DDW 2019

THE BEST OF THE BEST ABSTRACTS AND PRESENTATIONS ABOUT ERCP

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EAST SIDE ENDOSCOPY

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IS OUTPATIENT ERCP AS SAFE AS WE THINK?

- MANY HOSPITALS DO OUTPATIENT ERCP AND OTHER ENDOSCOPIES
- IN ORDER TO ENSURE THAT OUR PATIENTS ARE OK AFTER THE PROCEDURES, AND THAT WE ARE AWARE OF HOW OFTEN WE HAVE COMPLICATIONS, WE CALL PATIENTS TO CHECK ON THEM
- WE KNOW WE DON'T REACH ALL PATIENTS. ARE THE PATIENTS WE DON'T REACH HAVING COMPLICATIONS?
- ARE OUTPATIENT ENDOSCOPIES AS SAFE AS WE THINK?
- ARE WE UNDER APPRECIATING OUR COMPLICATION RATES WITH INADEQUTE PHONE FOLLOW UP???

PROSPECTIVE EVALUATION OF THE TIMING OF POST-PROCEDURE PHONE CALLS TO PATIENTS IN DETERMINING THE TRUE RATE OF ADVERSE EVENTS FOLLOWING ERCP

- This prospective study was conducted on consecutive patients undergoing ERCP at a tertiary care academic medical center from July 2018
- high rate of successful patient follow-up at 1 day (95%) and 7 days (92%), with 100% of patients reached on at least one occasion by day 7
- The assessed overall adverse event rate was 1.9% upon immediate post-procedure evaluation
- This increased to 3.2% at 1-day follow-up and to 10.1% at 7-day follow-up

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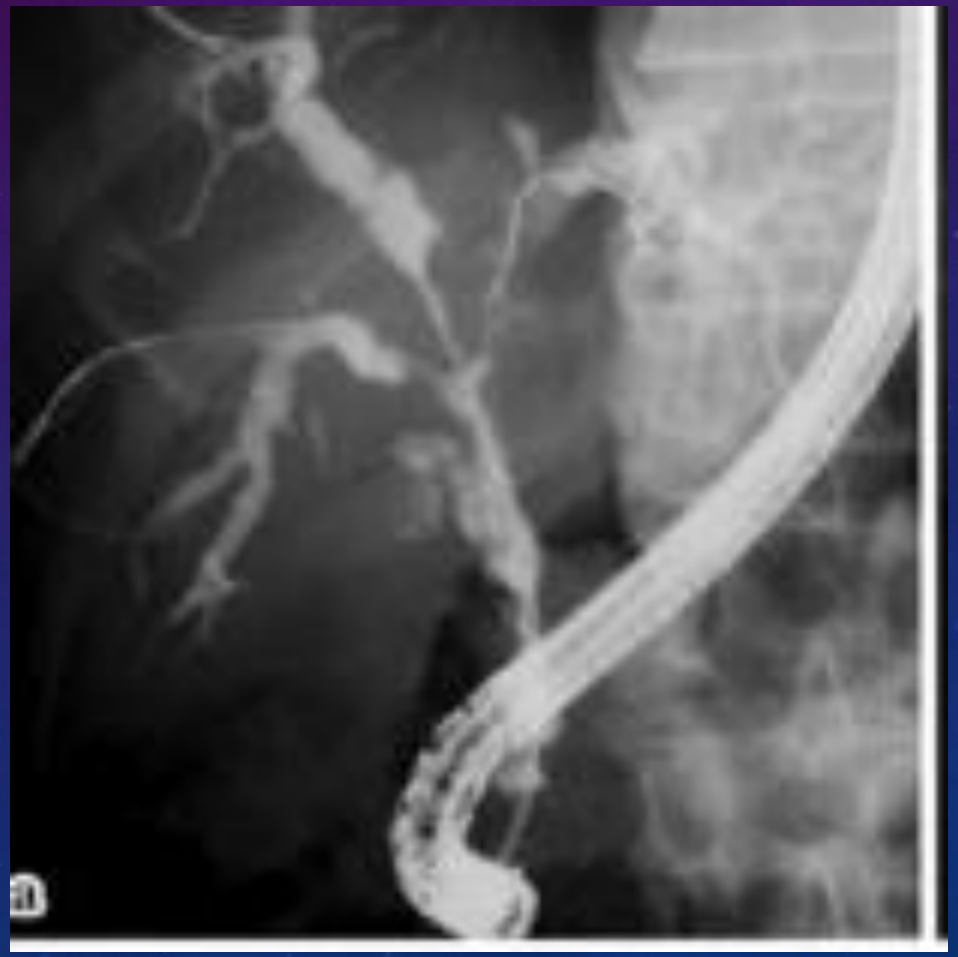
PROSPECTIVE EVALUATION OF THE TIMING OF POST-PROCEDURE PHONE CALLS TO PATIENTS IN DETERMINING THE TRUE RATE OF ADVERSE EVENTS FOLLOWING ERCP

- Summary: When studied “prospectively” ERCP complication rates are higher than we think

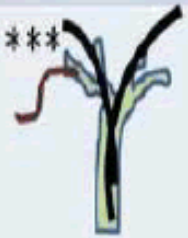
- QUESTION: WITH A COMPICATION RATE OF 10% - IS IT WISE TO SEND HOME PATIENTS AFTER EXTENSIVE ERCP’S, AND PERHAPS ESPECIALLY SPHINCTEROTOMIES??

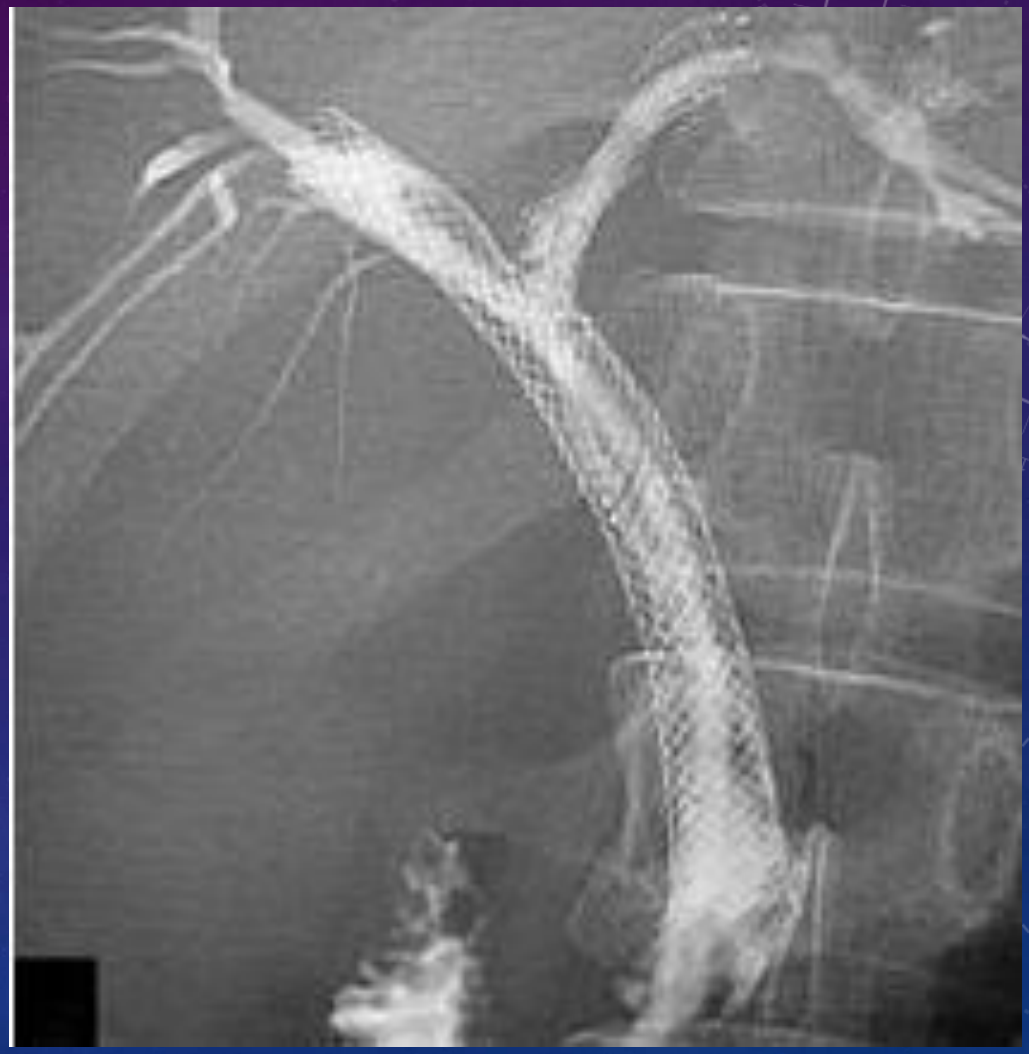
WHAT IS THE OPTIMAL METHOD FOR STENTING THE PATIENT WITH HILAR MALIGNANT OBSTRUCTION?



WHAT IS THE OPTIMAL METHOD FOR STENTING THE PATIENT WITH HILAR MALIGNANT OBSTRUCTION?

- We Have Several Stent Options:
- Plastic stents to one or both sides of liver
- Single metal stent to one side of liver
- Bilateral Metal Stents – side by side
- Bilateral Metal Stents – Stent in Stent (creating a Y)

I,II			Unilateral (Rt.)
IIIa	* 		Bilateral or Multiple segment-Unilateral
IIIb	** 		Unilateral or Bilateral
IV	*** 		(Multiple segments) Unilateral or bilateral



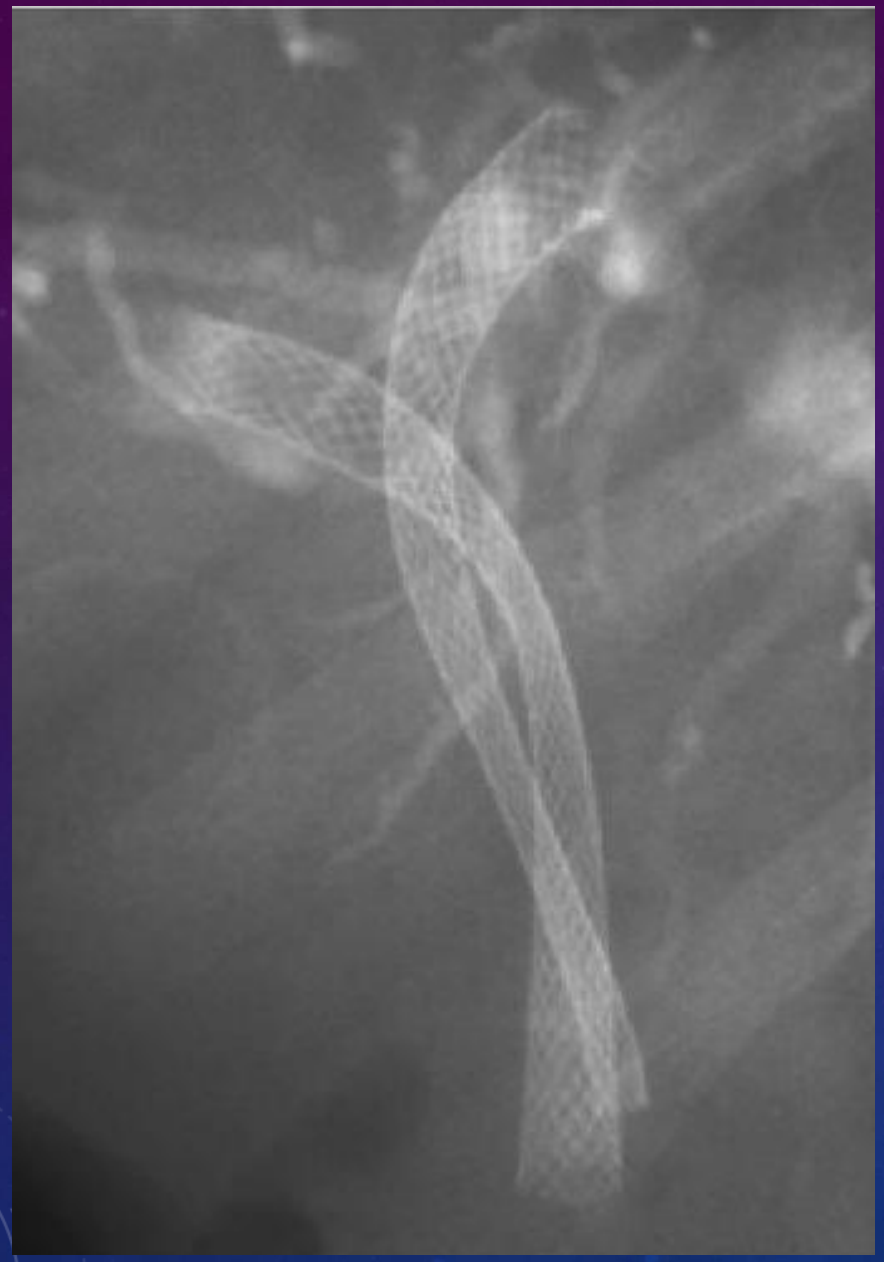
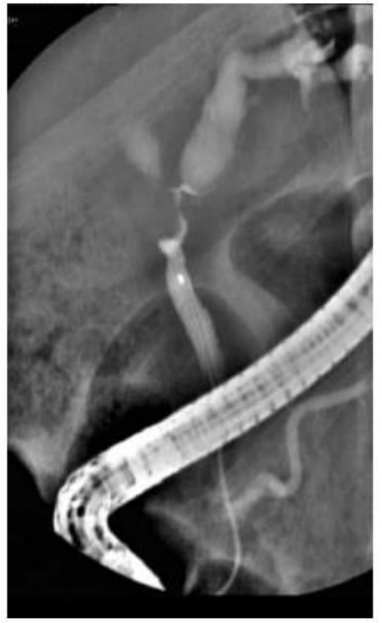


Figure **1** A biliary "Y" stent with a segment of wider mesh holes in the middle part (arrowheads), through which the second stent is passed toward the contralateral side.



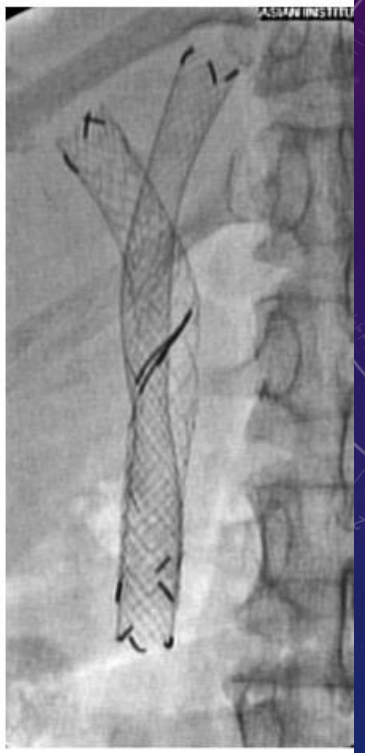


Figure **3** Radiograph showing the deploy Y stent.

patient was jaundice- and pruritis-fr 10 weeks after the procedure. The Y ste appears to represent a technically easi option for the managment of maligna hilar biliary strictures.

Endoscopy_UCTN_Code_TTT_1AR_2AZ

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PROSPECTIVE COMPARISON OF ENDOSCOPIC BILATERAL STENT-IN-STENT VERSUS STENT-BY-STENT DEPLOYMENT FOR INOPERABLE ADVANCED MALIGNANT HILAR BILIARY OBSTRUCTIONS

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KOREA

PROSPECTIVE COMPARISON OF ENDOSCOPIC BILATERAL STENT-IN-STENT VERSUS STENT-BY-STENT DEPLOYMENT FOR INOPERABLE ADVANCED MALIGNANT HILAR BILIARY OBSTRUCTIONS

- prospective, randomized, multicenter study compared bilateral stent-in-stent (SIS) with stent-by-stent (SBS) deployment in advanced inoperable malignant hilar stricture
- 69 of 74 pathologically diagnosed patients who met the eligibility criteria to SIS (n=34) or SBS (n=35) groups
- The total adverse event rates after stent deployment did not differ between the two groups (23.5% in the SIS group *vs*. 28.6% in the SBS group,
- The clinical success rates were 94.1% (32/34) and 90.6% (29/32),
- The stent patency rate at 3 months was 85.3% in the SIS group and 65.7% in the SBS group (p = 0.059). At 6 months, the stent patency rates were 47.1% and 31.4% in the SIS and SBS groups, (p = 0.184)

SIDE-BY-SIDE VERSUS STENT-IN-STENT UNCOVERED SELF-EXPANDABLE METALLIC STENT PLACEMENT FOR MALIGNANT PERIHILAR BILIARY OBSTRUCTION: A PROSPECTIVE, MULTICENTER, RANDOMIZED CONTROLLED TRIAL (PASSION STUDY)

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SIDE-BY-SIDE VERSUS STENT-IN-STENT UNCOVERED SELF-EXPANDABLE METALLIC STENT PLACEMENT FOR MALIGNANT PERIHILAR BILIARY OBSTRUCTION: A PROSPECTIVE, MULTICENTER, RANDOMIZED CONTROLLED TRIAL

- Between 2015 and 2017, ninety consecutive patients were randomized to the SBS (n = 47) and SIS (n = 43) groups
- Number of days to obstruction was 175 (95% confidence interval; 126-257 – SBS) and 285 (95% confidence interval; 114-427 – SIS)
- technical success rate was 89.1% and 85% (P = 0.567);
- early adverse event rate was 28.3% and 27.5% (P = 0.871)
- late adverse event rate was 15.2% and 15.0% (P = 0.784);
- overall survival rate was 222 and 388 days (P = 0.207

SIDE BY SIDE VERSUS STENT IN STENT: SUMMARY

- 2 large prospective studies give a good understanding of what best possible practice can accomplish in hilar strictures
- Two methods of metal stenting seem statistically similar, but both show strong trends to superiority of y-configuration stenting
- One wonders if a larger study would show superiority of Y configured stents.

EARLY ENDOSCOPIC RETROGRADE CHOLANGIOGRAPHY WITH BILIARY SPHINCTEROTOMY OR CONSERVATIVE TREATMENT IN PREDICTED SEVERE ACUTE BILIARY PANCREATITIS (APEC): A MULTICENTER RANDOMIZED CONTROLLED TRIAL

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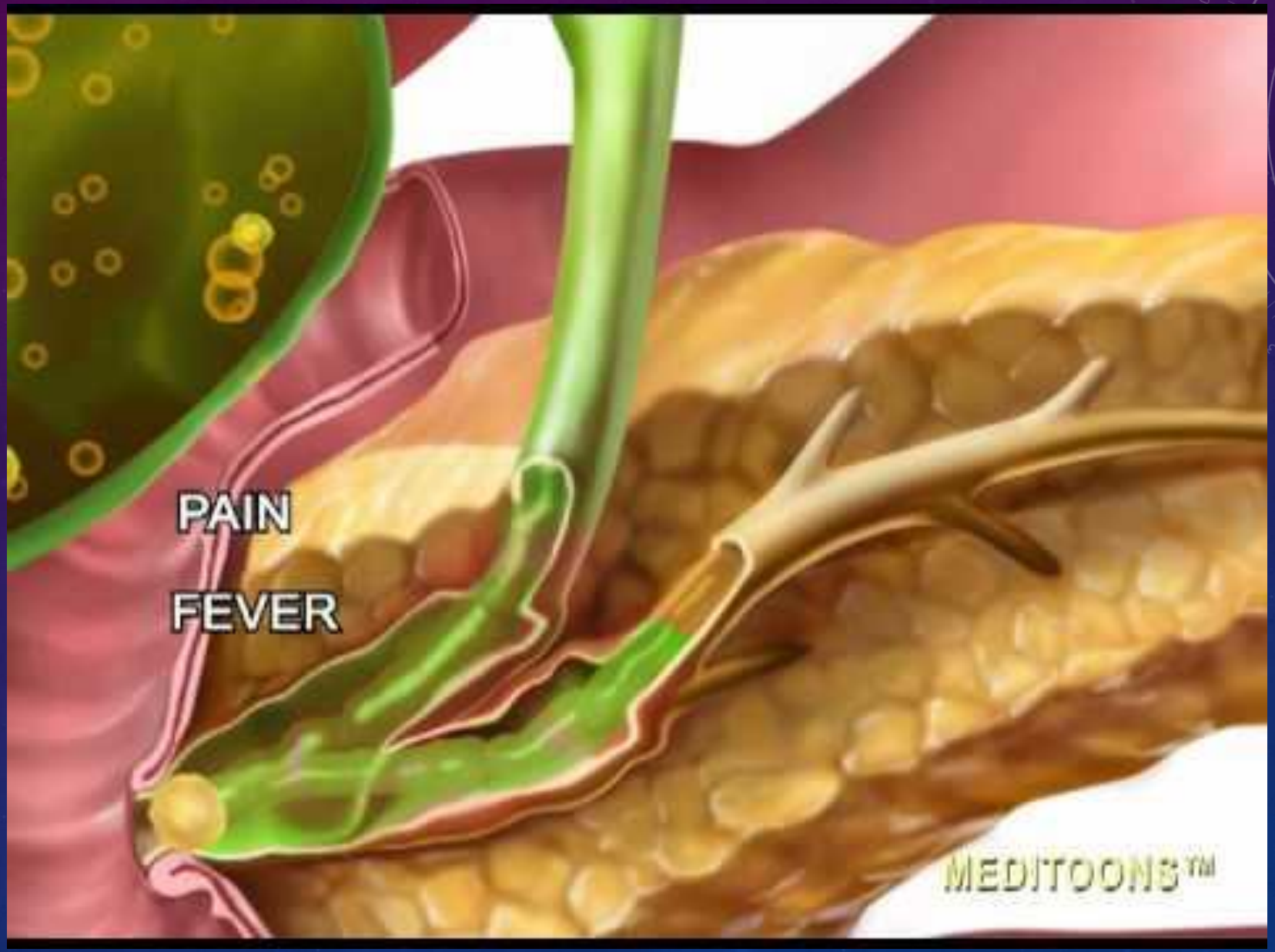
EARLY ERCP AND SPHINCTEROTOMY FOR GALLSTONE PANCREATITIS: BACKGROUND

- DOES RAPID DRAINAGE OF THE CBD IMPROVE OUTCOMES IN GALLSTONE PANCREATITIS, ESPECIALLY IN THE SICKEST PATIENTS?
- MOST GALLSTONE PANCREATITIS PATIENTS PASS THEIR STONE SPONTANEOUSLY, AND MOST CASES ARE MILD
- IN PATIENTS WITH CHOLANGITIS, WE KNOW FROM A LARGE HONG KONG STUDY THAT THE SICKEST PATIENTS BENEFIT FROM EARLY ERCP AS OPPOSED TO WAITING
- WHAT ABOUT THOSE PATIENTS WITHOUT CHOLANGITIS??


PAIN
FEVER
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- They randomized 232 patients in 26 Dutch hospitals with predicted severe acute biliary pancreatitis to early ERC with biliary sphincterotomy within 24 hours after presentation at the emergency department or conservative treatment
- 112 patients (96%) in the early group underwent ERC at a median of 20 hours after presentation at the emergency department and after a median of 29 hours after symptom onset
- Death or severe complications occurred in 45 of 117 patients (39%) in the early ERC group compared with 50 of 113 patients (44%) in the conservative group (NS)
- In the early ERC group, cholangitis occurred less often compared with conservative treatment (2% versus 10%; P=0.01) without significant differences in patient outcome including new-onset organ failure (19% versus 15%; P=0.45), death (7% versus 9%; P=0.57) or other components of the primary end point

SUMMARY:

EMERGENT ERCP IN GALLSTONE PANCREATITIS WITHOUT OBVIOUS CHOLANGITIS DOES NOT IMPROVE OUTCOMES. ERCP SHOULD BE PERFORMED FOR CHOLANGITIS OR DEFINITE PERSISTENT STONE, ON AN AS NEEDED BASIS

COMBINED PROPHYLACTIC TREATMENT WITH DICLOFENAC AND SUBLINGUAL NITROGLYCERINE IS SUPERIOR TO DICLOFENAC ALONE IN POST ERCP PANCREATITIS: A MULTI-CENTER PROSPECTIVE RANDOMIZED TRIAL

- *Toru Ueki[1], Takeshi Tomoda[2], Hironari Kato[2], Soichiro Kawahara[1], Yutaka Akimoto[3], Hidenori Hata[4], Masakuni Fujii[5], Ryo Harada[6], Tsuneyoshi Ogawa[7], Masaki Wato[8], Masahiro Takatani[9], Minoru Matubara[11], Yoshinari Kawai[10], Hiroyuki Okada[2]*
- JAPAN

BACKGROUND –

- RECTAL INDOMETHACIN ADMINISTERED AROUND THE TIME OF ERCP REDUCES THE INCIDENCE OF MILD AND SEVERE PANCREATITIS BY AT LEAST 3% AND PERHAPS MUCH MORE.
- STENTS IN THE PANCREATIC DUCT ALSO REDUCE THE CHANCE OF PANCREATITIS, PRESUMABLY BY MAINTAINING FLOW ACROSS AN IRRITATED OR EDEMATOUS PANCREATIC SPHINCTER
- NTG HAS BEEN SHOWN TO HAVE A RELAXATIVE EFFECT OF THE SPHINCTER OF ODDI
- COULD NTG ACT AS A STENT DOES, TO REDUCE THE CHANCE OF PANCREATITIS?

STUDY DESIGN

- eligible patients with native papilla who underwent ERCP at 12 endoscopic units in Japan were randomly medicated with a 50 mg diclofenac suppository within 15 minutes after the endoscopic procedure either alone (diclofenac alone group) or with 5 mg sublingual isosorbide dinitrate 5 minutes before the endoscopic procedure
- The primary endpoint was the occurrence of PEP which was defined as the development of abdominal pain and elevation of serum amylase levels by more than 3 times the upper normal limit within 24 h after an ERCP
- Secondary endpoints included the development of moderate or severe PEP, the frequency of PEP in the patients with the risk factors for PEP, adverse events (AE) related to the study drugs.

RESULTS:

- Between March 2015 and May 2018, we initially enrolled 900 patients and 14 were excluded after randomization (combination group: 444; diclofenac alone group: 442)
- Post-ERCP pancreatitis developed in 25 patients in the combination group (5.6%), and in 42 patients in the diclofenac alone group (9.5%) (relative risk, 0.59; 95% CI, 0.37–0.95; p=0.03).
- Moderate-to-severe pancreatitis developed in 4 patients (0.9%) in the combination group, and in 10 patients (2.3%)
- Among the high-risk patients for PEP which were well-known, PEP occurred in 24 of the 288 patients (8.3%) in the combination group, and in 39 of the 301 (13.0%) in the diclofenac alone group (P=0.08).
- 35 patients (7.9%) in the combination group and 13 (2.9%) in the diclofenac alone group presented mild transient hypotension during the ERCP procedures which was improved within several minutes (P=0.002). There was no significant difference in the frequency of the other AEs and was no serious AEs related to the additional administration of sublingual nitrate.

CONCLUSION:

- COMBINATION TREATMENT OF NTG PLUS RECTAL NSAIDS LOOKS BETTER THAN NSAIDS ALONE.
- MAYBE PANCREATIC STENTING, PLUS IV LACTATED RINGERS, MAY ADD EVEN ADDITIONAL BENEFIT.
- THERE WILL LIKELY BE MUCH WORK IN THE FIELD OF ADDITIVE MANEUVERS TO REDUCE PANCREATITIS IN ERCP.
- STAY TUNED!!