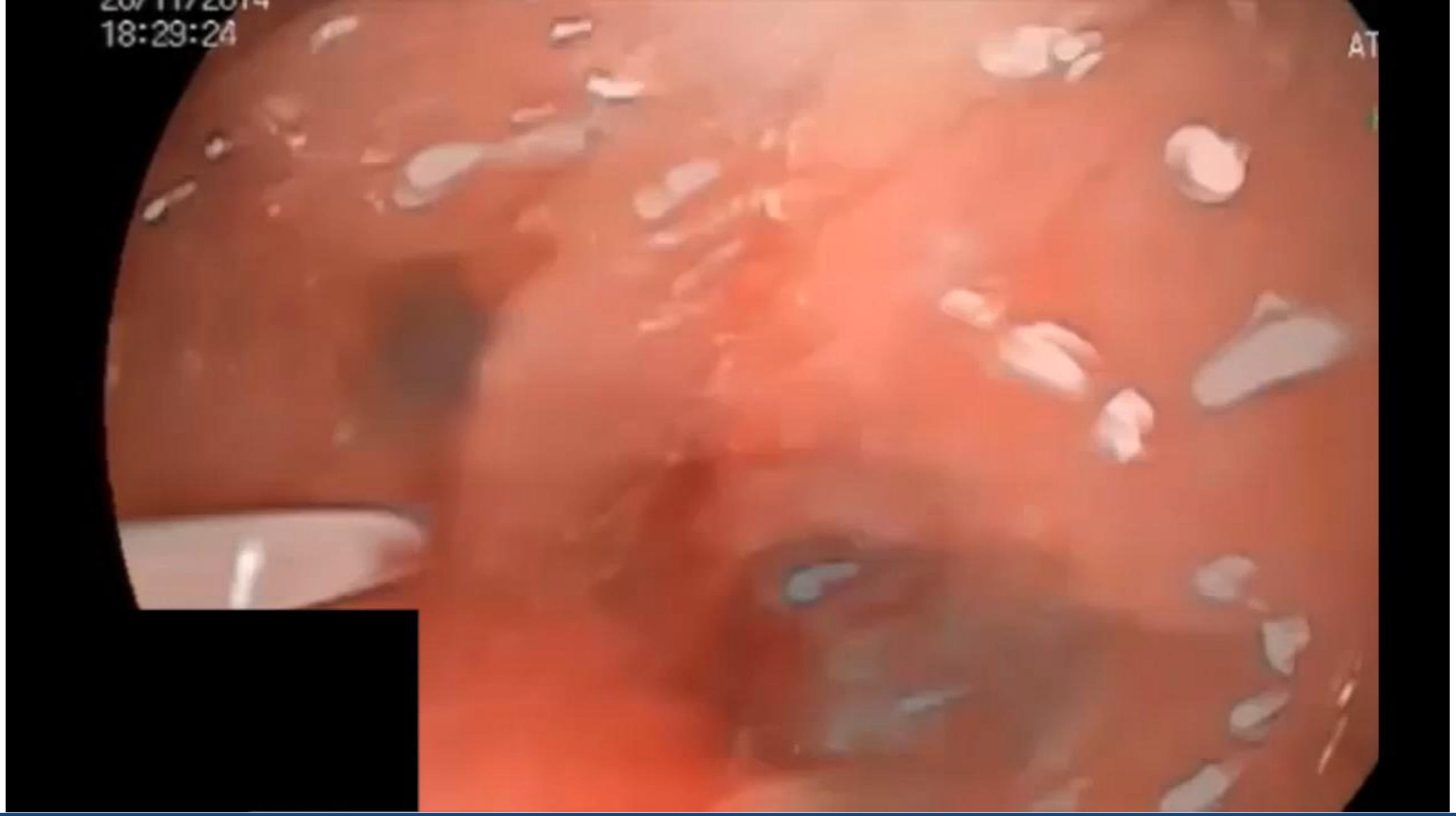
Rubenstein, H and Sawas T. et al. Gastroenterology, Volume 166, Issue 6, 1020 - 1055

Do Not	Do
Ablate visible lesion	Resection then ablation

Case # 2

- 48 yo female with history of RYGB presented with early satiety, nausea and vomiting for 2 months
- Her pre surgical BMI was 45 and her current BMI is 30. She denies weight gain
- She has not been able to tolerate solid food





Uchima et al. VIdeoGIE. 2016

Do Not	Do
Dilate above 15 mm	Stent in severe or refractory
	Remove foreign bodies

Case #3

- 76F with history of diffuse large B cell lymphoma who presented with RUQ pain. Labs revealed elevated WBC 18, Bilirubin 2.3 mg/dl, Alk phos 280 U/L, ALT 69, U/L

CT A

ec

F

Case #3

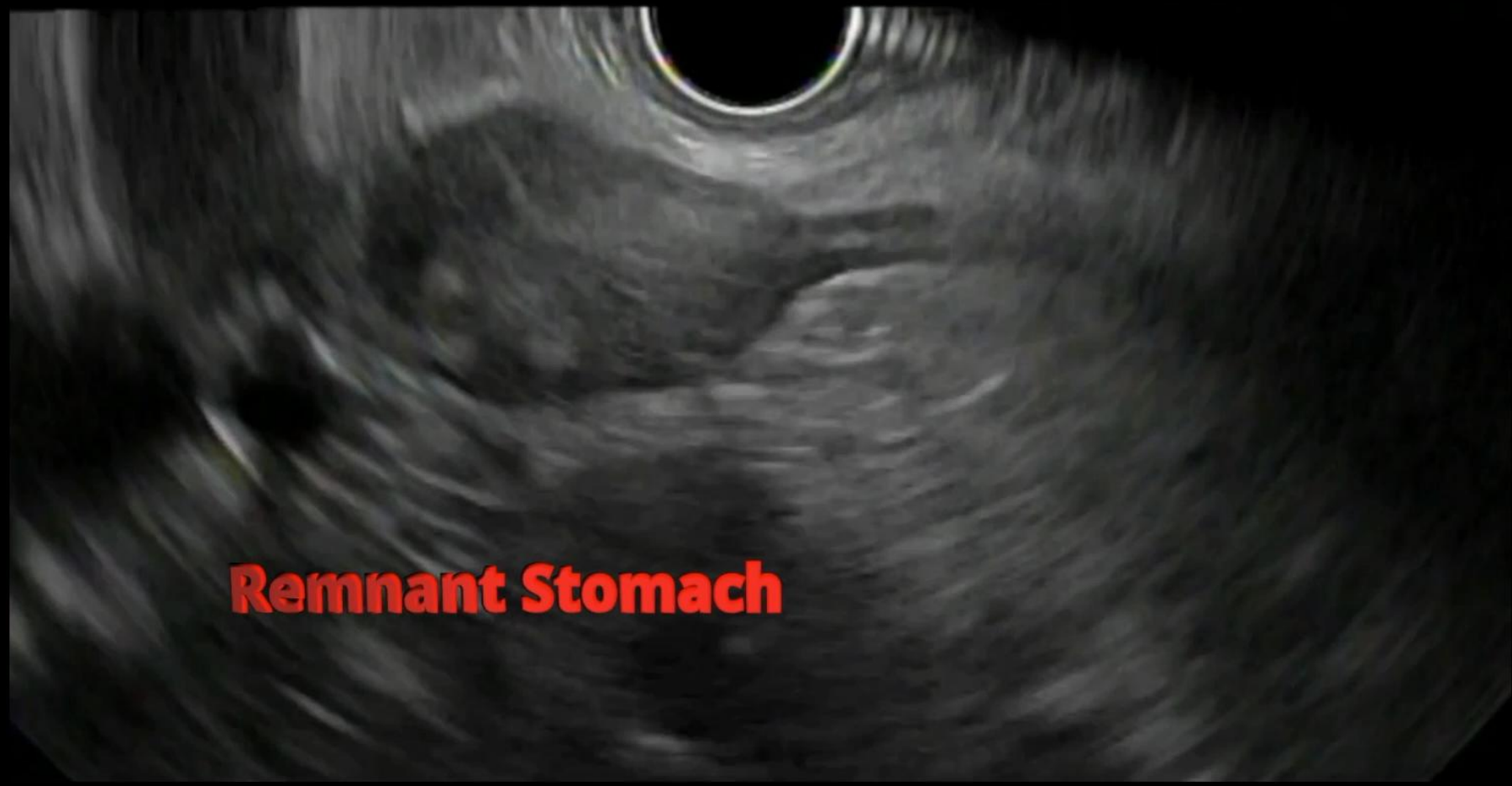
- Evaluated by surgery for consideration of cholecystectomy but felt not to be a surgical candidate due to presence of bulky intra-abdominal lymphadenopathy
- Biliary team was consulted

Do Not	Do
Perform EUS-guided GBD if might become surgical candidate	Trans-cystic stent or IR cholecystostomy

Case # 4

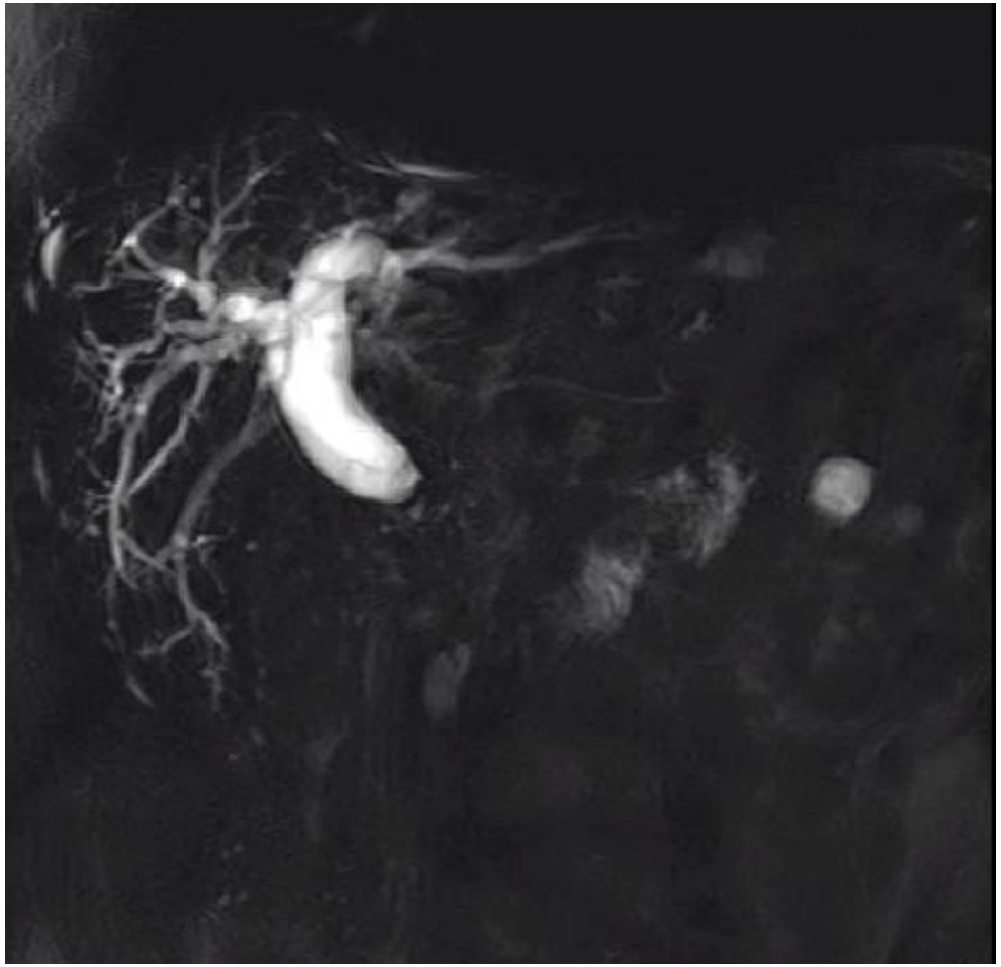
- A 60-year-old man with RYGB who presented with RUQ quadrant abdominal pain, fever and jaundice for 3 days
- Laboratory tests showed normal WBC, alkaline phosphatase 375 U/L and total bilirubin of 4.8 mg/dL, ALT 103 IU/L, AST 85 IU/L
- MRCP showed cholelithiasis with common bile ductal dilation and choledocholithiasis

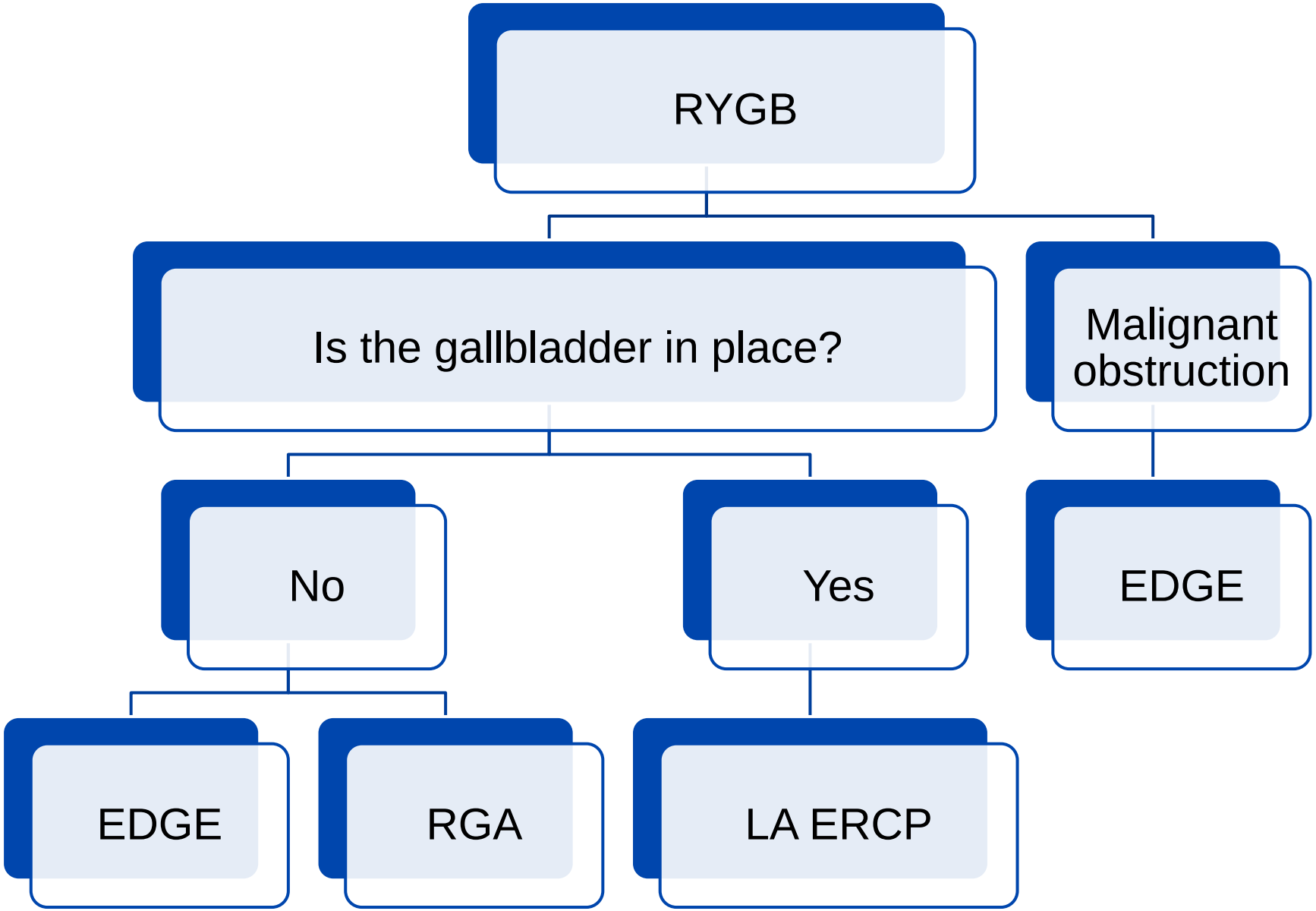
Video



Vallabh et al. VideoGIE 2018

MRCP




RYGB
Is the gallbladder in place?
Malignant obstruction
No
Yes
EDGE
EDGE
RGA
LA ERCP

Do Not	Do
Perform EDGE if gallbladder in place	Intra-operative ERCP if gallbladder in place
	EDGE if gallbladder absent

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Thank you

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