

Neste post estão listados alguns artigos interessantes publicados recentemente nas revistas Endoscopy e Gastrointestinal Endoscopy.

Transpancreatic precut papillotomy versus double-guidewire technique in difficult biliary cannulation: prospective randomized study

Trabalho publicado na Endoscopy em janeiro de 2018 comparando a taxa de sucesso no acesso biliar em pacientes com canulação difícil e cateterização pancreática inadvertida. Foi comparada a técnica de duplo fio guia com a esfínterectomia transpancreática.

Neste estudo, a esfínterectomia transpancreática mostrou uma taxa superior de sucesso no acesso biliar (94% x 59%) em relação à técnica de duplo fio guia, com uma incidência de complicações semelhante.

Abstract

Background and study aims Difficult biliary cannulation and unintentional pancreatic duct cannulation are thought to be important contributors to pancreatitis occurring after endoscopic retrograde cholangiopancreatography. Our aim was to compare and evaluate the rates of success and complications of transpancreatic precut papillotomy (TPPP) and the double-guidewire technique (DGT), both with prophylactic pancreatic stenting.

Patients and methods From April 2011 to March 2014, patients with difficult biliary cannulation, in whom we planned to first position a guidewire in the pancreatic duct, were enrolled, and 68 patients were prospectively randomly allocated to two groups (TPPP 34, DGT 34). We evaluated the rates of success and complications for each group.

Results TPPP had a significantly higher success rate (94.1 %) than DGT (58.8 %). The rate of post-ERCP pancreatitis was 2.9 % in both groups. There was no significant difference between the two groups in the overall rate of complications related to cannulation.

Conclusion If biliary cannulation cannot be achieved, TPPP should be selected first after unintentional pancreatic duct cannulation.

Link para o artigo: [AQUI](#)

Polypectomy for complete endoscopic resection of small colorectal polyps

A melhor técnica para remoção de pequenos pólipos colônicos (<1 cm) ainda não está bem definida. Estas lesões podem ser ressecadas por pinça de biópsia, pinça jumbo, hot biopsy, alça fria ou mucossectomia. As ressecções com pinça devem ser realizadas apenas em lesões menores do que 3 mm. Hot biopsy está associada a uma maior incidência de complicações. Nas lesões entre 5-10 mm, as técnicas de ressecção com alça fria ou mucossectomia parecem ser as mais indicadas.

Neste estudo foi comparada a taxa de ressecção incompleta em pólipos ressecados por alça fria e por mucossectomia, demonstrando uma significativa superioridade da mucossectomia na taxa de ressecção completa destas lesões.

Abstract

Small colorectal polyps are encountered frequently and may be incompletely removed during colonoscopy. The optimal technique for removal of small colorectal polyps is uncertain. The aim of this study was to compare the incomplete resection rate (IRR) by using EMR or cold snare polypectomy (CSP) for the removal of small adenomatous polyps.

Methods: This was a prospective randomized controlled study from a tertiary-care referral center. A total of 358 patients who satisfied the inclusion criteria (polyp sized 6-9 mm) were randomized to the EMR (n =179) and CSP (n =179) groups, and their polyps were treated with conventional EMR or CSP, respectively. After polypectomy, an additional 5 forceps biopsies were performed at the base and margins of polypectomy sites to assess the presence of residual polyp tissue. The EMR and CSP samples were compared to assess the IRR.

Results: Among a total of 525 polyps, 415 (79.0%) were adenomatous polyps, and 41 (16.4%) were advanced adenomas. The overall IRR for adenomatous polyps was significantly higher in the CSP group compared with the EMR group (18/212, 8.5% vs 3/203, 1.5%; $P = .001$). Logistic regression analysis revealed that the CSP procedure was a stronger risk factor for the IRR (odds ratio [OR] 6.924; 95% confidence interval [CI], 2.098-24.393; $P = .003$). In addition, piecemeal resection was the most important risk factor for the IRR (OR 28.696; 95% CI, 3.620-227.497; $P = .001$). The mean procedure time for polypectomy was not significantly different between the EMR and CSP groups (5.5 ± 2.7 vs 4.7 ± 3.4 minutes; $P = .410$). None of these patients presented with delayed bleeding. There were no severe adverse events related to the biopsies.

Conclusions: EMR was significantly superior to CSP for achieving complete endoscopic resection of small colorectal polyps. Patients with piecemeal resection of polyps had a higher risk for incomplete resection.

Link para o artigo: [AQUI](#)

Managing the patient with colorectal adenomas found at an early age

Pequena revisão publicada na Gastrointestinal Endoscopy comentando sobre o aumento da incidência na detecção de lesões colônicas em pacientes jovens e discutindo sobre como acompanhar e orientar estes pacientes. Artigo open access.

Karen Ma, MD, Joshua Melson, MD, MPH

Department of Medicine, Division of Digestive Diseases, Rush University Medical Center, Chicago, Illinois, USA

Abstract

Colorectal cancer (CRC) continues to be the third most common cause of cancer and the second leading cause of cancer mortality in the United States. The incidence of CRC and mortality in individuals over age 50 have both decreased in the setting of colonoscopy screening programs. Alarming, a recent analysis from the National Cancer Institute's Surveillance, Epidemiology, and End Results Program reported that the incidence of CRC is increasing among adults younger than 50 years of age. Colon cancer incidence rates increased by 1.0% to 2.4% annually since the mid-1980s in adults ages 20 to 39 years and by .5% to 1.3% since the mid-1990s in adults ages 40 to 54 years.

Link para o artigo: [AQUI](#)

