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Markers of immune responsiveness and post-ERCP pancreatitis?



To the Editor:

We read with great interest a 2014 article by Old et al.¹ reporting risks about post-ERCP pancreatitis (PEP), which retrospectively analyzed the data from 2699 patients undergoing ERCP. The study found that PEP was significantly less frequent in older patients (>80 years) (0.3% vs 2.2%; $P < .001$). A 2015 article in *Gastrointestinal Endoscopy* provides more evidence of a low risk of PEP in the elderly.² This has been speculated to possibly correlate with the decline in exocrine function of the pancreas with age.³ But this clinical manifestation may bring a new question about whether the lower incidence rate of PEP was related to the impaired inflammatory response of the immune system in elderly patients. Therefore, the value of neutrophil-to-lymphocyte ratio (NLR) and platelet-to-lymphocyte ratio (PLR) as possibly sensitive biomarkers of immune function was naturally evaluated for the correlation with PEP.

A total of 1136 patients undergoing ERCP were collected for retrospective analysis between December 2013 and September 2019. All patients with diagnoses of chronic diseases such as hematologic, kidney, and liver disease who underwent ERCP within 3 months, who had preoperative cholangitis, or who had a history of pancreatic surgery, PEP, or both were excluded. Finally, there were 1000

eligible patients and 128 patients who had PEP. The study showed that NLR and PLR are risk factors for PEP (odds ratio 1.035 and 1.003, $P < .05$). By further calculating the area under the curve of NLR and PLR, we found the optimum NLR and PLR cutoff values to be 5.625 and 101.7048, respectively. In conclusion, NLR and PLR may be valuable early prognostic biomarkers for predicting the incidence rate of PEP, and they may be new tools for the assessment of ERCP.

DISCLOSURE

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Warfarin should be switched to heparin bridging for patients with high thromboembolic risk



To the Editor:

We read with great interest the article by Tien et al.¹ The authors presented some new findings indicating that direct oral anticoagulants (DOAC) did not increase the risk of postendoscopic GI bleeding and thromboembolic (TE) events when compared with warfarin, as per the data of a large integrated healthcare system. Endoscopists need to continually strike a balance between bleeding and thromboembolism in patients taking anticoagulants. Notably, this research provided evidence for endoscopists regarding anticoagulant management in the preoperative stage, especially for DOAC. Because the conclusions are crucial to clinical practice, we briefly present some opinions regarding the results.

First, it is generally recommended to discontinue warfarin 5 days before endoscopic procedures in patients with low TE