accommodate an endoscope and the sponge. By contrast, we applied intraluminal methods when the opening of the fistula was positioned at an acute angulation deemed unsuitable for inserting a sponge into the fistula. Interestingly, the intracavitary method was significantly associated with EVT success.

On the basis of these results, we have been thinking about an efficient way to increase occlusion rates when EVT cannot be used in the cavity. According to the study by Jung et al., EID may also be a good option to increase the success rates for cases not suitable for intracavitary EVT, especially for small or angled leaks.

In a recent meta-analysis, the overall adverse event (AE) rate for the use of EVT was 13.6%. The nature or types of AEs consisted of stenosis, bleeding, dislocation, and visceral injury. However, EVT elicited a lower overall AE rate relative to other endoscopic modalities, such as self-expanding metal stents. Likewise, in our study, AEs included EVT dislocation, pneumonia, and stenosis. Also, we found no significant difference in the development of stenosis between the intracavitary group and the intraluminal group (20.0% vs 17.2%, P = .814). Notwithstanding, it is necessary to confirm whether there are differences in stenosis rates according to EVT methods through additional studies with large sample sizes and longer follow-up times. We also believe that additional studies are needed to determine whether EID can reduce the incidence of stenosis relative to EVT.

**DISCLOSURE**

Both authors disclosed no financial relationships.

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**Endoscopic ultrasonography: Complementary or alternative to radiology in evaluating pancreatic cystic neoplasms?**

To the Editor:

We read with great interest in, and congratulate Giannone et al on, their study entitled “Improving diagnostic accuracy and appropriate indications for surgery in pancreatic cystic neoplasms: the role of endoscopic ultrasound.” The authors reported a lower rate of incorrect preoperative diagnoses associated with EUS compared with radiologic evaluation with CT and/or MRI. Overtreatment rates were similar regardless of the diagnostic technique.

Accurate diagnosis of pancreatic cystic neoplasms is of great importance because it is the cornerstone in deciding between follow-up care or surgery. Several studies have investigated the weaknesses and strengths of different diagnostic techniques, with varying results.

The patients enrolled in the study by Giannone et al were divided into 2 groups: radiologic diagnosis versus radiologic and EUS diagnosis. Better diagnostic accuracy was observed in the latter group. Our opinion is that this lower rate of incorrect diagnosis is not solely attributable to EUS. Evaluation beforehand by either CT or MRI sets a guiding path for EUS, therefore increasing the accuracy of diagnosis. Comparison of EUS and radiologic diagnosis can be better investigated when the EUS operator is blinded, that is, no previous data about the lesion are revealed before the procedure.

In conclusion, the article by Giannone et al contributes greatly, and we agree with the authors that EUS, especially when paired with FNA, is an invaluable tool in the diagnosis of pancreatic cystic neoplasms. Further studies will reveal more about the importance of EUS as a complementary, or maybe a standalone, diagnostic tool on the topic.

**DISCLOSURE**

All authors disclosed no financial relationships.

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We read with interest the study by van Baar et al1 on hydrothermal duodenal mucosal resurfacing (DMR) to treat type 2 diabetes mellitus (T2DM). We believe that 2 issues deserve attention before its use in clinical practice.

In the study, no intraoperative adverse events (AEs) or procedure-related AEs were reported, except for the case with duodenal stenosis for ~1 month after the procedure. Moreover, previous studies indicated that postoperative AEs were mild and transient. The efficacy of DMR is mainly demonstrated by improved glycemic control (glycated hemoglobin A1c [HbA1c] and fasting blood glucose) and weight loss (correlated alanine transaminase) observed within 1 week and lasting for 2 years. The factors indicate that DMR is safe and efficient in patients with T2DM. However, the mechanism of DMR is unclear, and 2 concerns should be addressed before its use in clinical practice. One is the independent mucosa regeneration as the essence of DMR. Previously, we proposed that the regeneration of glucagon-like peptide-1 producing I cells may be involved in the mechanism of DMR to treat T2DM.2 It is a fact that patients receiving DMR treatment are followed up more regularly and closely with more health education on diet control and medication than are prerecruitment and unrecruited T2DM patients; that follow-up care also facilitates the formation of good habits and further contributes to the clinical management of T2DM. Consequently, indicators (eg, HbA1c and weight loss) in patients receiving DMR without follow-up care may be inferior to those of patients with follow-up care. Therefore, the independent role of DMR should be demonstrated after the confounding factors are controlled for, and the independent role of the whole process of treatment, apart from the DMR itself, should be explored. Further studies with larger sample sizes and randomized control trial grouping by the length of DMR, different follow-up intervals, and a comprehensive weight management program in patients with T2DM may distinguish the independent role of DMR from the bias of follow-up care.

DISCLOSURE

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Duodenal mucosal resurfacing before its use in clinical practice

To the Editor:

We read with interest the study by van Baar et al3 on hydrothermal duodenal mucosal resurfacing (DMR) to treat type 2 diabetes mellitus (T2DM). We believe that 2 issues deserve attention before its use in clinical practice.

In the study, no intraoperative adverse events (AEs) or procedure-related AEs were reported, except for the case with duodenal stenosis for ~1 month after the procedure. Moreover, previous studies indicated that postoperative AEs were mild and transient. The efficacy of DMR is mainly demonstrated by improved glycemic control (glycated hemoglobin A1c [HbA1c] and fasting blood glucose) and weight loss (correlated alanine transaminase) observed within 1 week and lasting for 2 years. The factors indicate that DMR is safe and efficient in patients with T2DM. However, the mechanism of DMR is unclear, and 2 concerns should be addressed before its use in clinical practice. One is the independent mucosa regeneration as the essence of DMR. Previously, we proposed that the regeneration of glucagon-like peptide-1 producing I cells may be involved in the mechanism of DMR to treat T2DM.2 It is a fact that patients receiving DMR treatment are followed up more regularly and closely with more health education on diet control and medication than are prerecruitment and unrecruited T2DM patients; that follow-up care also facilitates the formation of good habits and further contributes to the clinical management of T2DM. Consequently, indicators (eg, HbA1c and weight loss) in patients receiving DMR without follow-up care may be inferior to those of patients with follow-up care. Therefore, the independent role of DMR should be demonstrated after the confounding factors are controlled for, and the independent role of the whole process of treatment, apart from the DMR itself, should be explored. Further studies with larger sample sizes and randomized control trial grouping by the length of DMR, different follow-up intervals, and a comprehensive weight management program in patients with T2DM may distinguish the independent role of DMR from the bias of follow-up care.

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Response

We thank Drs Yang and Hu1 for their questions.

It is correct that the exact mechanism underlying duodenal mucosal resurfacing (DMR) remains unclear, as mentioned in our discussion.2 We are conducting additional mechanistic research, and we recently published 2 articles in which we report the results from our first mechanistic assessments: 1 report about the role of bile acids3 and a second report about changes in the microbiome.4 The changes we found are interesting and noteworthy, but the exact mechanism has still to be elucidated. In the upcoming months we will publish a third article to report our study of changes in the duodenal mucosa itself after DMR.

We agree with Drs Yang and Hu1 that our study patients were followed up more regularly and closely with more education on health and diet. The main goal of our feasibility study was to evaluate whether it was possible to discon-tinue insulin treatment in patients with type 2 diabetes by replacing it with DMR and GLP-1RA and to get an idea of the effect size of such a combined intervention. Because our small study was successful, it has been followed by an adequately powered, multicenter, sham controlled trial (Revitalize-1) to control for the addressed confounding factors. This mimics our prior approach, where we first con-ducted the uncontrolled Revita-1 study (DMR for patients

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