DISCLOSURE

Our authors disclosed no financial relationships relevant to this publication.

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Response:

We thank Saritas et al for their interest in our article. In case-control studies, the traditional rendezvous (RV) cannulation results in a lower risk of post-ERCP pancreatitis (PEP) in comparison with cannulation without RV. In this view, the advantages of traditional RV could be secondary to limitation of repeated cannulations of the papillary orifice and prevention of inadvertent cannulation or injection of contrast medium into the pancreatic ducts. In previous studies involving patients referred for cholecystectomy and in our series of patients with biliary adverse events after liver transplantation, mild PEP also occurred after traditional RV had been performed with great caution. The mechanisms leading to PEP during traditional RV are unknown, but instrumentation with the guidewire to pass into the duodenum and retrieval of the wire into the endoscope are probably major factors leading to trauma at the level of the papilla. To minimize as much as possible the risk of PEP in patients after liver transplantation, we have proposed direct duodenal cannulation over the wire during RV procedures. During nonrandomized consecutive cases, we have recorded no PEP after our duodenal RVs, possibly related to reduction of cannulation time compared with traditional RV.

We agree with Saritas et al that a large randomized study is needed to confirm our preliminary data. However, the large number of patients with biliary adverse events after liver transplantation needed for such a study (>200 per arm) makes it difficult to perform in centers with a high workload of liver transplantations, considering that approximately 10% to 15% of biliary adverse events occur yearly. Waiting for the best evidence in this field, we now routinely use duodenal RV as a first step to cannulate when a T tube is present, to avoid the unnecessary risk of pancreatitis in patients who have undergone liver transplantation, and we are glad to share this approach with Saritas et al.

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Management of novel oral anticoagulants for GI endoscopy procedures

To the Editor:

We read with great interest the American Society for Gastrointestinal Endoscopy guideline on the management of antithrombotic agents for patients undergoing GI...
endoscopy published in *Gastrointestinal Endoscopy*. The guidelines stratify endoscopy procedures in high and low bleeding risk, the latter including endoscopy with mucosal biopsy. Furthermore, the guidelines suggest continuing novel oral anticoagulants in the periendoscopic period in patients undergoing low-risk procedures and discontinuing them if high-risk procedures are planned. However, Table 6 on dabigatran management introduces an additional procedure group, at moderate risk of bleeding, for whom a short interruption (1-1.5 days) of the drug is advised; which procedures are included in this group is specified neither in the table nor in the text.

It seems this group is similar to the “intermediate” group of the European Heart Rhythm Association guidelines, which cautionary recognize a potential bleeding risk for endoscopy with biopsy sampling (in particular, if biopsy specimens are taken within a few hours after novel oral anticoagulant intake, when the drug is at peak concentration and at maximum effect) and, accordingly, advise a brief drug interruption whenever biopsy samplings are planned. If this interpretation is correct, the information reported in Table 6 of the American Society for Gastrointestinal Endoscopy guideline seems to be inconsistent with the guideline statement.

Moreover, unlike European Heart Rhythm Association guidelines, the American Society for Gastrointestinal Endoscopy guidelines advise different timing of drug interruption for patients taking rivaroxaban and apixaban in case of mild or moderate renal impairment. Nevertheless, these patients are likely to be receiving dosages adapted to renal function, and neither of these drugs, unlike dabigatran, have a dominant renal excretion. As a consequence, their elimination half-lives should not significantly vary, even in the presence of mild or moderate renal impairment. Thus, it is not clear why the intervals of drug interruption, which are based on elimination half-lives, should be longer.

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**Response:**

The Standards of Practice (SOP) Committee appreciates the author’s question regarding the inclusion in Table 6 of a moderate–procedural bleeding risk category, in addition to the high-procedural bleeding risk category. This moderate-risk group was included in Table 6 simply because that is how the data were originally presented in the article by Weitz JI et al in reference 53. For the purposes of this guideline, the SOP Committee stratified the groups into low-risk and high-risk bleeding, so we purposely ignored this moderate-bleeding risk group to simplify the recommendations. The recommendation to continue novel oral anticoagulants (NOACs) for patients undergoing low-risk procedures is in keeping with the previous version of this guideline, which supported continuing warfarin in patients undergoing low-risk procedures. Additionally, other recent antithrombotic therapy guidelines, which included the NOACs, also recommend continuing these agents for low-risk procedures, similar to warfarin. The Committee thought that the risk of stopping the anticoagulant and precipitating a serious clotting event was higher than the lower bleeding risk of the procedure in this scenario.

The author’s letter also states that both rivaroxaban and apixaban do not have a dominant renal excretion. On the contrary, rivaroxaban has a renal excretion of 66%, as listed in the product insert. The SOP Committee agrees that the renal excretion of apixaban is lower (27%); however, the product insert does make dose reduction recommendations that vary with decrements in renal function for both medications. Tables 7 and 8 are in keeping with these recommendations.

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