Ente Ospedaliero Cantonale

Giornata di formazione Gruppo Interesse Oncologia Ticino

Tumori gastro-intestinali : attualità e aspetti pratici

Onkologiepflege Schweiz
Soins en Oncologie Suisse
Cure Oncologiche Svizzera

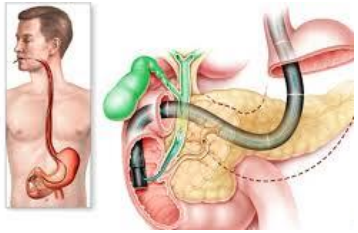
Endoscopia diagnostica e interventistica nelle patologie bilio-pancreatiche

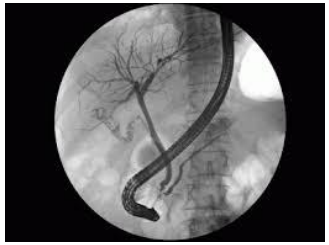
Emanuele Meroni

Gastroenterologo, FMH

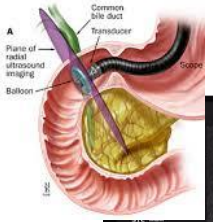
Ospedale Regionale Beata Vergine, Mendrisio

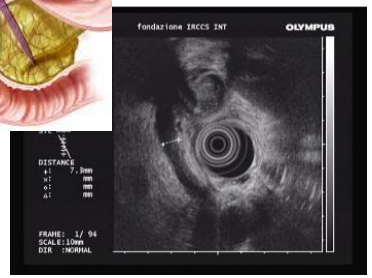
1968 : ERCP diagnostica

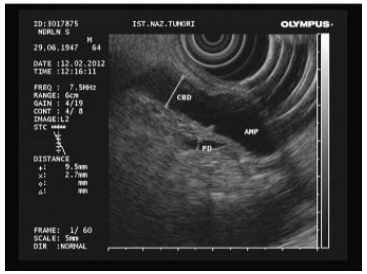




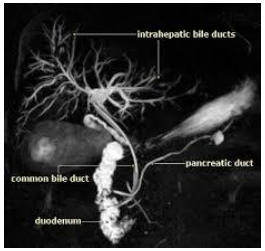
1980 : EUS diagnostica



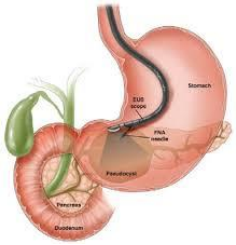


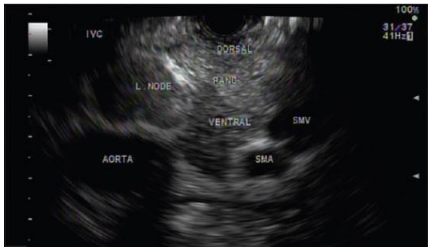


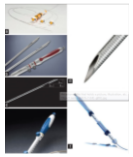
(MRCP)

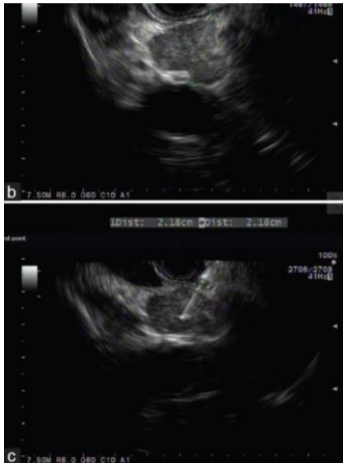


1992 : EUS interventistica

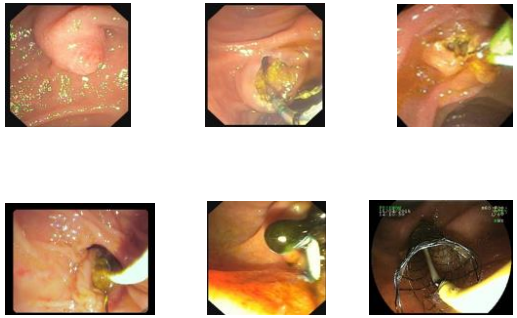








1974 : ERCP interventistica



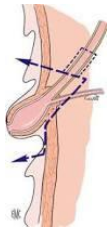
Endosc Ultrasound 2018: 141-160

TABLE 3. Appropriate indications for ERCP[15]

The jaundiced patient suspected of having biliary obstruction (appropriate therapeutic maneuvers should be performed during the procedure)
The patient without jaundice whose clinical and biochemical or imaging data suggest pancreatic duct or biliary tract disease
Evaluation of signs or symptoms suggesting pancreatic malignancy when results of direct imaging (eg, EUS, US, computed tomography [CT], magnetic resonance imaging [MRI]) are equivocal or normal
Evaluation of pancreatitis of unknown etiology
Preoperative evaluation of the patient with chronic pancreatitis and/or pseudocyst Evaluation of the sphincter of Oddi by manometry
Empirical biliary sphincterotomy without sphincter of Oddi manometry is not recommended in patients with suspected type III sphincter of Oddi dysfunction
Endoscopic sphincterotomy: Choledocholithiasis. Papillary stenosis or sphincter of Oddi dysfunction To facilitate placement of biliary stents or dilation of biliary strictures Sump syndrome Choledochocele involving the major papilla Ampullary carcinoma in patients who are not candidates for surgery Facilitate access to the pancreatic duct
Stent placement across benign or malignant strictures, fistulae, postoperative bile leak, or in high-risk patients with large unremovable common duct stones
Dilation of ductal strictures
Balloon dilation of the papilla
Nasobiliary drain placement
Pancreatic pseudocyst drainage in appropriate cases
Tissue sampling from pancreatic or bile ducts
Ampullectomy of adenomatous neoplasms of the major papilla
Therapy of disorders of the biliary and pancreatic ducts
Faciliation of cholangioscopy and/or pancreatoscopy

GASTROINTESTINAL ENDOSCOPY Volume 81, No. 1 : 2015

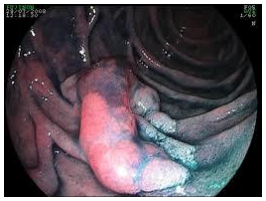
PATOLOGIE "BENIGNE "

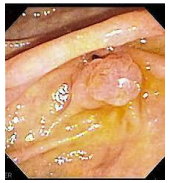


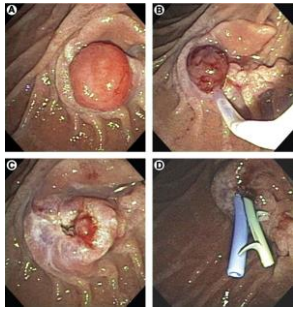
Ampullomi

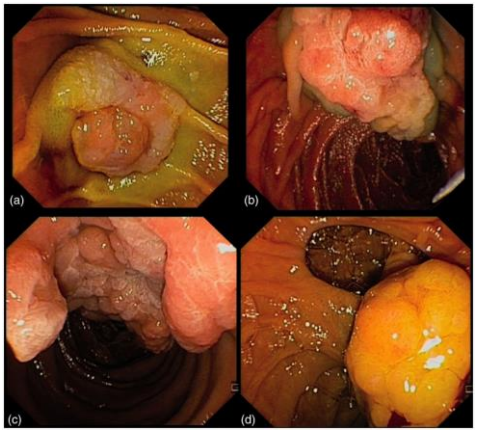
- diagnosi (FAP ?) + bx
- ampullectomia (dopo EUS / IDUS / SpyGlass per valutare estensione intraduttale)
- papillosfinterotomia (PST) e/o stent

ASGE guidelines. *GIE* 2015; 82: 773-780





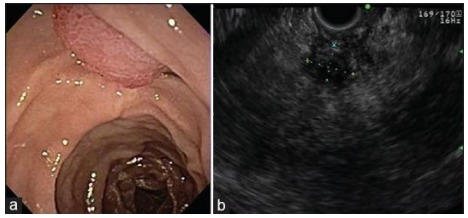




United European Gastroenterology J 2019 : 369-376

Ampullectomia endoscopica se EUS :

- lesione < 2.5 cm
- invasione ≤ 4 mm
- dilatazione PD ≤ 3 mm
- lesione ≤ T1, uN0
- no stent intrapapillare

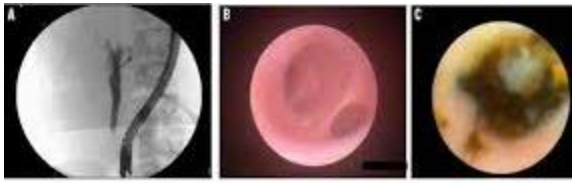


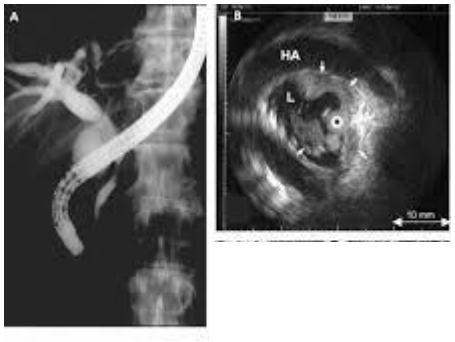
Endosc Ultrasound 2016: 184-188

PATOLOGIE MALIGNE

Neoplasie VBP

- Brushing/bx : sensibilità 18-60%
- Colangioscopia perorale : sens. e spec. ~ 90% per colangioca





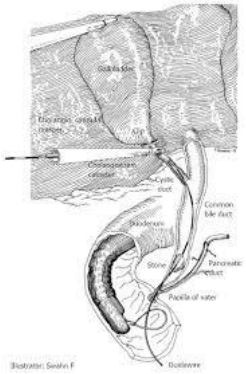
ESGE guidelines for biliary stenting. *Endoscopy* 2012; 44: 277-292

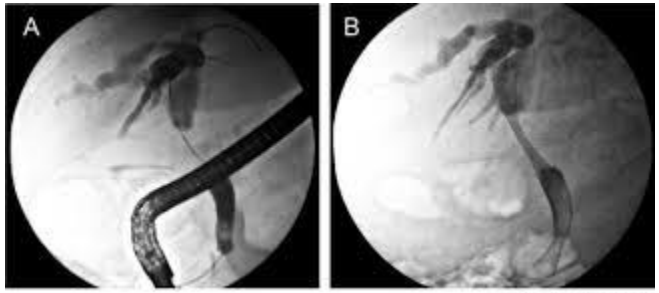
Update in Cochrane Database Syst Rev 2006; 2: CD004200

PATOLOGIE MALIGNE

Neoplasie VBP

- valutare resecabilità pre-ERCP, spt per stenosi ilo (target endoscopico : drenare > 50% del volume epatico)
- se <u>resecabile</u> : drenaggio pre-operatorio in pz (a) candidati a tx neoadiuvanti, (b) con colangite, (c) con ittero/prurito ingravescenti se chirurgia differita
- ⚠ NO EUS-FNA in pazienti candidati a OLT per colangioCA ilare *





ESGE guidelines for biliary stenting. *Endoscopy* 2012; 44: 277-292
Update in Cochrane Database Syst Rev 2006; 2: CD004200
**Clin Gastroenterol Hepatol* 2018

PATOLOGIE MALIGNE

Neoplasie VBP

- se <u>non resecabile</u> : cmq MRCP pre-ERCP per guidare drenaggio endoscopico (rischio colangite) → stent unilaterale efficace come bilaterale, ma con minori complicanze (colangite) e costi
- (PST ±) stent in plastica (polietilene meglio di teflon) vs SEMS : risultati simili a breve termine, scelta personalizzata (costi, prognosi, etc.)*

ESGE guidelines for biliary stenting. *Endoscopy* 2012; 44: 277-292

**Update in Cochrane Database Syst Rev* 2006; 2: CD004200

Ilo epatico ?

6.1.2. Preoperative drainage of malignant hilar strictures

RECOMMENDATION
ESGE suggests against routine preoperative biliary drainage in patients with malignant hilar obstruction. The indication and route for preoperative biliary drainage should be decided by a multidisciplinary team based on patient characteristics and institutional experience.
Weak recommendation, low quality evidence.

Two systematic reviews (11 studies, 711 patients and 9 studies, 892 patients) reported that preoperative biliary drainage of hilar cholangiocarcinoma was associated with a higher postoperative morbidity rate, in particular because of infections, and no significant difference in postoperative mortality [159, 160]. However, many authors have suggested that in specific situations (e.g., cholangitis, predicted future liver remnant volume of ≤ 30% following surgery), preoperative drainage could be indicated [161]. These situations have been associated with a high risk of postoperative liver failure and may thus benefit from portal vein embolization and drainage limited to the future liver remnant segments [162].

6.1.3. Palliative drainage of malignant hilar strictures

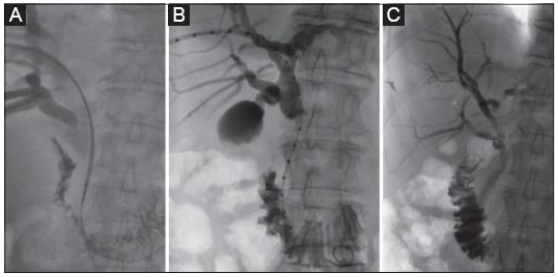
RECOMMENDATION
ESGE suggests palliative drainage of malignant hilar strictures by means of ERCP for Bismuth types I and II, and PTBD or a combination of PTBD and ERCP for Bismuth types III and IV, to be modulated according to local expertise.
Weak recommendation, low quality evidence.

RECOMMENDATION
ESGE suggests, for palliative endoscopic drainage of Bismuth types II–IV strictures, drainage of ≥ 50% of the liver volume and avoidance of the opacification of biliary ducts that will not be drained.
Weak recommendation, low quality evidence.

RECOMMENDATION
ESGE recommends uncovered SEMSs for palliative drainage of malignant hilar obstruction.
Strong recommendation, moderate quality evidence.

Endoscopic biliary stenting: indications, choice of stents, and results: European Society of Gastrointestinal Endoscopy (ESGE) Clinical Guideline – Updated October 2017

ESGE



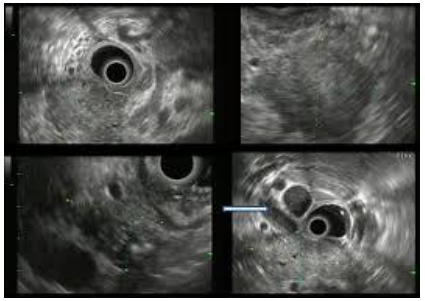
Ann Gastroenterol 2016 : 33-36

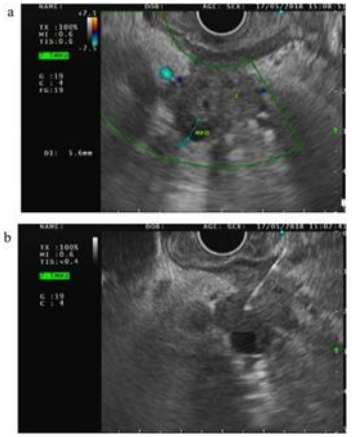
PATOLOGIE MALIGNE

(Neoplasie cistiche pancreatiche)

Neoplasie solide pancreatiche (ADK > NET > linfoma > mts)

- EUS ha sostituito ERCP per la diagnosi + stadiazione di lesioni cefalopancreatiche
- EUS-FNA/FNB : sens. 95%, spec. 100%
- se EUS-FNA non conclusiva : brushing (sens. 15-50%, spec.~ 100%), bx (sens. 50%, spec.~ 100%)
- PET/CT vs EUS : sens. 90.1% vs 81.2%, spec. 80.1% vs 93.2% *





ASGE guidelines. *GIE* 2016: 17-28

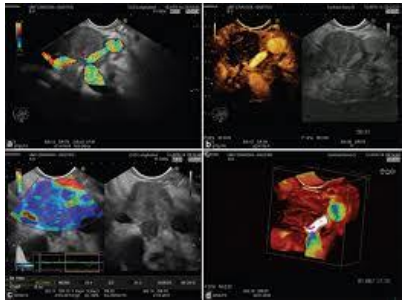
Update in Cochrane Database Syst Rev 2006; 2: CD004200

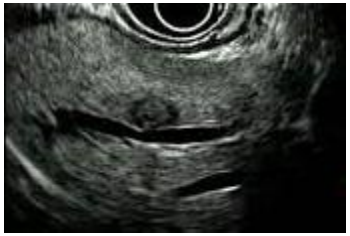
Eur J Radiol 2011: 142-150* **metaanalisi di 51 studi (3857 pz)

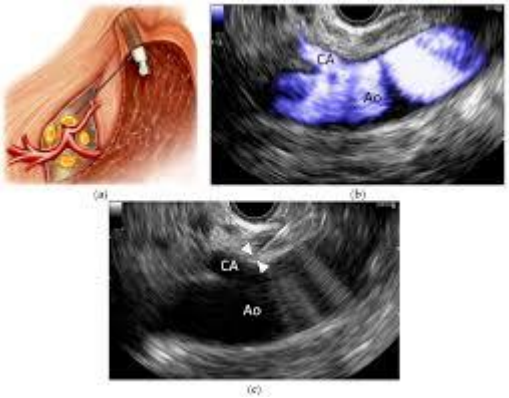
PATOLOGIE MALIGNE

Neoplasie solide pancreatiche

- EUS ± contrasto ± FNA fondamentale per diagnosi e localizzazione di NETs (sens. 82-93%) ; NO ERCP
- EUS per screening in alto rischio per CA pancreatico ?
- EUS per terapia del dolore (neurolisi / RFA) ?







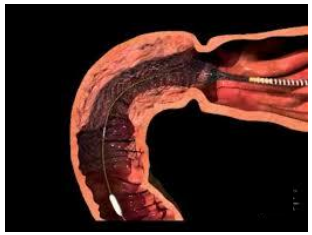
ASGE guidelines. *GIE* 2016; 83: 17-28

Update in Cochrane Database Syst Rev 2006; 2: CD004200

PATOLOGIE MALIGNE

Neoplasie solide pancreatiche

- maggior tasso di eventi avversi post-DCP in pz sottoposti a ERCP pre-operatoria → se npl resecabile : drenaggio endoscopico solo (a) con colangite, (b) quando prurito intenso, (c) se chirurgia non immediata, (d) se programmate chemio/radio neoadiuv.
- ERCP pre-operatoria in pz con ittero ostruttivo da npl resecabile NON è indicata in assenza di colangite (se chirurgia programmabile a breve)
- se npl non resecabile : (PST ±) stent in plastica (polietilene meglio di teflon) vs SEMS risultati simili a breve termine, scelta personalizzata (costi, prognosi, etc.)*
- ERCP + stent biliare è la terapia palliativa di prima scelta in pz sintomatici per npl non resecabile
- ev. associazione con stent gastroduodenale

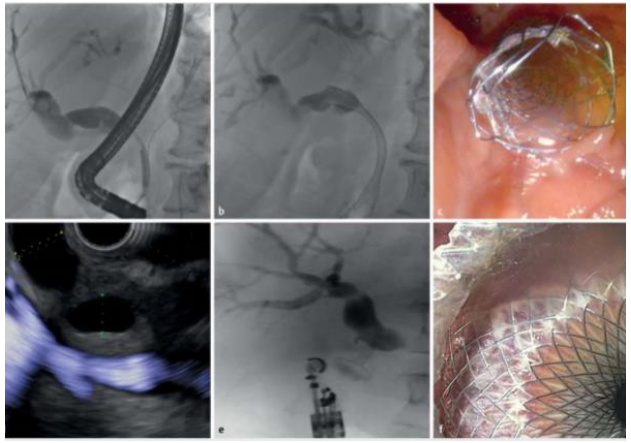


ASGE guidelines. *GIE* 2016; 83: 17-28

**Update in Cochrane Database Syst Rev* 2006; 2: CD004200

PATOLOGIE MALIGNE

Decompressione primaria delle ostruzioni biliari maligne : EUS vs. ERCP



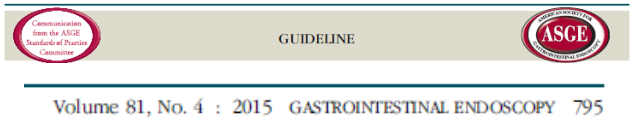
- SEMS transduodenale (EUS-BD) vs SEMS transpapillare (ERCP-BD)
- 5/776 studi inclusi (396 pz)
- Successo clinico globale : RR 0.98
- Complicanze generali : RR 0.84 (ma pancreatite RR 0.22)
- Occlusione stent : RR 0.32
- Re-interventi : RR 0.65

Endoscopy 2019: 950-960

CAVEATS

studio coagulazione :

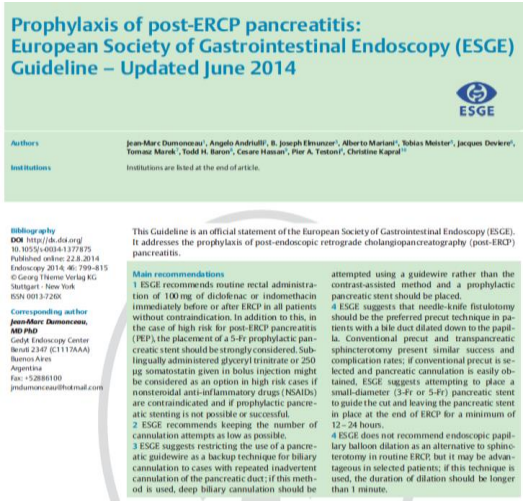
- coagulopatia nota
- terapia anticoagulante
- colestasi prolungata


GUIDELINE

Volume 81, No. 4 : 2015 GASTROINTESTINAL ENDOSCOPY 795

profilassi antibiotica :

- motivi cardiologici
- sospetta ostruzione biliare con possibilità di drenaggio incompleto (inclusa PSC → MRCP pre-ERCP)
- stenosi post-OLT
- fistole biliari


Prophylaxis of post-ERCP pancreatitis: European Society of Gastrointestinal Endoscopy (ESGE) Guideline – Updated June 2014

ESGE

Authors Jean-Marc Dumonceau[1], Angelo Andriulli[2], B. Joseph Elmunzer[3], Alberto Mariani[4], Tobias Meister[5], Jacques Devière[6], Tomasz Marek[7], Todd H. Baron[8], Cesare Hassan[9], Pier A. Testoni[2], Christine Kapral[10]

Institutions Institutions are listed at the end of article.

Bibliography
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This Guideline is an official statement of the European Society of Gastrointestinal Endoscopy (ESGE). It addresses the prophylaxis of post-endoscopic retrograde cholangiopancreatography (post-ERCP) pancreatitis.

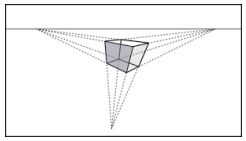
Main recommendations
1 ESGE recommends routine rectal administration of 100 mg of diclofenac or indomethacin immediately before or after ERCP in all patients without contraindication. In addition to this, in the case of high risk for post-ERCP pancreatitis (PEP), the placement of a 5-Fr prophylactic pancreatic stent should be strongly considered. Sublingually administered glyceryl trinitrate or 250 µg somatostatin given in bolus injection might be considered as an option in high risk cases if nonsteroidal anti-inflammatory drugs (NSAIDs) are contraindicated and if prophylactic pancreatic stenting is not possible or successful.
2 ESGE recommends keeping the number of cannulation attempts as low as possible.
3 ESGE suggests restricting the use of a pancreatic guidewire as a backup technique for biliary cannulation to cases with repeated inadvertent cannulation of the pancreatic duct; if this method is used, deep biliary cannulation should be attempted using a guidewire rather than the contrast-assisted method and a prophylactic pancreatic stent should be placed.
4 ESGE suggests that needle-knife fistulotomy should be the preferred precut technique in patients with a bile duct dilated down to the papilla. Conventional precut and transpancreatic sphincterotomy present similar success and complication rates; if conventional precut is selected and pancreatic cannulation is easily obtained, ESGE suggests attempting to place a small-diameter (3-Fr or 5-Fr) pancreatic stent to guide the cut and leaving the pancreatic stent in place at the end of ERCP for a minimum of 12–24 hours.
4 ESGE does not recommend endoscopic papillary balloon dilation as an alternative to sphincterotomy in routine ERCP, but it may be advantageous in selected patients; if this technique is used, the duration of dilation should be longer than 1 minute.

profilassi pancreatite post-ERCP (PEP) :

- cateterismo biliare difficile
- sospetta SOD
- storia di pregressa PEP
- sfinterotomia pancreatica
- dilatazione pneumatica di sfintere biliare intatto
- ampullectomia (papillectomia)

QUALITA' dell'endoscopia

"Performance measures"



- ✓ approccio olistico alla diversità di prospettive (qualità dei processi e delle procedure, outcomes, qualità percepita dagli utenti, qualità dell'organizzazione, etc.)

fasi

- ✓ misure pre-, intra- e post-procedurali

contesto

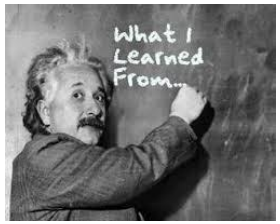
- ✓ misure di struttura : condizioni di erogazione delle prestazioni (volumi di attività, livelli di preparazione del personale, sistemi database, etc.)

azioni

- ✓ misure di processo : attuazione dei protocolli (profilassi antibiotica, campionamento bx in RCU, etc.)

esiti

- ✓ misure di outcome : analisi dei risultati (riduzione delle complicanze procedurali, prevenzione CCR, etc.)



1. conoscenze appropriate
2. *training* (medici e staff) e volumi di attività adeguati
3. requisiti strutturali
4. utilizzare indicatori di qualità
5. monitorare costantemente risultati
6. audit periodici
7. *team work* multidisciplinare

Ente Ospedaliero Cantonale

GRAZIE

Emanuele Meroni

Gastroenterologo, FMH

Ospedale Regionale Beata Vergine, Mendrisio