Covered self-expanding metal stents: a promising therapy for difficult stone disease

To the Editor:

We read with great interest the article by Hartery et al.1 entitled “Covered self-expanding metal stents for the management of common bile duct stones.” This retrospective study evaluated the safety and efficacy of inserting covered self-expanding metal stents (CSEMSs) alongside “difficult” stones in 44 patients at 2 tertiary referral centers. After the work by Cereﬁce et al2 in 2011, this is the second case series in the literature that has evaluated this modality in treating difficult stones after failed endoscopic extraction.

In our unit, we have also been evaluating the role of CSEMSs in managing difficult stones in the common bile duct (CBD) after the failure of conventional therapy. The provisional data from our prospective case series (30 months) have shown favorable outcomes in line with the results of Hartery et al., with the notable difference that all cases were performed at a large district general hospital in North London, United Kingdom (CBD clearance 98% with the use of standard extraction techniques).

Hitherto we have inserted 6 CSEMSs for large impacted stones (average diameter 28 mm, range 14-35 mm). Bile duct clearance was achieved in all patients: 5 patients after a single CSEMS insertion and 1 patient after a second period of CSEMS insertion (35-mm stone). The average duration of stent deployment was 60 days, which is slightly longer than those reported by both Hartery et al1 (56 days) and Cereﬁce et al2 (45 days). Thus far, procedural adverse events have not been identified.

Our provisional results further corroborate the conclusions of those other two groups that CSEMS insertion is an effective and safe technique in removing difficult stones. Moreover, our study highlights that referrals to tertiary centers can be eliminated by the introduction of this modality alongside standard extraction techniques in a district general hospital. We entirely agree that large, multicenter, randomized controlled studies will help answer some of the questions around cost beneﬁt and required duration of stent insertion.

DISCLOSURE

All authors disclosed no ﬁnancial relationships relevant to this publication.

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Inadequate bowel preparation rates should be considered before screening colonoscopy is recommended

To the Editor:

Rex et al.1 provided a comprehensive update of the U.S. Multi-Society Task Force of Colorectal Cancer recommendations on colon cancer screening. They cite good evidence in support of a sequential approach based on colonoscopy, ﬁrst based on sensitivity and cost effectiveness. The authors also discuss tools for patients (and primary care physicians) to judge whether colonoscopy is performed at a high level. These include asking about adenoma detection rate, cecal intubation rate, and use of split-dosing bowel preparation. An important quality indicator missing from this list is the rate of inadequate bowel preparation, which has adverse consequences for patients, health care systems, and the society.

The reported rate of inadequate bowel preparation is 5% to 60% (median about 25%).2-4 In an earlier study, Rex et al5 reported that an inadequate bowel preparation increased the direct cost of colonoscopy by 12% to 22% depending on the practice setting because of the increased duration of the examination and the need for repeated procedures. It is estimated that population-wide inadequate bowel preparation results in colonoscopy being repeated every 7.8 years in average-risk patients instead of every 10 years.6 Indeed, a recent cost-effective analysis reported that screening colonoscopy is not a cost-effective strategy if more than 13% of colonoscopies are repeated.
because of inadequate bowel preparation. The European Society of Gastroenterology recommends an inadequate bowel preparation rate of less than 10%, whereas the American College of Gastroenterology set this target as less than 15% for outpatients.

Choosing an optimal bowel preparation requires attention to details such as the patient’s medical history (for example, constipation), ability to understand and comply with instructions, and preference of choice of laxative. Hassan et al proposed a predictive model based on patients’ demographics and comorbidities that could theoretically decrease the inadequate preparation rate from 33% to 13%. In practice, most endoscopy units prescribe a standard bowel preparation to all patients because individualizing colon preparations can be resource intensive.

Colonoscopy is the preferred colon cancer screening test if we meet the quality indicators—and that should include inadequate bowel preparation rates. The best test for colon cancer screening is the one that gets done and gets done well the first time.

DISCLOSURE

The author disclosed no financial relationships relevant to this publication.

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Response:

We appreciate the thoughtful comments of Dr Agrawal regarding the Multi-Society Task Force (MSTF) recommendations on colorectal cancer screening. Dr Agrawal suggests that the MSTF should advise patients to ask prospective colonoscopists for their rate of adequate preparations. Dr Agrawal cites the ≥85% target for adequate preparations, which he attributes to the American College of Gastroenterology (ACG). This target, although endorsed by the ACG, was first presented by the MSTF. Thus, we strongly agree that colonoscopists should measure rates of adequate bowel preparation (defined by the use of bowel preparation descriptors or scores consistent with adequacy plus adherence to screening or surveillance recommendations appropriate to the examination findings) and make changes when needed to exceed this target.

The MSTF considers whether each of its recommendations is clinically valuable and also feasible to both measure and achieve by those expected to follow it. Usually a period of time is needed for a proposed new quality target to be integrated into clinical practice. For example, the MSTF developed and presented the adenoma detection rate (ADR) in 2002. Since then, there has been slow growth in the fraction of colonoscopists using ADR, stimulated by studies that validated the association of ADR with cancer protection by colonoscopy, a host of studies investigating techniques to improve ADR, development of registries that facilitate ADR measurement, and federal financial incentives to measure ADR. Fifteen years after the presentation of ADR, it seems quite reasonable to expect colonoscopists to respond to patient inquiries by reporting their personal ADRs.

Regarding bowel preparation, the ACG endorsed split dosing in 2008. Extensive evidence supports split dosing (or same-day dosing) as the key bowel preparation advance in 2 decades, including a randomized controlled trial of split dosing that used ADR as the primary endpoint. The 85% target for adequate preparations was proposed by the MSTF about 3 years ago. To comply with this recommendation, clinicians need to become aware of it, prioritize measurement among multiple practice demands, develop systems and resources for measurement and reporting, apply corrective measures if needed, and in some cases remeasure performance. Often the proposed target stimulates research that may validate the target as a quality indicator and strengthen the rationale for compliance. Given the fairly recent