Endoscopic vacuum therapy in the treatment of postesophagectomy leaks: Is intracavitary the way?

To the Editor:

We have read with great interest the article by Jung et al.1 assessing the efficacy of endoscopic vacuum therapy (EVT) in the treatment of upper GI leaks and perforations. The authors reported a clinical success rate of 76% in a sample size of 118 patients, the largest in EVT reports, confirming the high efficacy of this technique.2,3

In that study, EVT was performed either as primary treatment (74.8% of cases) or as rescue therapy (25.2% of cases) for anastomotic leaks. Technically, the sponge was placed in an intracavitary manner (55 cases) for fistulas at least 10 to 15 mm or intraluminally (64 patients) when the intracavitary insertion was impossible because of the size of the orifice or acute angulation of the fistula. In the multivariate analysis, the intraluminal method and neo-adjuvant therapy were predictors of clinical failure.

During the follow-up time (range, 3-603 days), post-treatment stenosis occurred in 22 patients (18.4%). Even though it is not reported, the hypothesis is that intraluminal placement of the sponge, resulting in the application of negative pressure directly within the lumen of the esophagus, could be more associated with the development of visceral stenosis.

Recently, Jung et al.4 have reported a slightly higher success rate of endoscopic internal drainage (EID) with double pigtail stents, compared with EVT, in the treatment of upper GI postsurgical leaks (100% vs 85.2%, \( P = .003 \)), where EVT was performed for leaks not associated with cavities. EID also has shown a higher efficacy rate than esophageal stenting (95% and 77%, \( P = .06 \)).5

Data based on prospective studies will be useful to confirm EVT as first-line treatment for cavity-related leaks and to define whether EID may be associated with higher efficacy and lower rates of long-term stenosis for small or angled leaks that are not suitable for intracavitary EVT placement.

DISCLOSURE

Dr Danese has served as a speaker, consultant, and advisory board member for Schering-Plough, AbbVie, Actelion, Alphawasserman, AstraZeneca, Cellerix, Cosmo Pharmaceuticals, Ferring, Genentech, Grunenthal, Johnson and Johnson, Millenium Takeda, MSD, Nikkiso Europe GmbH, Novo Nordisk, Nycomed, Pfizer, Pharma-

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REFERENCES


Response:

We thank Mandarino and colleagues1 for their interest in our recent publication on endoscopic vacuum therapy (EVT) for the management of upper GI (UGI) leaks and perforations.2 Several endoscopic methods have been used to manage UGI leaks and perforation, including placement of self-expanding metal stents, clipping, histoacryl injection, and vacuum therapy.2 Recently, Jung et al.3 reported an excellent closure rate for endoscopic internal drainage (EID) with double-pigtail stents for leakage after UGI surgery. As the authors stated, the efficacy of EID appears to be promising, especially for leaks not associated with cavities. In our study, we placed a sponge in the cavity if the defect size was large enough to technically