

Title:

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Is endoscopic retrograde cholangiopancreatography still the elective primary biliary drainage technique in patients with malignant distal biliary obstruction? Response to García-Cano et al.

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Conflict of interest: Juan J. Vila is consultant for Boston Scientific and has lectured for Olympus, Cook and Pentax. The other authors declare no conflict of interest.

Artificial intelligence: the authors declare that they did not use artificial intelligence (AI) or any AI-assisted technologies in the elaboration of the article.

Keywords: ERCP. Endosonography. Biliary drainage. Malignant biliary obstruction.

Dear Editor,

We have read the letter from García-Cano et al. (1) regarding our editorial (2) and are very grateful for the response as it contributes to deepening the debate we aim to generate on the topic. We are aware that changing a paradigm is always difficult, takes

years, and requires the publication of good quality studies. However, the way to progress in medicine and provide the best care for patients involves questioning existing paradigms and considering the possibility of changing them.

Currently, the outcomes of endoscopic ultrasonography guided transmural biliary drainage (EUS-TBD) have been progressively improving and the rate of adverse events (AE) has considerably decreased. The data currently available suggest that primary EUS-TBD in a specific setting is not inferior to endoscopic retrograde cholangiopancreatography (ERCP) drainage and may even entail a lower rate of AE (2). One of the issues that García-Cano et al. mentioned regarding EUS-TBD is the drainage dysfunction of the common bile duct provided by EUS-guided choledochoduodenostomy. A recent meta-analysis reported rates of stent migration or occlusion of 1.7 % and 11 % for EUS-TBD, respectively (3). Placement of a coaxial plastic stent may reduce the incidence of EUS-guided choledochoduodenostomy dysfunction, although the benefit of this maneuver is still being evaluated in research studies.

The second issue refers to establishing a protocol for patients with malignant distal biliary obstruction, starting with ERCP and switching to EUS-TBD during the same procedure, whenever biliary cannulation is not possible. Currently, similar protocols are already established in many hospitals with experience in ERCP and EUS-TBD, including our center. However, the concept we proposed goes beyond this strategy and aims to completely avoid any possible AE related to papillary manipulation by performing EUS-TBD as a first-line therapy. This strategy may entail lower rates of AE in patients with large biliary dilation (2). Trying cannulation first may increase these AE and also procedural time (4,5).

As García-Cano et al. state, the selection of patients for each technique is the most important issue to achieve better outcomes while minimizing risks. Firstly, and in accordance with published data, we believe that a common bile duct diameter of at least 15 mm constitutes the ideal setting for EUS-TBD. Secondly, some other factors such as the presence of an intradiverticular papilla or previous records of acute pancreatitis may further support the decision to perform primary EUS-TBD. In any case, we agree that biliary endoscopists must be trained in both ERCP and EUS-TBD

techniques.

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