

Endoscopic and/or laparoscopic full-layer resection of gastric ectopic pancreas arising from submucosal and muscular layers



To the Editor:

We read with interest the article by Gong et al¹ on endoscopic submucosal dissection (ESD) of a gastric ectopic pancreas with pancreatitis and pseudocyst. They conservatively managed acute pancreatitis of the ectopic pancreas, but severe inflammation and pseudocyst developed. EUS showed a homogenous hypoechoic lesion with a ductal structure localized in the third (submucosa) and fourth (muscularis propria) echo-layers. Although they performed ESD of the ectopic pancreas and pseudocyst, we believe that their management would be insufficient.

We have described the EUS appearance of an ectopic pancreas characterized by an indistinct margin, heterogeneous appearance, and location within either the third and fourth echo-layers (fusion type) or only in the third echo-layer (separate type).² All lesions of the fusion type were Heinrich type I (all elements of the normal pancreatic tissue); those of the separate type were Heinrich type II (pancreatic tissue without islet cells) or type III (pancreatic ducts only). Because the lesion described by Gong et al¹ was the fusion type, we suspect that the lesion was Heinrich type I.

Most patients with ectopic pancreas are asymptomatic, but nonspecific GI symptoms associated with pancreatitis, cyst formation, jaundice, abscess formation, gastric outlet obstruction, or malignant change have been described.³⁻⁶ When symptomatic lesions were not resected, the patient's symptoms were unchanged.^{5,7} Therefore, symptomatic lesions should be resected.^{2,4-6,8} Although Gong et al¹ performed ESD of the lesion, we believe that residual ectopic pancreas tissue would be present in the muscularis propria.

Endoscopic resection of submucosal tumors arising from the muscular layer is challenging and harbors a significant risk of adverse events.^{9,10} Recently, endoscopic full-thickness resection by the use of an over-the-scope clip, and laparoscopic and endoscopic cooperative surgery by combining laparoscopic resection with ESD, have been devised as minimally invasive alternatives.^{9,10} We therefore recommend full-layer resection, either endoscopically, or laparoscopically, or both, as appropriate management of a Heinrich type I gastric ectopic pancreas.

DISCLOSURE

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REFERENCES

- Gong EJ, Kim do H, Cho CJ, et al. Endoscopic submucosal dissection of ectopic pancreas with pancreatitis and pseudocyst formation. *Gastrointest Endosc* 2015;82:1126.
- Matsushita M, Hajiro K, Okazaki K, et al. Gastric aberrant pancreas: EUS analysis in comparison with the histology. *Gastrointest Endosc* 1999;49:493-7.
- Matsushita M, Hajiro K, Takakuwa H. Acute pancreatitis occurring in gastric aberrant pancreas accompanied by paralytic ileus. *Am J Gastroenterol* 1997;92:2121-2.
- Matsushita M, Takakuwa H, Nishio A. Endosonographic features of gastric adenomyoma, a type of ectopic pancreas. *Endoscopy* 2003;35:621-2.
- Matsushita M, Takakuwa H, Nishio A. Endoscopic removal of gastric ectopic pancreas for histologic diagnosis and treatment. *Gastrointest Endosc* 2002;55:456-8.
- Matsushita M, Takakuwa H, Nishio A. Endoscopic removal of heterotopic pancreas for the relief of symptoms. *Am J Gastroenterol* 2002;97:3205-6.
- Riyaz A, Cohen H. Ectopic pancreas presenting as a submucosal gastric antral tumor that was cystic on EUS. *Gastrointest Endosc* 2001;53:675-7.
- Matsushita M, Hajiro K, Okazaki K, et al. Preoperative histological diagnosis of heterotopic pancreas. *Dig Dis Sci* 1999;44:552.
- Schmidt A, Meier B, Cahyadi O, et al. Duodenal endoscopic full-thickness resection (with video). *Gastrointest Endosc* 2015;82:728-33.
- Matsuda T, Hiki N, Nunobe S, et al. Feasibility of laparoscopic and endoscopic cooperative surgery for gastric submucosal tumors (with video). *Gastrointest Endosc* 2016;84:47-52.

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Colonoscopy adenoma detection rates: Room for cognitive load theory?



To the Editor:

Atkins et al¹ have done wonders in researching the factors responsible for variations in adenoma detection rates. They noted concerns related to which polyps to resect; a need for greater interprofessional teamwork, communication, and leadership; endoscopy room-based