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 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 neoadjuvant 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, Alphawasseran, AstraZeneca, Cellerix, Cosmo Pharmaceuticals, Ferring, Genentech, Grunenthal, Johnson and Johnson, Millennium Takeda, MSD, Nikkiso Europe GmbH, Novo Nordisk, Nycomed, Pfizer, Pharma-

cosmos, UCB Pharma and Vifor. The remaining authors disclosed no financial relationships.

Francesco Vito Mandarino, MD
Alberto Barchi, MD
Lorella Fanti, MD
Francesco Azzolini, MD
Division of Gastroenterology and Gastrointestinal Endoscopy
Department of Experimental Oncology
Riccardo Rosati, MD
Department of Gastrointestinal Surgery
Silvio Danese, MD, PhD
Division of Gastroenterology and Gastrointestinal Endoscopy
IRCCS San Raffaele Scientific Institute
Vita-Salute San Raffaele University
Milan, Italy

REFERENCES


Response:

We thank Mandarino and colleagues\(^1\) 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
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.

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Da Hyun Jung, MD
Jun Chul Park, MD, PhD
Division of Gastroenterology
Department of Internal Medicine
Severance Hospital
Yonsei University College of Medicine
Seoul, Republic of Korea

REFERENCES


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 al1 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 al1 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 al1 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.

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Serkan Ocal
Osman Cagin Buldukoğlu, MD
Galip Egemen Atar
Ferda Akbay Harmandar
Ayhan Hilmi Cekin
Department of Gastroenterology
Antalya Training and Research Hospital
Antalya, Turkey