snare group in SMSA level 1 (18.51 [SD: 8.26] seconds vs. 23.84 [SD: 15.07] seconds, \( P = 0.013 \)) and in SMSA level 2 (25.03 [SD: 15.32] seconds vs. 29.15 [SD: 24.82] seconds, \( P = 0.009 \)), respectively. (figure 1)

**Conclusions** Colorectal polyps could be removed more efficiently by using rotary snares than traditional snares in SMSA level 1 and SMSA level 2.

**Background** Periampullary diverticulum is an outpouching of the duodenum arising within the radius of 2–3 cm from the ampulla of Vater. It is usually asymptomatic and discovered incidentally during ERCP. The prevalence of this finding widely varies from 1% to 32.8% and its association with pathological conditions has been recognized in various studies. The aim of this study was to evaluate the prevalence of periampullary diverticulum and its association with pancreatobiliary diseases in the studied population.

**Methods** The study group of 2350 patients who underwent ERCP between 2014 and 2018 at the gastroenterology unit of the National Hospital of Sri Lanka was analyzed. The prevalence of patients with periampullary diverticulum was calculated. The demographic features and its association with pancreatobiliary diseases were analyzed in patients with periampullary diverticulum.

**Results** 132 patients with periampullary diverticulum with a mean age of 62 (range 25–89) were identified. Out of 132 patients, 72% were males. The prevalence rate of periampullary diverticulum was 5.6% in the studied population. Successful biliary or pancreatic cannulation was achieved in 97% of patients with periampullary diverticulum. The presence of choledocholithiasis was diagnosed in 73 (55.3%) patients. 13 (9.8%) patients had benign common bile duct stricture and cholangiocarcinoma was found in 11 (8.3%) patients. In addition, a small number of patients had chronic calcified pancreatitis (6, 4.5%) choledochal cyst (4, 3%) pancreatic carcinoma (4, 3%) and ampullary neoplasm (3, 2.3%). However, 14 (10.6%) patients had no structural lesion as a cause for biliary obstruction.

**Conclusions** The prevalence of periampullary diverticulum in our study population is lower than most previous reports. The presence of periampullary diverticulum is found more commonly in the elderly population with male preponderance. A significant association between choledocholithiasis and periampullary diverticulum is observed in this study.

**Background** The most common diseases that cause isolated gastric varices (IGV) are pancreatic diseases, such as pancreatic cancer, pseudocyst, or pancreatitis. In this case, surgical pathology eventually proved to be pancreatic cancer.

**Methods** A 56-year-old man who presented intermittent abdominal pain and abdominal distension was admitted to our hospital. The pain was located in the upper abdomen. These symptoms persist for about a year and become...
increasingly severe and unbearable. But no obvious abnormality was found in physical examination except varicose veins in the lower extremities. His gastroscope found severe gastric varices with a red-color sign and no active bleeding (figure 1.). So what causes the Severe gastric varices? For the isolated gastric varices (IGV), he was first suspected of liver cirrhosis, but he had no medical history of viral hepatitis, and the liver fibrosis determination was normal. Laboratory findings were as follows: white blood cells:5.11*10^9/L; hemoglobin:156g/L; platelets:180*10^9/L; CEA:185ng/ml and CA199:1000.00U/ml. Due to the increase of CA199 and no evidence of liver cirrhosis, we did more examinations. The investigation revealed multiple low-density foci occur in the pancreas on computed axial tomography (CT) of the portal vein (figure 2.). These low-density foci are multiple cystic lesions of the pancreas, with the largest lesions about 1.6 cm in diameter.

Results This patient was taken to the operation. After laparotomy, a 4×5 cm tumor was found in the body of the pancreas (figure 3.). The tumor was hard, adherent to the surrounding tissues, and the para-aortic lymph nodes were enlarged. The general surgical team resection the para-aortic lymph nodes and the freezing results are reported as adenocarcinoma. So they decided to perform distal pancreatectomy and splenectomy. After the operation, the specimens were sent to the pathology examination to be confirmed as moderately/poorly differentiated pancreatic ductal adenocarcinoma, and partly mucinous adenocarcinoma (figure 4.).

Conclusions So we should pay attention to the possibility that IGV may be caused by pancreatic lesions, as well as the possibility of malignant transformation of PCN.