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EXPERT RECOMMENDATIONS

- 2893 Recommendations for perinatal and neonatal surgical management during the COVID-19 pandemic
Ma LS, Zhao YL, Wei YD, Liu C

MINIREVIEWS

- 2902 Clinical applicability of gastroscopy with narrow-band imaging for the diagnosis of *Helicobacter pylori* gastritis, precancerous gastric lesion, and neoplasia
Cho JH, Jeon SR, Jin SY

ORIGINAL ARTICLE**Clinical and Translational Research**

- 2917 Identification of *APEX2* as an oncogene in liver cancer
Zheng R, Zhu HL, Hu BR, Ruan XJ, Cai HJ

Retrospective Cohort Study

- 2930 Restenosis after recanalization for Budd-Chiari syndrome: Management and long-term results of 60 patients
Zhang W, Tian YL, Wang QZ, Chen XW, Li QY, Han JH, Chen XD, Xu K

Retrospective Study

- 2942 Comparison of microendoscopic discectomy and open discectomy for single-segment lumbar disc herniation
Pang JY, Tan F, Chen WW, Li CH, Dou SP, Guo JR, Zhao LY
- 2950 Clinical characteristics of patients with COVID-19 presenting with gastrointestinal symptoms as initial symptoms: Retrospective case series
Yang TY, Li YC, Wang SC, Dai QQ, Jiang XS, Zuo S, Jia L, Zheng JB, Wang HL

Observational Study

- 2959 Effects of policies and containment measures on control of COVID-19 epidemic in Chongqing
Liang XH, Tang X, Luo YT, Zhang M, Feng ZP
- 2977 Role of shear wave elastography in the evaluation of the treatment and prognosis of supraspinatus tendinitis
Zhou J, Yang DB, Wang J, Li HZ, Wang YC
- 2988 Endoscopic retrograde cholangiopancreatography in elderly patients: Difficult cannulation and adverse events
Tabak F, Wang HS, Li QP, Ge XX, Wang F, Ji GZ, Miao L

- 3000** Diagnostic value of orbicularis oculi muscle electromyography in functional epiphora

Lu H, Liu PD, Yao X, Wang ZF, Gao LF, Wang SP

META-ANALYSIS

- 3006** Diagnostic value of liquid-based cytology and smear cytology in pancreatic endoscopic ultrasound-guided fine needle aspiration: A meta-analysis

Pan HH, Zhou XX, Zhao F, Chen HY, Zhang Y

SCIENTOMETRICS

- 3021** Bibliometric analysis of randomized controlled trials of colorectal cancer over the last decade

Wang CY, Zhou SC, Li XW, Li BH, Zhang JJ, Ge Z, Zhang Q, Hu JH

CASE REPORT

- 3031** Spontaneous pneumothorax in a single lung transplant recipient-a blessing in disguise: A case report

Deshwal H, Ghosh S, Hogan K, Akindipe O, Lane CR, Mehta AC

- 3039** Endoscopic third ventriculostomy in obstructive hydrocephalus: A case report and analysis of operative technique

Munda M, Spazzapan P, Bosnjak R, Velnar T

- 3050** Underwater endoscopic mucosal resection for neoplasms in the pyloric ring of the stomach: Four case reports

Kim DH, Park SY, Park CH, Kim HS, Choi SK

- 3057** Successful treatment of basaloid squamous cell carcinoma in the rectosigmoid colon: A case report and review of literature

Lee TG, Yoon SM, Kim MJ

- 3064** Synchronous sporadic bilateral multiple chromophobe renal cell carcinoma accompanied by a clear cell carcinoma and a cyst: A case report

Yang F, Zhao ZC, Hu AJ, Sun PF, Zhang B, Yu MC, Wang J

- 3074** Intra-abdominal hemorrhage during pregnancy: Four case reports

Yang L, Liu N, Long Y

- 3082** Pulmonary benign metastasizing leiomyoma: A case report and review of the literature

Dai HY, Guo SL, Shen J, Yang L

- 3090** Mucoepidermoid carcinoma in the infratemporal fossa: A case report

Zhang HY, Yang HY

- 3097** Intra-abdominal inflammatory pseudotumor-like follicular dendritic cell sarcoma associated with paraneoplastic pemphigus: A case report and review of the literature

Zhuang JY, Zhang FF, Li QW, Chen YF

- 3108** Multiple recurrent cystic echinococcosis with abdominal aortic involvement: A case report
Taxifulati N, Yang XA, Zhang XF, Aini A, Abulizi A, Ma X, Abulati A, Wang F, Xu K, Aji T, Shao YM, Ahan A
- 3114** Dental focal infection-induced ventricular and spinal canal empyema: A case report
Xue H, Wang XH, Shi L, Wei Q, Zhang YM, Yang HF
- 3122** Effect of chidamide on treating hepatosplenic T-cell lymphoma: A case report
Wang XT, Guo W, Sun M, Han W, Du ZH, Wang XX, Du BB, Bai O
- 3130** Acute esophageal obstruction caused by reverse migration of gastric bezoars: A case report
Zhang FH, Ding XP, Zhang JH, Miao LS, Bai LY, Ge HL, Zhou YN

ABOUT COVER

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AIMS AND SCOPE

The primary aim of *World Journal of Clinical Cases* (*WJCC*, *World J Clin Cases*) is to provide scholars and readers from various fields of clinical medicine with a platform to publish high-quality clinical research articles and communicate their research findings online.

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Underwater endoscopic mucosal resection for neoplasms in the pyloric ring of the stomach: Four case reports

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Abstract

BACKGROUND

Tumors located in the pylorus are technically more complex to resect by endoscopic resection, as the anatomical characteristics of this region can affect the adequate assessment of margins and performance of the procedure. We reported the results of underwater endoscopic mucosal resection (UEMR) of benign mucosal neoplasms located in the pyloric ring.

CASE SUMMARY

This case series describes 4 patients with 4 mucosal neoplasms located in the pyloric ring. The diameter of each neoplasm was less than 15 mm. We performed UEMR for the lesions. Water immersion enabled slight floating of the lesions, resulting in easy identification. We achieved en bloc resection with a snare and electrocautery unit. All procedure were performed within 3 min without adverse events. Pathologic examination showed low-grade dysplasia with clear resection margins in one case and hyperplastic polyps in three cases.

CONCLUSION

UEMR can be an effective and safe treatment method for neoplasms in the gastric pyloric ring.

Key words: Duodenoscopy; Endoscopic mucosal resection; Neoplasm; Pylorus; Stomach; Case report

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Core tip: We present four patients who underwent underwater endoscopic mucosal resection (UEMR) for the resection of neoplasms in the pyloric ring. UEMR for neoplasms

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in the pyloric ring has benefits similar to those of UEMR for colonic neoplasms: (1) Superficial lesions float into the snare as protruding lesions in underwater conditions; (2) UEMR decreases thermal damage; (3) Submucosal vessels usually remain within the resection wound, as the resection plane is superficial; and (4) The pyloric narrow lumen is constantly distended, retaining enough working space. Our case series suggested the potential of UEMR for treating neoplasms in the pyloric ring.

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INTRODUCTION

Performing endoscopic resection for tumors located in the pyloric ring is technically more difficult, as the anatomical characteristics of this region can affect the adequate assessment of margins and the working space for the procedure. Moreover, peristaltic movements of the peripyloric muscles are aggravated by submucosal injection or thermal stimuli during endoscopic procedures, preventing meticulous dissection of the lesion. These technical difficulties may be associated with incomplete resection of tumors and an increase in local recurrence and adverse events. Recently, underwater endoscopic mucosal resection (UEMR) was suggested by Binmoeller *et al*^[1], which has been used in the treatment of challenging lesions in the duodenum and colorectum near the appendiceal orifice and dentate line; UEMR has shown good treatment results with a high complete resection rate and low adverse event rate^[2-5]. UEMR has also been adapted for recurrent or residual lesions after endoscopic resection^[6,7]. Here, we reported our experience of using UEMR for benign mucosal neoplasms located in the pyloric ring. To our knowledge, it is the first report on the effectiveness of UEMR for tumors in the pyloric ring.

CASE PRESENTATION

Chief complaints

Gastric neoplasms on pyloric ring.

History of present illness

Four patients diagnosed with gastric neoplasms on pyloric ring through screening endoscopy.

History of past illness

All four patients had no underlying disease that could promote bleeding or medications to promote bleeding.

Physical examination upon admission

All patients had no abnormal findings on physical examination.

Laboratory examinations

In all patients, hemoglobin level, platelet count, activated partial thromboplastin time, and prothrombin time were all within normal range.

Process of performing underwater endoscopic mucosal resection

We performed UEMR for 4 patients with 4 mucosal neoplasms located in the pyloric ring. For moderate sedation, balanced sedation was performed in case 1, 3 and 4. Patients received initial intravenous induction of 25 mg pethidine and 0.05 mg/kg midazolam. After 2 min, intravenous propofol (10-20 mg increments) was given repetitively, to achieve an adequate sedation level. In case 2, the endoscopic procedure was consciously performed with an initial intravenous bolus administration of 25 mg

pethidine. We used cap-assisted duodenoscopy with narrow-band imaging and a water jet pump device (GIF HQ290, Olympus). All endoscopic procedures were performed with the patient in the left lateral decubitus position. The stomach and the duodenal bulb were initially collapsed by aspiration, followed by instillation of 200–400 mL of water into the antrum and duodenal bulb. After performing UEMR, we removed instilled water as soon as possible to reduce the risk of aspiration pneumonia. The diameter of each neoplasm was less than 15 mm. We achieved *en bloc* resection with a crescent-type snare (Olympus device) and electrosurgical unit (VAIO 300D, ERBE Co. Ltd., Tübingen, Germany) with a high-frequency generator in all 4 patients. The settings of the VAIO 300D were as follows: Endocut-Q, effect 2, incision time 3, and incision interval 5. In a 48-year-old woman (Case No. 1), a 10-mm sized Yamada type III polyp on the pyloric ring of the stomach could not be entirely visualized using forward-viewing endoscopes (Figure 1). However, water infusion enabled slight floating of the lesion, and it was easily identified and grasped using a snare. A 64-year-old woman (Case No. 2) presented with a 7-mm sized Yamada type II polyp on the pyloric ring of the stomach. UEMR was performed in the same way as in the first case. In a 50-year-old man (Case No. 3), water infusion enabled slight floating of the lesion, and it was easily grasped using a snare (Figure 2). Finally, in a 60-year-old woman (Case No. 4), a 10-mm sized Yamada type II polyp was successfully removed by UEMR. All procedures were performed within 3 min without adverse events. Pathologic examination showed low-grade dysplasia with a clear resection margin in Case No. 3 and hyperplastic polyps in the other three cases (Table 1).

FINAL DIAGNOSIS

Mucosal neoplasm in the pyloric ring of the stomach.

TREATMENT

Underwater endoscopic mucosal resection.

OUTCOME AND FOLLOW-UP

UEMR was successfully performed within 3 min without adverse events in 4 patients with a mucosal neoplasm in the pyloric ring. All patients were discharged without any adverse events after the procedure.

DISCUSSION

It is difficult to achieve complete resection of tumors located in the pyloric ring using conventional endoscopic mucosal resection (EMR) or endoscopic submucosal dissection (ESD) due to limited working space, incomplete visualization using forward-viewing endoscopes, and peristaltic contractions of the lesion. These technical difficulties may lead to an increase in local recurrence^[8]. To overcome incomplete visualization of the entire tumor or to determine the distal tumor margin, retroflexion maneuvers in the duodenum are suggested for the management of tumors in the pyloric ring. Another option is transnasal endoscope-assisted endoscopic resection, which enables submucosal tissue retraction to visualize the cutting line and increase the rate of complete resection^[8–10]. However, these techniques need highly advanced endoscopic skills and facilities.

Our case series suggested the potential of UEMR for the treatment of neoplasms located in the pyloric ring. UEMR, with a relative short procedure time and low rate of adverse events, does not require high technical skills in endoscopic procedures^[6]. UEMR for the management of neoplasms in the pyloric ring has benefits similar to those of UEMR for colorectal neoplasms: (1) Superficial lesions float into the snare as protruding lesions in underwater conditions; (2) UEMR decreases the thermal damage to the gastrointestinal wall, which helps prevent delayed perforation; and (3) The resection plane in UEMR is superficial; thus, the submucosal vessels usually remain within the resection wound, whereas in conventional EMR, the submucosal vessels are

Table 1 Patient characteristics

| Case No. | Age (yr)/sex | Neoplasm diameter | Yamada classification | Location of the lesion | Procedure time (s) | <i>En bloc</i> resection | Pathology |
|----------|--------------|-------------------|-----------------------|------------------------|--------------------|--------------------------|---------------------|
| 1 | 48/Female | 10 mm | III | LC-AW | 129 | Yes | Hyperplastic polyp |
| 2 | 64/Female | 7 mm | II | PW | 169 | Yes | Hyperplastic polyp |
| 3 | 50/Male | 10 mm | I | GC | 147 | Yes | Low-grade dysplasia |
| 4 | 60/Female | 10 mm | II | PW | 144 | Yes | Hyperplastic polyp |

AW: Anterior wall; GC: Great curvature; LC: Lesser curvature; PW: Posterior wall.

disrupted^[2]. Moreover, the narrow pyloric lumen is constantly distended, resulting in sufficient working space.

Even though our case series included patients with neoplasms less than 15 mm in diameter located in the pyloric ring, UEMR for mucosal neoplasms involving the pyloric ring can be expected to have advantages over conventional EMR or ESD. Further studies are needed to elucidate the effectiveness and safety of UEMR for larger mucosal neoplasms located in the pyloric ring.

CONCLUSION

UEMR can be an effective and safe treatment method for lesions in the pyloric ring of the stomach. Further studies are needed to elucidate the effectiveness and safety of UEMR for variable-sized mucosal neoplasms in the pyloric ring.

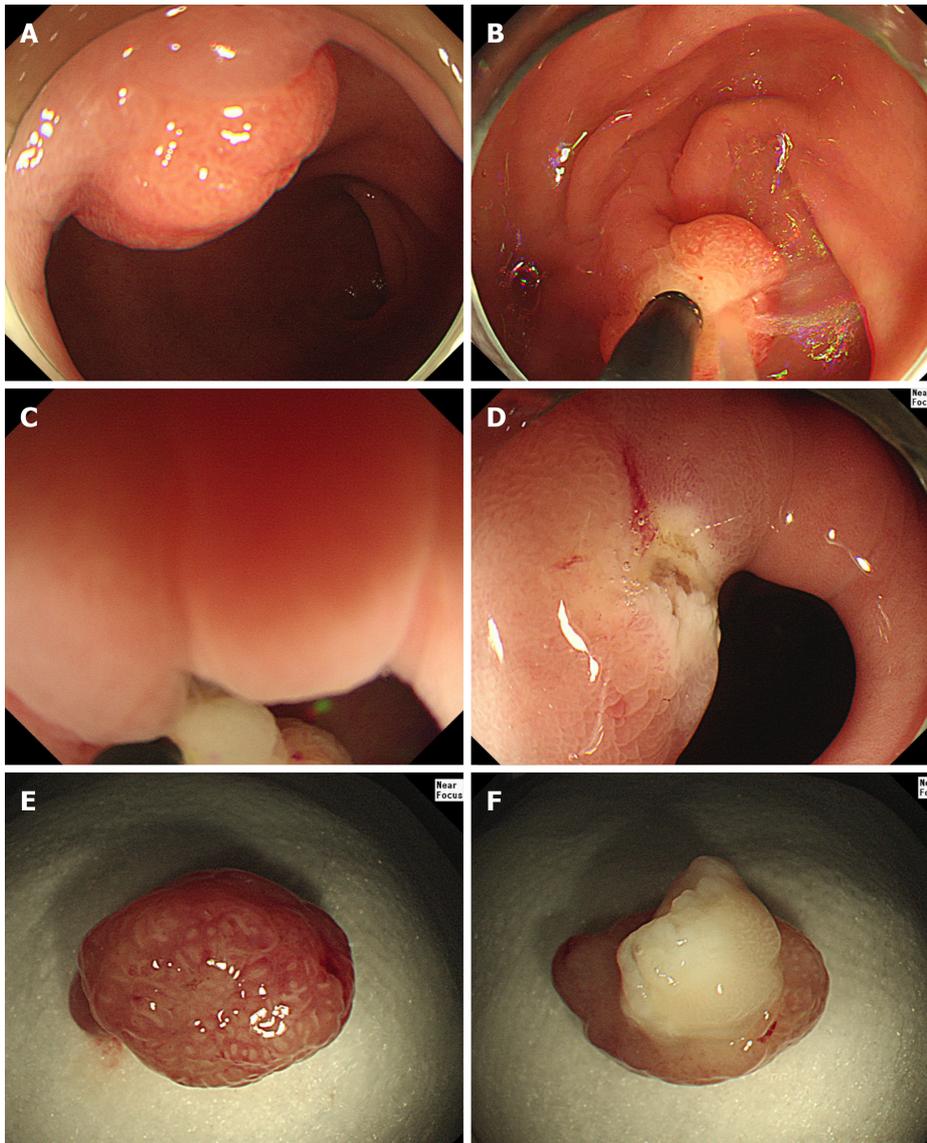


Figure 1 Underwater endoscopic mucosal resection in the first case. A: Endoscopic view of the polyp in the pyloric ring; B: Filling water around the lesion; C: Snaring of the lesion in water; D: Endoscopic view of the resected area after endoscopic resection; E: The head portion of the resected polyp; F: The stalk portion of the resected polyp.

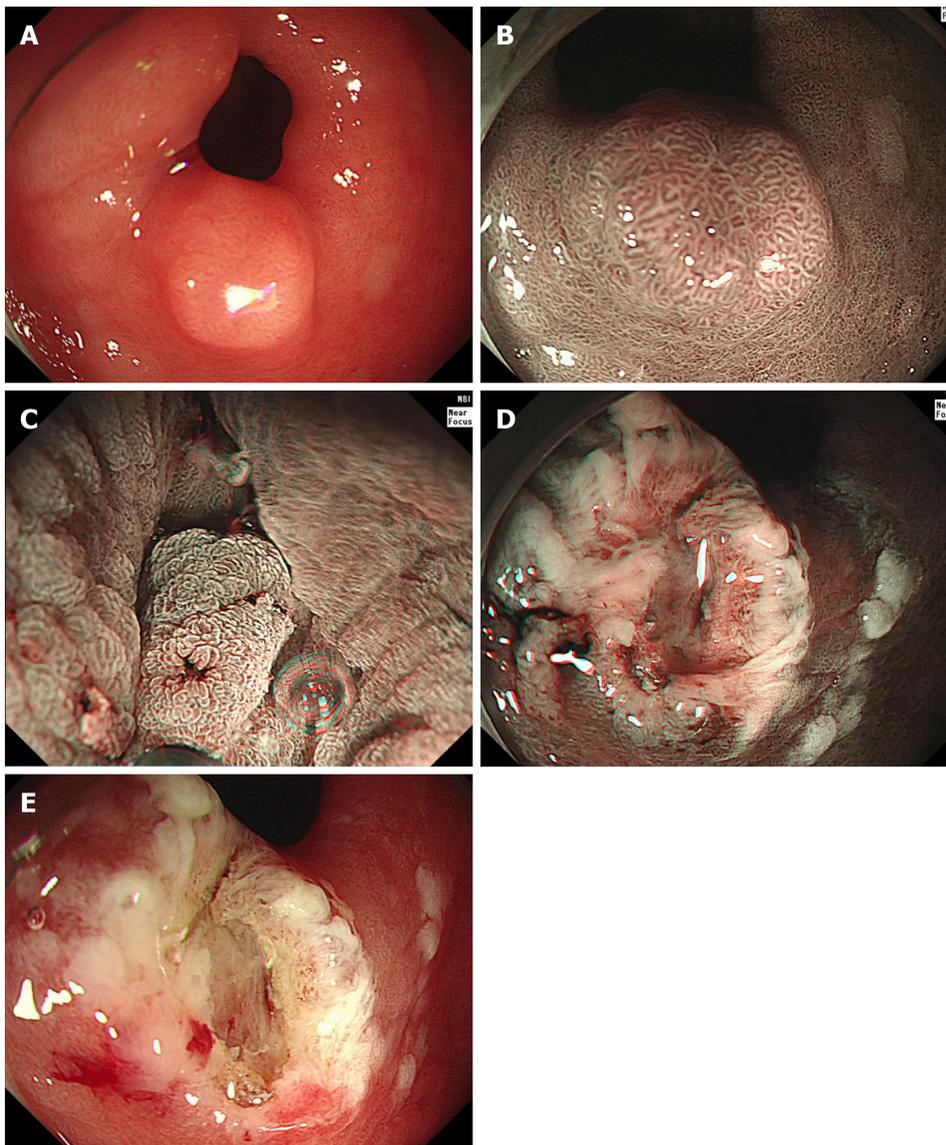


Figure 2 Underwater endoscopic mucosal resection in the third case. A: Endoscopic view of the neoplasm in the pyloric ring; B: Endoscopic view of the neoplasm in the pyloric ring under narrow-band imaging; C: Snaring of the lesion in water under narrow-band imaging; D: Endoscopic view of the resected area after endoscopic resection under narrow-band imaging; E: Endoscopic view of the resected area after endoscopic resection.

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