Previously undetected chronic pancreatitis, pancreatic malignancy, or pancreas divisum may be diagnosed by either ERCP or EUS. Sphincter of Oddi dysfunction or stenosis is a potential cause for pancreatitis and can be diagnosed by manometric studies performed during ERCP. Autoimmune pancreatitis may require EUS-guided pancreatic biopsy for histologic diagnosis.

Severe pancreatitis often results in pancreatic fluid collections. Both pseudocysts and areas of walled-off pancreatic necrosis can be drained into the stomach or duodenum endoscopically, using transpapillary and transmural endoscopic techniques. Pancreatic necrosis can be treated by direct endoscopic necrosectomy **(see Video 346e-2)**.

CANCER STAGING

Local staging of esophageal, gastric, pancreatic, bile duct, and rectal cancers can be obtained with EUS (Fig. 345-15). EUS with fine-needle aspiration (Fig. 345-16) currently provides the most accurate preoperative assessment of local tumor and nodal staging, but it does not detect most distant metastases. Details of the local tumor stage can guide treatment decisions including resectability and need for neoadjuvant therapy. EUS with transesophageal needle biopsy may also be used to assess the presence of non-small-cell lung cancer in mediastinal nodes.

OPEN-ACCESS ENDOSCOPY

Direct scheduling of endoscopic procedures by primary care physicians without preceding gastroenterology consultation, or *open-access endoscopy*, is common. When the indications for endoscopy are clear-cut and appropriate, the procedural risks are low, and the patient understands what to expect, open-access endoscopy streamlines patient care and decreases costs.

Patients referred for open-access endoscopy should have a recent history, physical examination, and medication review. A copy of such an evaluation should be available when the patient comes to the endoscopy suite. Patients with unstable cardiovascular or respiratory conditions should not be referred directly for open-access endoscopy. Patients with particular conditions and undergoing certain procedures should be prescribed prophylactic antibiotics prior to endoscopy (Table 345-1). In addition, patients taking anticoagulants and/or antiplatelet drugs may require adjustment of these agents before endoscopy based on the procedure risk for bleeding and condition risk for a thromboembolic event (Table 345-2).

Common indications for open-access EGD include dyspepsia resistant to a trial of appropriate therapy; dysphagia; gastrointestinal bleeding; and persistent anorexia or early satiety. Open-access colonoscopy is often requested in men or postmenopausal women with iron-deficiency anemia, in patients over age 50 with occult blood in the stool, in patients with a previous history of colorectal adenomatous polyps or cancer, and for colorectal cancer screening. Flexible sigmoidoscopy is commonly performed as an open-access procedure.

When patients are referred for open-access colonoscopy, the primary care provider may need to choose a colonic preparation. Commonly used oral preparations include polyethylene glycol lavage solution, with or without citric acid. A "split-dose" regimen improves the quality of colonic preparation. Sodium phosphate purgatives may cause fluid and electrolyte abnormalities and renal toxicity, especially in patients with renal failure or congestive heart failure and those over 70 years of age.