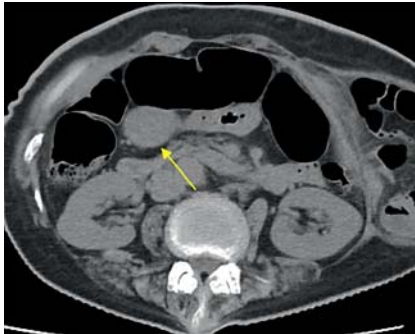


Pyloric ring section with a papillotomy knife for removing an ingested plastic bag closure penetrating the pyloric ring

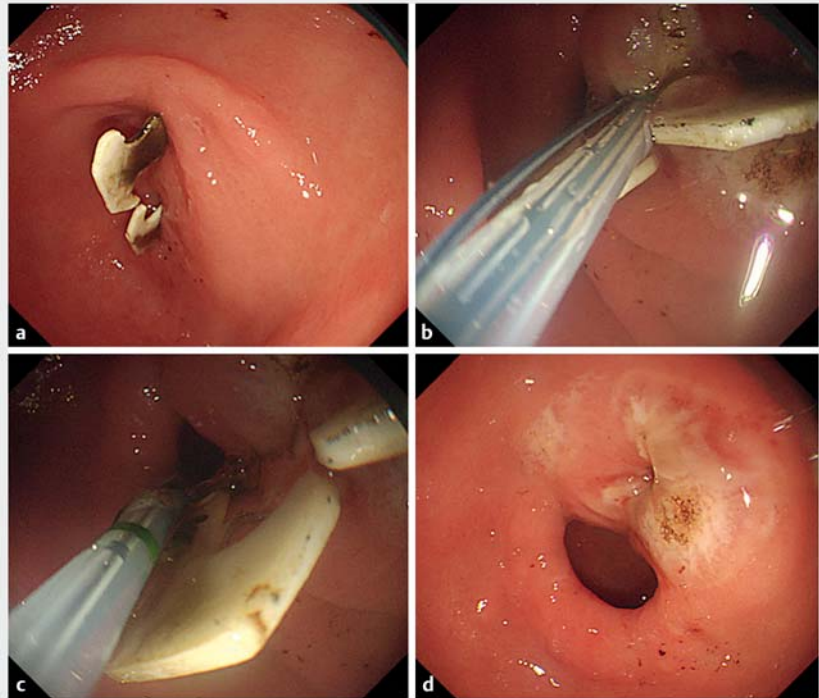
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► **Fig. 1** Abdominal computed tomography (CT) revealing significant duodenal wall thickness (yellow arrow) and the hernia.

The European Society of Gastrointestinal Endoscopy's clinical guideline recommends urgent therapeutic esophagogastroduodenoscopy (EGD) for esophageal blunt foreign bodies (FBs) without complete obstruction. Delayed intervention decreases the likelihood of successful FB removal and increases the risk of complications. However, non-urgent therapeutic EGD using suitable extraction devices is recommended, depending upon the type and location of blunt FBs in the stomach [1]. This article describes an endoscopic pyloric ring section procedure for removing an accidentally ingested blunt FB lodged in the pyloric ring (p-ring) like an earring.

A 69-year-old woman was referred to our department with persistent nausea, vomiting, and a 4-kg body-weight loss in a month comorbid with a ventral hernia. Blood count and biochemical parameters were within the normal range. However, an abdominal computed tomography (CT) revealed significant duodenal wall thickness beside the hernia (► **Fig. 1**). Urgent EGD revealed a plastic bag closure embedded in the p-ring like an earring (► **Fig. 2a**). Since removing it with grasping forceps and argon plasma melting was ineffectual, we advanced a papil-



► **Fig. 2** Endoscopic images of ingested plastic bag closure penetrating p-ring. **a** Ingested plastic bag closure penetrating p-ring. **b** Over-the-guidewire papillotomy knife insertion into the fistula. **c** Pyloric ring section toward the lumen. **d** After pyloric ring section.



► **Video 1** Pyloric ring section with a papillotomy knife for removing an ingested plastic bag closure penetrating the pyloric ring.

lotomy knife (CleverCut 3V; Olympus, Tokyo, Japan) with a guidewire through the pierced p-ring into the duodenal lumen and severed the p-ring muscle. Subsequently, we easily detached the FB from the p-ring without complications (► **Fig. 2b, c, d**, ► **Video 1**). An earring hole-like fistula had formed around the FB from accidental clipping and necrosis by compression on the p-ring. Over-the-guidewire pyloric ring section securely opened the fistula up to the pylorus.

Endoscopic pyloromyotomy is an emerging treatment option for refractory gastroparesis [2,3]. Herein we demonstrated the possibility and safety of endoscopic ultrasonography-guided pyloromyotomy. The procedure enables ultrasonography-guided p-ring puncture, guidewire advancement into duodenum, dilation, and incision with minimal risk of gastric perforation.

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Competing interests

The authors declare that they have no conflict of interest.

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