



This video can be viewed directly from the GIE website or by using the QR code and your mobile device. Download a free QR code scanner by searching “QR Scanner” in your mobile device’s app store.

Although the feasibility and safety of EUS-TA-FNA of lung tumors and para-aortic lymph nodes located adjacent to the thoracic aorta have been demonstrated, to the best of our knowledge, this is the first report of EUS-TA-FNA for intra-abdominal lymphadenopathy (Fig. 1B).

DISCLOSURE

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Endoscopic features of lymphoproliferative diseases

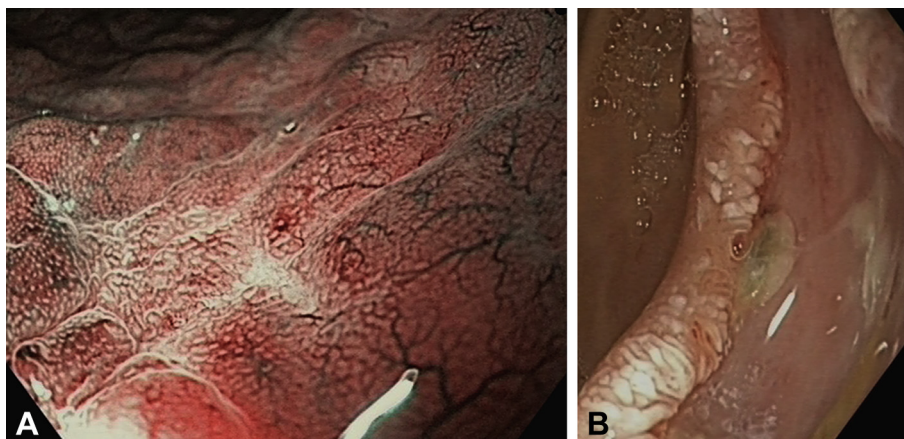


Figure 1. **A**, Gastric MALT lymphoma: combined narrow-band imaging and zoom endoscopy showing a nodular aspect of the mucosa with lack of normal glandular epithelium and abnormal microvessels. **B**, Posttransplantation lymphoproliferative disorder of the duodenum: endoscopy disclosing multiple ulcers with elevated borders covered with white granules.

Lymphoproliferative diseases of the digestive tube are rare diseases with a large spectrum of clinical manifestations and endoscopic features. This video production (Video 1, available online at www.giejournal.org) presents in detail the endoscopic, histologic, and radiologic findings along with the clinical background and management of several distinct endoscopic presentations of gastric mucosa-associated lymphoid tissue (MALT) lym-

phoma (Fig. 1A), duodenal follicular lymphoma, post-transplantation lymphoproliferative disorder of the duodenum (Fig. 1B), colonic MALT lymphoma, solitary rectal plasmacytoma, and high-grade diffuse large B cell colorectal lymphoma. The purpose of this video is to familiarize gastroenterologists with the endoscopic manifestations of lymphoproliferative diseases and their management.



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Percutaneous endoscopic debridement and washout of a bilateral, loculated, hepatic abscess: a minimally invasive approach to a high-risk surgical situation

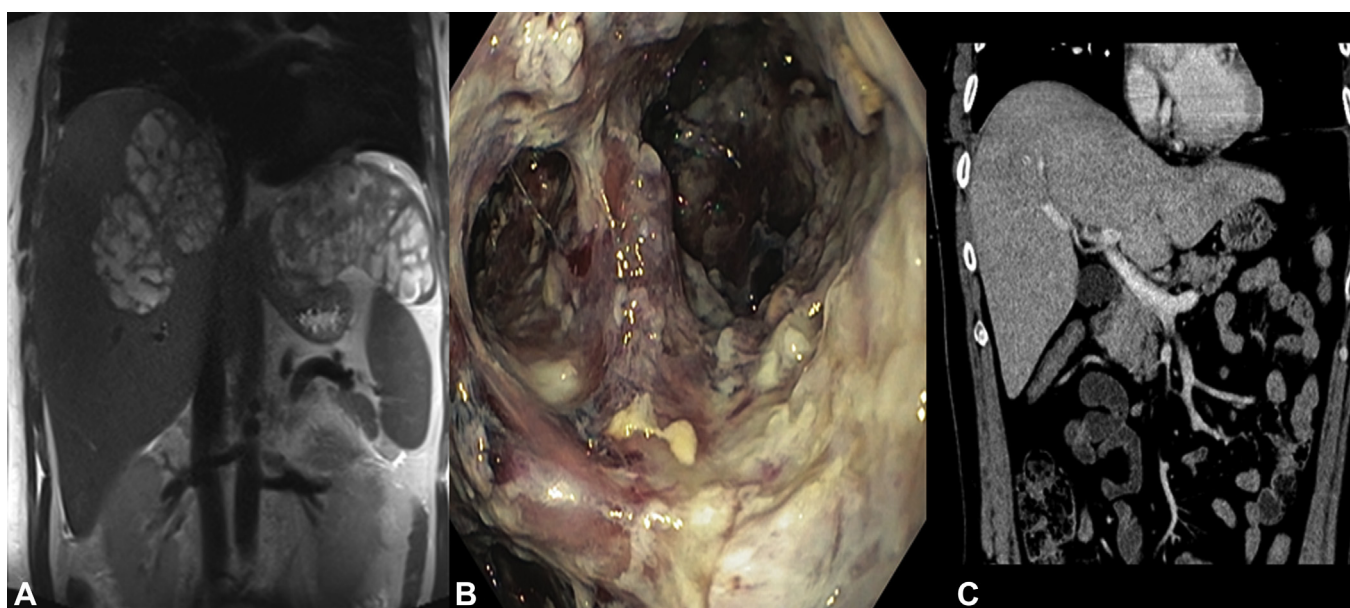


Figure 1. Successful endoscopic debridement and washout of bilateral hepatic abscesses over a series of 4 percutaneous necrosectomies. **A**, Enhanced MRI of the abdomen at the initial evaluation showing a large pyogenic abscess burden involving the right and left liver. **B**, The interior of the left liver abscess cavity as seen endoscopically during percutaneous debridement and lavage. **C**, CT imaging at 10 weeks from the first procedure confirming complete resolution of both liver abscesses.

A 46-year-old man presented with abdominal pain, acute sepsis syndrome, and large, bilateral, multiloculated hepatic abscesses (Fig. 1A, Video 1, available online at www.giejournal.org). The patient underwent a series of CT-guided percutaneous drainage procedures, resulting in placement of two 24F multipurpose drains and one 28F drain. Despite repeat catheter exchanges and lavage protocols, limited progress in removal of necrosis was made.



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Faced with the high level of morbidity and mortality associated with surgical resection, a novel approach applying the principles of endoscopic treatment for pancreatic necrosis was offered (Fig. 1B, Video 1).

Initially, the left liver abscess was addressed, removing the 28F drain with a 9-mm flexible endoscope then introduced and used for debridement followed by high volume, saline solution washout and drain replacement. Subsequently, the right abscess was treated in a similar manner. The patient improved markedly, was discharged, and returned for 2 additional debridement and washouts with drain downsizing as an outpatient. The patient continued to enjoy progressive improvement, and the remaining drains were removed. Imaging 10 weeks after the initial debridement showed complete resolution (Fig. 1C). In summary, this novel, minimally