Turk J Gastroenterol *2017; 28: 225-6*

Endoscopic biopsy techniques for proximal biliary strictures

To the Editor,

We read the paper by Meng et al. (1) entitled "Accurate biopsy of bile duct without destroying duodenal papilla" with great interest. They described a new technique to perform endoscopic biopsy in a 75-year-old male with a biliary stricture, which was presumed to be a malignancy, in the hilar region. They used a 7-Fr dilatation catheter (COOK, Winston-Salem, North Carolina, USA) and inserted it into the bile duct and across the stenosis along a guidewire. The withdrawal of the guidewire was followed by the insertion of a 1-mm SpyBite™ forceps (Boston Scientific, El Coyol, Alajuela, Costa Rica) through a dilatation catheter. When the tip of SpyBite™ passed the top, the tissue was grasped. We believe that this technique is highly effective to make a histopathological diagnosis.

However, SpyBite™ forceps is expensive and may not be available in many endoscopy centers. We have previously described a similar technique in which we used a stent pusher instead of a dilatation catheter and a biopsy forceps (diameter, 1.8 mm; length, 160 cm; Endo-Technik, Solingen, Germany) instead of a SpyBite™ forceps (2). We believe that our method using a biopsy forceps through a stent pusher is cheaper and can be performed advantageously to obtain adequate tissue samples from proximal biliary strictures for making an accurate diagnosis.

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Received: January 28, 2017 **Accepted:** February 05, 2017
Available Online Date: March 15, 2017
 • DOI: 10.5152/tjg.2017.17059

Author's Reply

Re: Forceps-related endoscopic transpapillary biliary biopsy programmes, reply: endoscopic biopsy techniques for proximal biliary strictures

To the Editor,

We quite appreciate the attention of Tekin et al. (1) to our research and thanks for their valuable questions. Actually, in addition to the biopsy technique of biliary dilatation catheter combined with SpyBite™ forceps for proximal biliary strictures, we also did tissue sampling with the method as Tekin et al. (1) mentioned of a stent pusher combined with a large-diameter forceps. The necessary working length of the sheath and forceps for hilar billiary biopsy is nearly 1600 mm which includes 1400 mm of working channel in duodenoscope and 100 mm of both ends respectively. Significantly, the end of stent pusher needs to be cut about 50-100 mm because its smaller internal diameter could allow passage of not any forceps but only one guidewire (Figure 1). The current available forcipes used in biliary biopsy in our clinical center can be seen in Table 1, stent pushers and biliary dilatation catheters in Table 2 and Table 3 separately. Further, we have our own single-center experience in the combination scheme that forcipes are matched with stent pushers or dilatation catheters (Table 4).

As a surgical endoscopy center, we found it very common intraoperatively that inflammation and edema of the hepatoduodenal ligament, both of which may result from endoscopic retrograde cholangiopancreatography (ERCP) related destruction of Oddi's sphincter such as endoscopic sphincterotomy (EST) or endoscopic papillary balloon dilation (EPBD) and, would have an adverse effect on subsequent surgery and prognosis (2). In the research we reported previously,