

DISCLOSURE

All authors disclosed no financial relationships relevant to this publication.

Surinder Singh Rana, DM
Vishal Sharma, DM
Ravi Sharma, MSc

*Department of Gastroenterology
Post Graduate Institute of Medical Education and Research
Chandigarh, India*

REFERENCES

1. Yang D, Amin S, Gonzalez S, et al. Transpapillary drainage has no added benefit on treatment outcomes in patients undergoing EUS-guided transmural drainage of pancreatic pseudocysts: a large multicenter study. *Gastrointest Endosc* 2016;83:720-9.
2. Trevino JM, Tamhane A, Varadarajulu S. Successful stenting in ductal disruption favorably impacts treatment outcomes in patients undergoing transmural drainage of peripancreatic fluid collections. *J Gastroenterol Hepatol* 2010;25:526-31.
3. Hookey LC, Debroux S, Delhaye M, et al. Endoscopic drainage of pancreatic-fluid collections in 116 patients: a comparison of etiologies, drainage techniques, and outcomes. *Gastrointest Endosc* 2006;63: 635-43.
4. Bhasin DK, Rana SS. Combining transpapillary pancreatic duct stenting with endoscopic transmural drainage for pancreatic fluid collections: two heads are better than one! *J Gastroenterol Hepatol* 2010;25:433-4.
5. Varadarajulu S, Rana SS, Bhasin DK. Endoscopic therapy for pancreatic duct leaks and disruptions. *Gastrointest Endosc Clin N Am* 2013;23: 863-92.
6. Varadarajulu S, Noone TC, Tutuian R, et al. Predictors of outcome in pancreatic duct disruption managed by endoscopic transpapillary stent placement. *Gastrointest Endosc* 2005;61:568-75.
<http://dx.doi.org/10.1016/j.gie.2016.03.1490>

Competency in colonoscopy: Should we focus on the “how”?



To the Editor:

Sedlack et al¹ have highlighted the impact of a new competency assessment tool for colonoscopy. The validated measure encompasses motor and cognitive skills focused on aspects such as scope control, loop reduction, visualization, and pathology identification, to name but a few. They identified typical thresholds for minimal competency and the average number of procedures that will enable a practitioner to be deemed competent.

I fully agree with the use of such a tool. However, as yet, we have difficulty determining what factors are relevant in achieving competency. Areas of interest from an educational slant could include, for example, additional pedagogic measures including simulation use, hands-on workshops both locally and abroad, and the adoption of mastery learning styles. For example, in terms of pathology

identification, were additional teaching platforms such as videos or online resources used? Was recognition of learning theory adopted; for example, learner autonomy and a sense of relatedness, freedom for learners to explore their own ideas, safeguards to avoid too-rapid a move to gain competency beyond their reasonable limits at a particular time, reflection/feedback in a bidirectional nonjudgmental fashion, measures to deliver training in stages from low to high complexity, creation of a safe learning environment, external peer feedback, and self-directed learning?

Such aspects constitute various recognized learning theory domains, namely, self-determination, cognitive load, and situated cognition.² Other factors that could implicate competency achievement may include the type of endoscope used, with a focus on other modalities, eg, high-definition, magnification, or narrow-band imaging, and, of course, the use of expert centers, which typically house expert endoscopists.

I look forward to determining more the “how” as opposed to the “is.”

DISCLOSURE

The author disclosed no financial relationships relevant to this publication.

Neel Sharma, MD
*National University Hospital
Singapore*

REFERENCES

1. Sedlack RE, Coyle WJ; ACE Research Group. Assessment of competency in endoscopy: establishing and validating generalizable competency benchmarks for colonoscopy. *Gastrointest Endosc* 2016;83:516-23.
2. Schumacher DJ, Englander R, Carraccio C. Developing the master learner: applying learning theory to the learner, the teacher, and the learning environment. *Acad Med* 2013;88:1635-45.
<http://dx.doi.org/10.1016/j.gie.2016.03.1491>

ERCP-related retroperitoneum: Should postprocedure CT features alone guide the decision-making process?



To the Editor:

We read with keen interest the article by Kumbhari et al,¹ who reported on a substantive series of ERCP-related perforations and proposed a predetermined management algorithm based on the mechanism of injury. Nevertheless, several concerns arose, and we worry about the generalizability of their findings.

The authors state that only Stapfer I and II perforations were included in the analysis, claiming that types III and

IV should be routinely managed medically. Nevertheless, the authors considered 3 radiologic diagnostic findings: retroperitoneal collection, retroperitoneal gas isolated, or retroperitoneal gas combined with pneumoperitoneum/pneumodiastinum. Of note, only 10 patients presented with more than 1 feature, and retroperitoneum alone was found in 44% of cases. Moreover, nearly all diagnoses (90%) were reached postprocedurally, with about 24 hours being the mean time to diagnosis, with a standard deviation of about 13 hours, which suggests significant variability among cases. Thus, it is likely that a significant number of type IV perforations were eventually included.

In the original report by Stapfer et al² (14 patients), most lesions were diagnosed during ERCP, with the rest being diagnosed without CT assessment. In contrast, in this study, in nearly all patients the diagnosis was based on radiologic investigation (CT 82%), realistically obtained because of some clinical deterioration while the patient was in the hospital.

The problem of opting for the most appropriate treatment is generally encountered in front of clinical or radiologic findings, rather than a given extemporaneous recognition during the procedure.³⁻⁶ Indeed, radiologic evidence may vary significantly according to the timing of assessment and thus has been considered by several authors to be an unreliable factor in predicting the need for surgery.⁵⁻⁷ Actually, retroperitoneal air alone, solely in the absence of physical or laboratory findings, should not be considered cause for alarm and likely can be managed medically.^{4,5,7-10}

Although we congratulate Kumbhari and colleagues on their valuable and timely article, we recommend caution in interpreting and generalizing their data in drawing definitive guidelines.

DISCLOSURE

All authors disclosed no financial relationships relevant to this publication.

Francesco Guerra, MD
Fabio Pulighe, MD
 Department of Surgery
 San Francesco Hospital
 Nuoro, Italy

REFERENCES

1. Kumbhari V, Sinha A, Reddy A, et al. Algorithm for the management of ERCP-related perforations. *Gastrointest Endosc* 2016;83:934-43.
2. Stapfer M, Selby RR, Stain SC, et al. Management of duodenal perforation after endoscopic retrograde cholangiopancreatography and sphincterotomy. *Ann Surg* 2000;232:191-8.
3. Chung RS, Sivak MV, Ferguson DR. Surgical decisions in the management of duodenal perforation complicating endoscopic sphincterotomy. *Am J Surg* 1993;165:700-3.
4. Assalia A, Suissa A, Ilivitzki A, et al. Validity of clinical criteria in the management of endoscopic retrograde cholangiopancreatography related duodenal perforations. *Arch Surg* 2007;142:1059-64.
5. Enns R, Eloubeidi MA, Mergener K, et al. ERCP-related perforations: risk factors and management. *Endoscopy* 2002;34:293-8.
6. Knudson K, Raeburn CD, McIntyre RC Jr, et al. Management of duodenal and pancreaticobiliary perforations associated with perampullary endoscopic procedures. *Am J Surg* 2008;196:975-81.
7. Cohen SA, Siegel JH, Kasmin FE. Complications of diagnostic and therapeutic ERCP. *Abdom Imaging* 1996;21:385-94.
8. Rabie ME, Mir NH, Al Skaini MS, et al. Operative and non-operative management of endoscopic retrograde cholangiopancreatography-associated duodenal injuries. *Ann R Coll Surg Engl* 2013;95:285-90.
9. Dunham F, Bourgeois N, Gelin M, et al. Retroperitoneal perforations following endoscopic sphincterotomy: clinical course and management. *Endoscopy* 1982;14:92-6.
10. Avgerinos DV, Llaguna OH, Lo AY, et al. Management of endoscopic retrograde cholangiopancreatography: related duodenal perforations. *Surg Endosc* 2009;23:833-8.

<http://dx.doi.org/10.1016/j.gie.2016.04.005>

Response:



We thank Drs Guerra and Pulighe for their comments on our manuscript entitled “An algorithm for the management of ERCP-related perforations” and offer the following in response.¹

We excluded Stapfer type III and type IV because the management of these perforations is essentially always nonsurgical. Stapfer type III perforations are generally detected intraprocedurally and are treated with stent placement. We do not believe that Stapfer type III perforations should be managed medically if detected intraprocedurally. Stapfer type IV perforations are asymptomatic, and no therapy is necessary.

Our study documented 4 diagnostic radiologic findings in our patient cohort (in addition to the 3 mentioned in the letter, oral contrast medium extravasation was also included). Drs Guerra and Pulighe claim that it is unusual for patients with Stapfer type I or type II perforations to have only 1 imaging abnormality on CT. Furthermore, they indicate that it is uncommon for Stapfer type I or type II perforations to manifest with retroperitoneal gas only on CT. However, several studies have demonstrated that retroperitoneal gas alone is the most common CT finding in patients with Stapfer type II perforations.^{2,3}

We believe it is of greater clinical interest that the majority of the patients in our study had their diagnosis detected postprocedurally. With current endoscopic accessories and techniques, all intraprocedurally detected ERCP-related perforations, regardless of Stapfer type, should undergo an immediate attempt at endoscopic therapy. Therefore, a management algorithm is most relevant to those patients with a postprocedurally detected perforation. Drs Guerra and Pulighe commented that the mean time to diagnosis