4. Mohan BP, Jayaraj M, Asokkumar R, et al. Lumen apposing metal stents in drainage of pancreatic walled-off necrosis, are they any better than plastic stents? A systematic review and meta-analysis of studies published since the revised Atlanta classification of pancreatic fluid collections. Endosc Ultrasound 2019;8:82-90.
5. Yoon SB, Lee IS, Choi MG, et al. Metal versus plastic stents for drainage of pancreatic fluid collection: a meta-analysis. United European Gastroenterol J 2018;6:729-38.
6. Bang JY, Navaneethan U, Hasan MK, et al. Non-superiority of lumen-apposing metal stents over plastic stents for drainage of walled-off necrosis in a randomised trial. Gut 2019;68:1200-9.

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Response:

We thank Rizzatti et al[1] for their comments on our work entitled "International multicenter comprehensive analysis of adverse events associated with lumen-apposing metal stent placement for pancreatic fluid collection drainage," recently published in *Gastrointestinal Endoscopy*.[2] Indeed, in their letter, some important questions about the current knowledge of pancreatic fluid collection (PFC) endoscopic management are raised, and most of them do not yet have a definitive answer. We fully agree with the authors that several uncertainties persist in this field, in particular about the use of lumen-apposing metal stents (LAMSs) for PFC drainage. Indeed, this was the main reason that led us to develop this work. Nevertheless, we believe that our data helped advance the understanding of some mechanisms underlying the occurrence of adverse events (AEs) in these patients and remarked the need of countermeasures to prevent and treat such events. In particular, pneumatic dilation of the LAMSs was associated with a lower risk of AEs (infection and stent occlusion) without increasing the risk of stent migration or dislodgement. Moreover, patients with walled-off necrosis emerge as a high-risk subgroup, therefore deserving targeted studies aimed at defining the specific mechanisms of AEs. In this regard, bleeding has been already attributed to friction of the distal flange of the LAMS against retroperitoneal vessels after cavity collapse, and this was considered a delayed event.[3] Interestingly, we found that most bleeding episodes (13/22, 59%) occurred in the first 14 days from the positioning of the LAMS, thus suggesting that a further reduction in the timing of LAMS removal should be considered. Many other points have not yet been completely addressed, including the pressing issue of the cost effectiveness of such procedures.[4-6] For this reason, as already underlined in the conclusions of our article, we agree with the conclusion of Rizzatti et al[1] about the urgent need for well-designed controlled trials that give a more solid basis to our clinical practice.

DISCLOSURE

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REFERENCES

1. Rizzatti G, Rimbas M, Larghi A. Adverse events of lumen-apposing stents for pancreatic fluid collections: opening the Pandora's box. Gastrointest Endosc 2020;91:1217-8.
2. Fugazza A, Sethi A, Trindade AJ, et al. International multicenter comprehensive analysis of adverse events associated with lumen-apposing metal stent placement for pancreatic fluid collection drainage. Gastrointest Endosc 2020;91:574-83.
3. Bang JY, Hasan M, Navaneethan U, et al. Lumen-apposing metal stents (LAMS) for pancreatic fluid collection (PFC) drainage: may not be business as usual. Gut 2017;66:2054-6.
4. Chen YI, Barkun AN, Adam V, et al. Cost-effectiveness analysis comparing lumen-apposing metal stents with plastic stents in the management of pancreatic walled-off necrosis. Gastrointest Endosc 2018;88:267-76 e1.
5. Chen YI, Khashab MA, Adam V, et al. Plastic stents are more cost-effective than lumen-apposing metal stents in management of pancreatic pseudocysts. Endosc Int Open 2018;6:E780-8.
6. Bang JY, Navaneethan U, Hasan MK, et al. Non-superiority of lumen-apposing metal stents over plastic stents for drainage of walled-off necrosis in a randomised trial. Gut 2019;68:1200-9.

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Randomized studies for Barrett's ablation: identifying the most cost-effective solutions by keeping an open mind

To the Editor:

We would like to respond to the editorial by van Munster et al,[1] which accompanied our pilot trial (BRIDE) comparing argon plasma coagulation (APC)

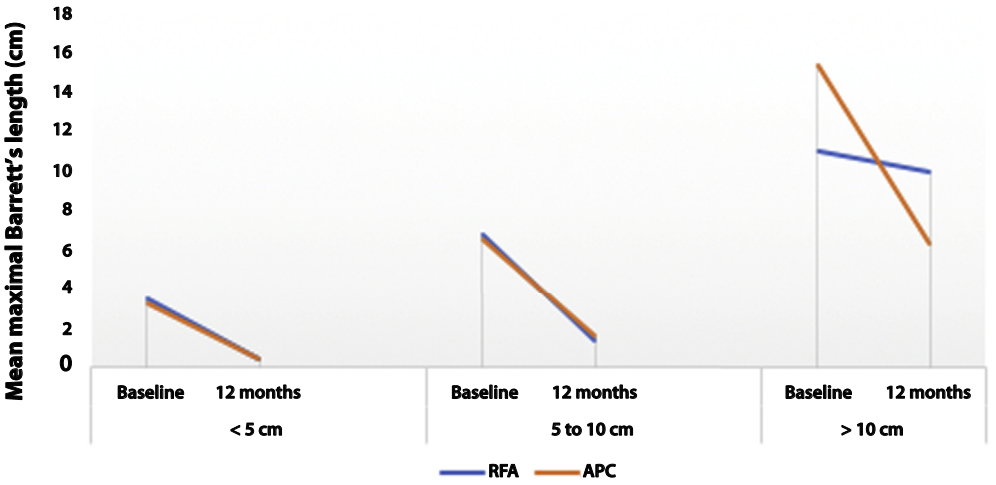

Figure 1. Change in mean Barrett's esophagus (BE) length (cm) for radiofrequency ablation (RFA) and argon plasma coagulation (APC) at 12 months, stratified according to initial BE length (<5 cm, n = 23; 5-10 cm, n = 39; >10 cm, n = 3). Patients are grouped by initial BE length and randomized ablation technique at start and end of study. (Drawn by the use of data in reference 2: Peerally MF, Bhandari P, Ragunath K, et al. Radiofrequency ablation compared with argon plasma coagulation after endoscopic resection of high-grade dysplasia or stage T1 adenocarcinoma in Barrett's esophagus: a randomized pilot study (BRIDE). Gastrointest Endosc 2019;89:680-9.)

with radiofrequency ablation (RFA) for the ablation of dysplastic Barrett's esophagus (BE).[2] They conclude that RFA is the established standard, modalities such as APC being reserved for special situations (strictures, refractory BE), and that comparative randomized controlled trials (RCTs) versus RFA are not warranted unless safety and efficacy have been established with large prospective trials, like EURO II for RFA.[3] They believe that APC has not met this criterion.

We disagree. The APC technique was standardized as part of BRIDE (despite less restrictive inclusion criteria on both endoscopic resection size, in keeping with current treatment guidelines,[4,5] and BE length than in EURO II). Together with the APE study by Manner et al,[6] we believe there exist sufficient safety and efficacy data for a fully powered comparison with RFA. This is needed because of the cost saving we observed, although this was challenged; in fact, our health economist also included costs of sizing and energy delivery systems unique to RFA.

We would like to respond to other points raised that question safety and efficacy: stricture rate was 8% (not 13%) with APC, similar to that in the APE study (9%).[6] Complete BE eradication (CR-BE) at 12 months (not 24 months as the editorial implies) after 4 treatments is lower than in EURO II[3] and APE[6] (both allowed more treatments and time) although similar to a large RFA registry in the United States.[7] BRIDE was a pilot study with time constraints limited by resources available to conduct the study; nevertheless, CR-BE was similar for APC/RFA, as shown in Figure 1.

Finally, van Munster et al[1] criticize the primary endpoint in BRIDE (or for any proposed comparative RCT) of complete histologic remission of dysplasia, even though others have used this in RCTs of RFA (AIM,[8] SURF[9]) or APC versus surveillance (APE[6]). Instead, they believe that CR-BE is more appropriate. Ablation after endoscopic resection, the most important staging and treatment step,[4,5] aims to reduce metachronous neoplasia, elegantly shown with the use of APC.[6] Complete CR-BE is desirable, but BE recurred at 6% to 7% per year for as long as 8 years in large follow-up studies.[7,10,11] Therefore, annual surveillance is recommended indefinitely.[10] We therefore disagree with CR-BE as the primary endpoint and the suggested noninferiority margin for a comparative RCT of 5% because CR-BE is not durable.

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REFERENCES

1. van Munster SN, Pouw RE, Bergman JJGHM. Randomized studies for Barrett's ablation: just because we can doesn't mean we should. Gastrointest Endosc 2019;89:690-2.
2. Peerally MF, Bhandari P, Ragunath K, et al. Radiofrequency ablation compared with argon plasma coagulation after endoscopic resection of high-grade dysplasia or stage T1 adenocarcinoma in Barrett's esophagus: a randomized pilot study (BRIDE). Gastrointest Endosc 2019;89:680-9.
3. Phoa KN, Pouw RE, Bisschops R, et al. Multimodality endoscopic eradication for neoplastic Barrett oesophagus: results of an European multicentre study (EURO-II). Gut 2016;65:555-62.
4. Bennett C, Vakil N, Bergman J, et al. BADCAT consensus statements for management of Barrett's dysplasia and early-stage esophageal adenocarcinoma, based on a Delphi process. Gastroenterology 2012;143:336-46.
5. Fitzgerald RC, di Pietro M, Ragunath K, et al. British Society of Gastroenterology guidelines on the diagnosis and management of Barrett's oesophagus. Gut 2014;63:7-42.
6. Manner H, Rabenstein T, Pech O, et al. Ablation of residual Barrett's epithelium after endoscopic resection: a randomized long-term follow-up study of argon plasma coagulation vs. surveillance (APE study). Endoscopy 2014;46:6-12.
7. Gupta M, Iyer PG, Lutzke L, et al. Recurrence of esophageal intestinal metaplasia after endoscopic mucosal resection and radiofrequency ablation of Barrett's Esophagus: results from a US multicenter consortium. Gastroenterology 2013;145:79-86.
8. Shaheen NJ, Sharma P, Overholt BF, et al. Radiofrequency ablation in Barrett's esophagus with dysplasia. N Engl J Med 2009;360:2277-88.
9. Phoa KN, van Vilsteren FG, Weusten BL, et al. Radiofrequency ablation vs endoscopic surveillance for patients with Barrett esophagus and low grade dysplasia: a randomized clinical trial. JAMA 2014;311:1209-17.
10. Sami SS, Ravindran A, Kahn A, et al. Timeline and location of recurrence following successful ablation in Barrett's oesophagus: an international multicentre study. Gut 2019;68:1379-85.
11. Krishnamoorthi R, Singh S, Ragunathan K, et al. Risk of recurrence of Barrett's esophagus after successful endoscopic therapy. Gastrointest Endosc 2016;83:1090-106.

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Response:

We would like to respond to the letter of De Caestecker et al[1] in reply to our editorial that reflected on the BRIDE study, a randomized pilot study comparing radiofrequency ablation with argon plasma coagulation for the treatment of Barrett's esophagus (BE).[2] Our main point of disagreement is that in the BRIDE study, complete eradication of dysplasia (CE-D) at 12 months was chosen as an endpoint. Although eradication of dysplasia may be the most relevant short-term outcome for the patient, we think that in light of a study comparing 2 ablation techniques, CE-D is a suboptimal endpoint, and its clinical relevance is questionable.

As described in current guidelines, the rationale of ablation therapy for BE with dysplasia is to eradicate the whole BE, not only to treat the dysplasia. Using CE-D as an endpoint is therefore clinically not relevant. Also, this endpoint is hampered by biopsy sampling error and interobserver agreement between pathologists.

Furthermore, the statement that annual follow-up is recommended indefinitely after ablation therapy is, in our opinion, quite blunt. Maybe this is recommended in the referenced article; however, on the basis of our long-term outcomes after radiofrequency ablation and deliberate calculations on the optimal follow-up strategy, which we are currently working on, we dare to say that follow-up can safely be stopped at some point, provided that complete eradication of Barrett's esophagus has been achieved.

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REFERENCES

1. De Caestecker JS, Barr H, Bhandari P, et al. Randomized studies for Barrett's ablation: identifying the most cost-effective solutions by keeping an open mind. Gastrointest Endosc 2020;91:1219-20.
2. van Munster SN, Pouw RE, Bergman JJGHM. Randomized studies for Barrett's ablation: just because we can doesn't mean we should. Gastrointest Endosc 2019;89:690-2.

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