American Society for Gastrointestinal Endoscopy Guideline on the Role of Endoscopy in the Diagnosis and Management of Solid Pancreatic Masses: Summary and Recommendation

Ghady Moafa, MD

Updated evidence-based guidelines from ASGE 2016 guidelines.

Endoscopic Approach

Essential for diagnostic and therapeutic uses including EUS with different tools and ERCP with stunting as well as Rapid on-Site evaluation ROSE.

Pancreatic Cancer

The second most common GI malignancy and the third leading cause of cancer-related death in the United States.

Diagnosis: Endoscopic Ultrasound-Guided Tissue Acquisition (EUS-TA)

- Use a linear Echoendoscope to identify the lesion and to advance the needle into the lesion.
- Use color Doppler to identify and avoid interposing vessels

1 Fine-needle biopsy (FNB) over fine-needle aspiration (FNA) for EUS-TA

Due to:

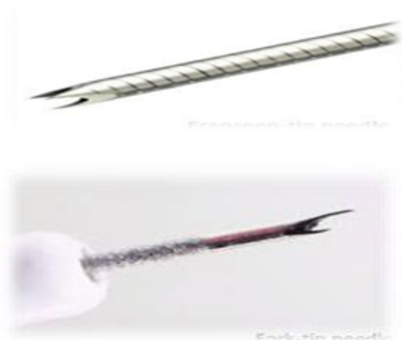
- Superiority in diagnostic accuracy
- Sample adequacy
- Fewer needle passes required
- Higher DNA yield
- Cost of FNB higher than FNA.
- Cost-effectiveness analysis: 2» FNB passes without ROSE were more cost-effective than FNA passes dictated by ROSE

Rating: *Strong recommendation/moderate quality of evidence*

2 Needle Type (Fork-tip/Franseen vs. Alternatives)

- Use novel or contemporary FNB needles over alternative designs
- No differences were found between Fork-tip and Franseen needle in diagnostic accuracy
- Yield higher accuracy and adequacy.

Rating*: strong recommendation/ moderate quality of evidence*



3 Needle Gauge (22G vs 25G)

- Using 22-G needles over 25-G needles
- 22G needles improve the likelihood of obtaining a higher-quality tissue specimen: (total tissue sample >1*10 high-power field in length; number of needle passes; and adverse events)

Rating*: Conditional recommendation/moderate quality of evidence*

A 25-gauge needle may be considered:

- If 22-G is expected to have limited manipulability
- Cannot be advanced into the lesion Anatomical challenges

4 Rapid On-Site Evaluation (ROSE)

Against the routine use of ROSE during the initial EUS-TA of solid pancreatic masses

Rating: conditional recommendation/low quality of evidence

Circumstances to consider ROSE:

- Prior non-diagnostic EUS
- Lesion is not clear on EUS or is obscured by artifact (eg, stent, pancreatitis)
- If preliminary diagnosis may guide immediate decisions (eg, biliary stent selection, celiac plexus neurolysis, management of gastric outlet obstruction)

ASGE Standards of Practice Committee; Machicado JD, Sheth SG, Chalhoub JM, Forbes N, Desai M, Ngamruengphong S, Papachristou GI, Sahai V, Nassour I, Abidi W, Alipour O, Amateau SK, Coelho-Prabhu N, Cosgrove N, Elhanafi SE, Fujii-Lau LL, Kohli DR, Marya NB, Pawa S, Ruan W, Thiruvengadam NR, Thosani NC, Qumseya BJ; ASGE Standards of Practice Committee Chair. American Society for Gastrointestinal Endoscopy guideline on the role of endoscopy in the diagnosis and management of solid pancreatic masses: summary and recommendations. Gastrointest Endosc. 2024 Nov;100(5):786-796. doi: 10.1016/j.gie.2024.06.002. Epub 2024 Oct 9. PMID: 39387777.

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Management of distal malignant biliary obstruction requiring decompression

Pain Management for patient with Unresectable pancreatic cancer

- ✓ First line: Analgesic therapy alone preferred
- ✓ If refractory pain or adverse effects of opioid are not well tolerated:
- ➢ Consider Celiac Plexus Neurolysis CPN
- ➢ ASGE suggests CPN as an adjunct to medical analgesic therapy

***Rating**: conditional recommendation/ low quality of evidence*

CPN associated with:

- ➢ Spinal cord infarction with paralysis (0.2%)
- ➢ Transient diarrhea (9%)
- ➢ Pain exacerbation (8%)
- ➢ Hypotension (6%)

When to consider metal stent?

1. Patients confirmed malignancy and distal biliary obstruction in whom biliary drainage with ERCP is warranted.
2. Patient with biliary obstruction has a pancreatic mass highly suspicious for malignancy and the patient undergoes simultaneous EUS-TA during ERCP.

***Rating:** Conditional recommendation/low quality of evidence*

- ➢ Improved stent patency
- ➢ Reduced risk of complications: (Cholangitis, Stent failure)
- ➢ Less endoscopic re-interventions

- ➢ More expensive
- ➢ More cost-effective in patients with survival > 6 months and in patients without liver metastasis.

When to consider plastic stent?

1. Pancreatic head cancer with liver metastasis or expected survival of <3 months.
2. Patients who have planned surgical resection within 3 months.
3. Pancreatic mass is highly suspicious of malignancy and EUS-TA is not simultaneously performed
4. Low suspicion for malignancy.

Patient with distal biliary obstruction undergoing ERCP with SEMS

Confirmed malignancy?
Suggest using covered over uncovered SEMS

***Rating**: conditional recommendation / low quality of evidence*

Unconfirmed malignancy?
Recommends against uncovered SEMS.

***Rating**: Strong recommendation / low quality of evidence*

Covered (cSEMS) vs. Uncovered (uSEMS)?

Uncovered SEMS

- ➢ uSEMS can be embedded in the bile duct → extremely difficult to remove.
- ➢ uSEMS in patients with resectable tumors: position the stent top below the hilum → for easier biliary dissection and surgical anastomosis in future.

Covered SEMS

- ➢ cSEMS → longer patency
- ➢ Fully covered SEMS minimized interruptions of neoadjuvant chemotherapy due to ↓ risk of stent occlusion

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