

# Duodenal adenomas

## Management

Dr Stratis Alexandridis  
Consultant Gastroenterologist  
BRI

# Introduction

- Ampullary and non ampullary polyps of the duodenum are diagnosed within and outside genetic syndromes.
- Adenomas are the most common encountered lesions although hyperplastic polyps and other mucosal tumours also occur.
- Similar to colonic polyps have malignant potential

# Introduction

- Endoscopic identification of duodenal adenomas can also be hampered by the similarly appearing, adjacent normal villiform duodenal mucosa (false negative results in 15-60 % of patients)
- Endoscopic Resection (ER) is the first line treatment
- Limited resections and Pancreaticoduodenectomy remains as the standard treatment for large and complex adenomas which are technically impossible to remove using endoscopic techniques
- Optimal method of ER depends upon a range of factors including lesion location, size and morphology.

# Epidemiology

- 0.3-4.6% of patients attending Upper GI endoscopy
- Absence of randomised control trials, recommendations based on observational studies and clinical experience.
- Ampullary and non ampullary polyps

# Epidemiology of duodenal polyps associated with genetic syndromes

- 90% of Familial Adenomatous Polyposis (FAP) Syndrome
- cumulative risk of duodenal cancer is 3%-10%
- Spigelman system

Criterion	Points		
	1	2	3
Polyp number	1-4	5-20	>20
Polyp size (mm)	1-4	5-10	>10
Histology	Tubular	Tubulovillous	Villous
Dysplasia	Mild	Moderate	Severe

Stage 0, 0 points; stage I, 1-4 points; stage II, 5-6 points; stage III, 7-8 points; stage IV, 9-12 points.

# Epidemiology of duodenal polyps associated with genetic syndromes

- MUTYH-associated polyposis (MAP)
- Duodenal adenomas -17%-25% of patients with MAP, lifetime duodenal cancer risk 4%

# Ampullary adenomas

- Adenomas: most common benign lesions of the ampulla but with potential to malignant transformation (15-60% of ampullary adenomas harbour foci of adeno ca).
- Sporadic or in the setting of Familial adenomatous syndromes (FAP or MUTYH polyposis)

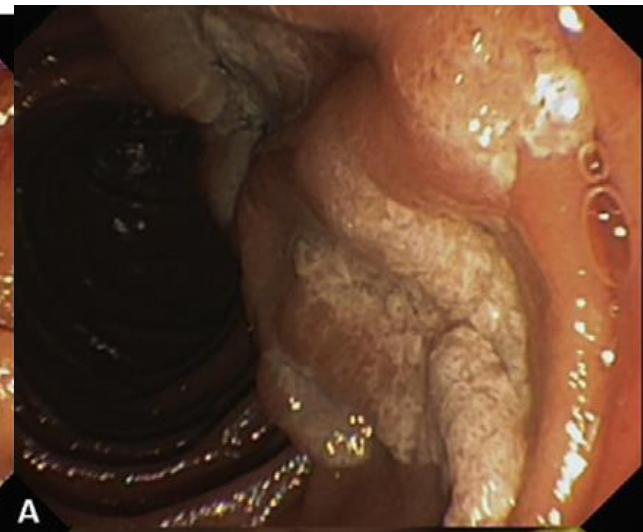
# Ampullary adenomas work up

- Duodenoscopy with a side view scope.
- Preferably HD endoscopy with digital chromoendoscopy (NBI)
- Chromoendoscopy with indigocarmine to identify margins.
- EUS to assess relationship with Common Bile Duct (CBD) and Pancreatic Duct (PD) and intraductal extension (IDE)



# Non Ampullary adenomas

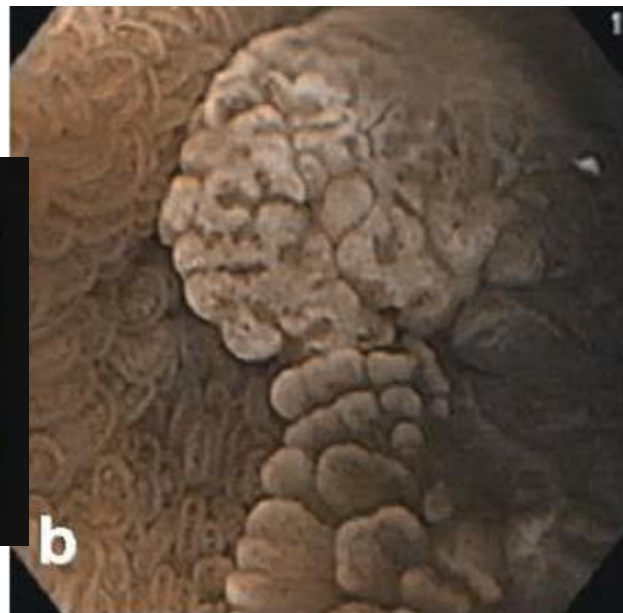
- Duodenoscopy with a straight and or a side view endoscope.
- Preferably HD with NBI.
- Chromoendoscopy with indigocarmine
- EUS assessment is not mandatory.



A



DR. MURRA



b



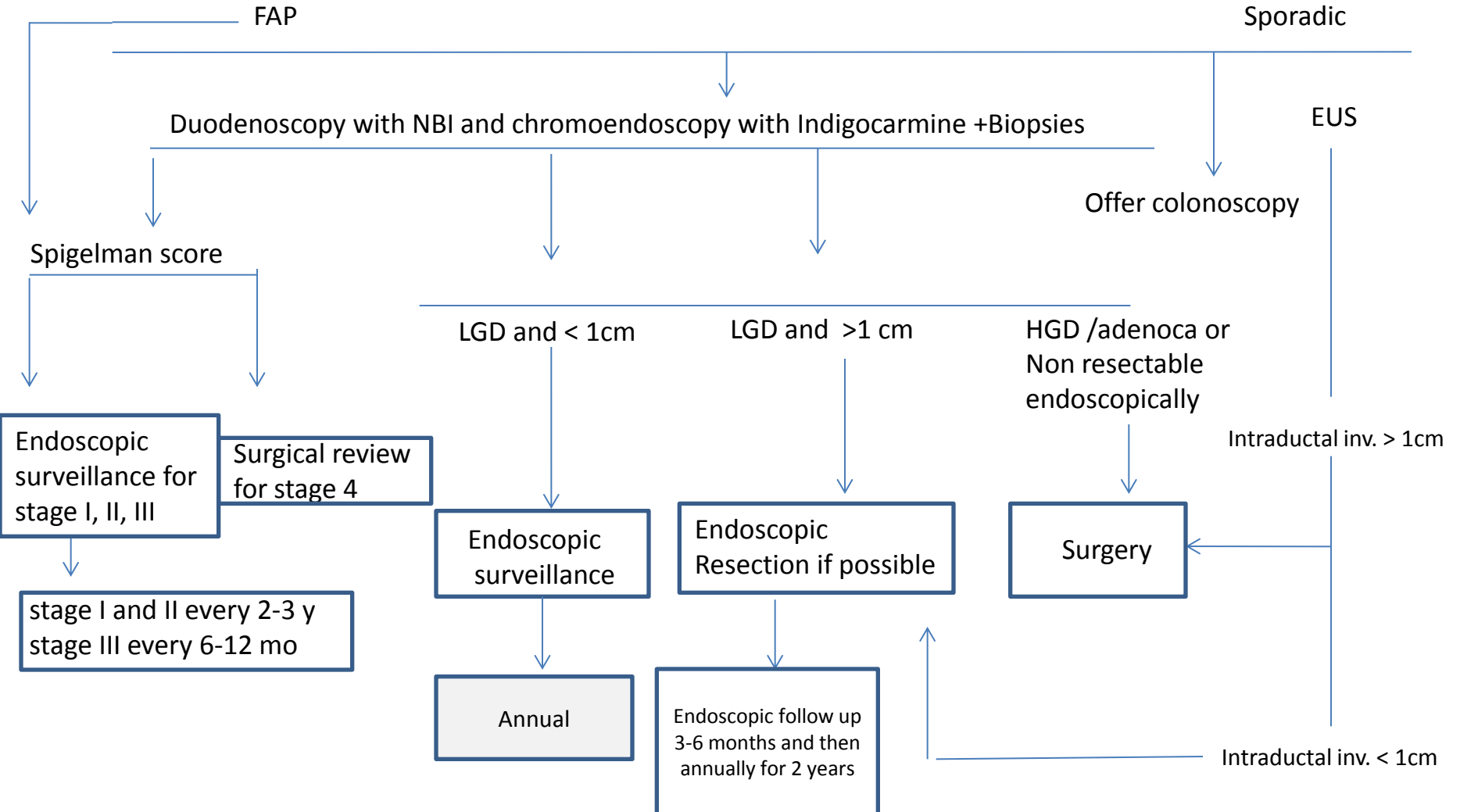
07/04/2010  
14:43:52  
SCV : 29

C: N E: A1  
G: 2.2: 1.0

Switch1 : Freeze  
Switch2 : Zoom  
Switch3 : AFI  
Switch4 : NBI  
CP-H260A1  
Serial No. : 2701834  
Distal End : 13.2  
Insertion Tube : 12.9  
Channel : 3.7

NBI

# Ampullary adenomas



Non Ampullary Adenomas.

