Endosonography in diagnosing and staging duodenal villous adenoma

T L Tio, L H Sie, P C M Verbeek, L T De Wit, G N J Tytgat

Abstract
Endosonography was carried out in a patient with an extensive juxtapapillary tumour. Radiology and endoscopy were unable to distinguish a villous adenoma from an invasive carcinoma. Endosonography revealed a mucosal hypoechoic tumour without penetration into the submucosa and muscularis propria. The common bile duct, pancreatic duct, and pancreas were normal. Lymph node abnormalities were not found. Based on the endosonography findings, local surgical tumour resection was undertaken instead of a Whipple procedure. The histology of the resected specimen confirmed the endosonography diagnosis.

Villous adenomas in the upper gastrointestinal tract have been increasingly reported probably because of the refinement and increased application of imaging techniques. Endoscopy, however, is not always accurate in diagnosing and staging of extensive villous adenomas because the depth of infiltration of sessile adenomatous proliferation cannot be assessed. Moreover, adequate endoscopic removal of such often extensive lesions is usually difficult, if not impossible.

Endosonography is accurate in diagnosing gastrointestinal abnormalities because of its ability to image the intestinal wall architecture and its surrounding structures in detail.1 The purpose of this case report is to describe the value of endosonography in diagnosing villous adenoma of the duodenum and in planning the strategy of treatment before surgery.

Case report
A 38 year old woman was referred for abdominal discomfort and periodic epigastric pain. Physical
examination revealed no abnormalities. Laboratory investigation was non-diagnostic. Transcutaneous abdominal ultrasound showed a normal liver, gall bladder and pancreas. Upper gastrointestinal radiography revealed an extensive exophytic tumour mass with a nodular appearance of the surface localised in the middle portion of the descending part of the duodenum (Fig 1). As well as a hiatal hernia with some reflux oesophagitis, endoscopy revealed a mass protruding into the duodenal lumen. This mass was covered with a finely nodular mucosa and was located proximal to the major papilla. Endoscopy showed an extensive hypoechoic tumour located at the level of the mucosa without penetration into the adjacent submucosal layer and muscularis propria. No adjacent lymph node abnormality was found. The pancreatic duct, common bile duct and pancreas did not reveal any abnormalities. The tumour was diagnosed as a villous adenoma limited to the mucosa (Figs 2A, B). After consultation with the surgeon a local resection of the tumour was performed to a Whipple resection procedure because the lesion was limited to the mucosa. A longitudinal excision adjacent to the tumour margin was made and tumour resection was carried out as described elsewhere.  

Discussion

Villous adenomas can vary in size and location. Endoscopic biopsies are often inaccurate because specimens are small and not representative of the entire lesion. Endoscopic polyectomy is not always possible particularly in the case of an extensive sessile lesion. Endosonography combines endoscopy and ultrasound in one single instrument (Fig 4), hence taking advantage of assessing the depth of the gastrointestinal tumour by direct endoscopic location and by ultrasonic imaging of the submucosal extent of the target lesion and its surrounding structures. This case report illustrates that endosonography is accurate in diagnosing duodenal sessile villous adenomas, and therefore useful in planning treatment. This is particularly important for juxtapapillary villous adenomas. Minimal invasive surgery has been increasingly reported for the treatment of locally limited tumours in the gastrointestinal tract.  

Minimal invasive surgery requires previous endosonography investigation because submucosal infiltration cannot be assessed during surgery. We therefore believe that endosonography will become the standard diagnostic procedure to identify superficial neoplasias, which can then be removed by a local tumour resection.