

FIGURE 345-33 Biliary and duodenal self-expanding metal stents (SEMS) for obstruction caused by pancreatic cancer. **A.** Endoscopic retrograde cholangiopancreatography (ERCP) demonstrates a distal bile duct stricture (*arrow*). **B.** A biliary SEMS is placed. **C.** Contrast injection demonstrates a duodenal stricture (*arrow*). **D.** Biliary and duodenal SEMS in place.

whether the benefit of ERCP is mainly attributable to treatment and prevention of ascending cholangitis or to relief of pancreatic ductal obstruction. ERCP is warranted early in the course of gallstone pancreatitis if ascending cholangitis is suspected, especially in a jaundiced patient. Urgent ERCP may also benefit patients predicted to have severe pancreatitis using a clinical index of severity, such as the Glasgow or Ranson score. Because the benefit of ERCP is limited to patients with a retained bile duct stone, a strategy of initial MRCP or EUS for diagnosis decreases the utilization of ERCP in gallstone pancreatitis and improves clinical outcomes by limiting the occurrence of ERCP-related adverse events.



FIGURE 345-34 Sigmoid volvulus with the characteristic radiologic appearance of a “bent inner tube.”

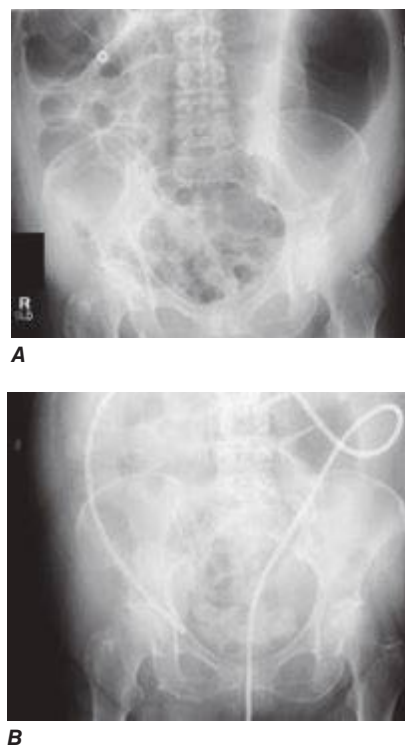


FIGURE 345-35 Acute colonic pseudoobstruction. **A.** Acute colonic dilatation occurring in a patient soon after knee surgery. **B.** Colonoscopic placement of decompression tube with marked improvement in colonic dilatation.

ELECTIVE ENDOSCOPY

DYSPEPSIA

Dyspepsia is a chronic or recurrent burning discomfort or pain in the upper abdomen that may be caused by diverse processes such as gastroesophageal reflux, peptic ulcer disease, and “nonulcer dyspepsia,” a heterogeneous category that includes disorders of motility, sensation, and somatization. Gastric and esophageal malignancies are less common causes of dyspepsia. Careful history-taking allows accurate differential diagnosis of dyspepsia in only about half of patients. In the remainder, endoscopy can be a useful diagnostic tool, especially in patients whose symptoms are not resolved by an empirical trial of symptomatic treatment. Endoscopy should be performed at the outset in patients with dyspepsia and alarm features, such as weight loss or iron-deficiency anemia.

GASTROESOPHAGEAL REFLUX DISEASE (GERD)

When classic symptoms of gastroesophageal reflux are present, such as water brash and substernal heartburn, presumptive diagnosis and empirical treatment are often sufficient. Endoscopy is a sensitive test for diagnosis of esophagitis (Fig. 345-38), but will miss nonerosive reflux disease (NERD) because some patients have symptomatic reflux without esophagitis. The most sensitive test for diagnosis of GERD is 24-h ambulatory pH monitoring. Endoscopy is indicated in patients with reflux symptoms refractory to antisecretory therapy; in those with alarm symptoms, such as dysphagia, weight loss, or gastrointestinal bleeding; and in those with recurrent dyspepsia after treatment that is not clearly due to reflux on clinical grounds alone. Endoscopy should be considered in patients with long-standing (≥ 10 years) GERD, because they have a sixfold increased risk of harboring Barrett’s esophagus compared to a patient with < 1 year of reflux symptoms. Patients with Barrett’s esophagus (Fig. 345-3) generally undergo a surveillance program of periodic endoscopy with biopsies to detect dysplasia or early carcinoma.

Barrett’s Esophagus Barrett’s esophagus is specialized columnar metaplasia that replaces the normal squamous mucosa of the distal esophagus in some persons with GERD. Barrett’s epithelium is a major risk factor