

## EUS-guided antegrade pancreatic duct access: Burning questions



In patients with symptomatic chronic pancreatitis, adequate access to the pancreatic duct has remained the Achilles' heel of endoscopic treatment, fueling endoscopic failure rates varying from 47% up to 62% [1, 2]. In the April issue of *Endoscopy International Open*, Douglas Motomura and colleagues elegantly describe the value of endoscopic ultrasound (EUS)-guided pancreatic duct drainage (EUS-PDD) in overcoming this hurdle in patients who failed retrograde access [3]. Similar to our own practice, the primary goal was to perform rendezvous in patients with favorable anatomy [4], which was successful in 39% of patients, followed by transmural stenting or pancreatogastrostomy in case of rendezvous failure ( $n=30$ , 70% technical success). The authors furthermore accentuate the fact that experience plays a crucial role in EUS-PDD, entrusting us with various valuable pearls of wisdom that were picked up during the course of the study. Although we fully agree with almost all of the points raised, we felt that some important elements were missing, which have the potential to greatly improve outcomes for these patients.

It is generally accepted that rendezvous should be preferred over direct transmural stenting or pancreatogastrostomy, as this has the potential to reduce complications and a more physiological drainage route is obtained [4]. However, manipulating the guidewire across tight strictures or large stones with the wire tip alone only succeeds in a minority of cases in our experience. In case of failure, we typically insert a 6F cystotome, which is first used to gain electrocautery-assisted access to the pancreatic duct, and subsequently advanced inside the duct and used as a stiff diagnostic catheter, providing a more stable platform for transpapillary guidewire advancement. In our retrospective EUS-PDD analysis, for example, cystotome-assisted wire advancement was required

in 48% of rendezvous cases to achieve successful transpapillary access [5]. Should initial rendezvous fail, this fistulous tract immediately facilitates transmural stent placement and antegrade re-intervention following tract maturation.

Another piece of the puzzle for successful endoscopic therapy has become the concept of complete ductal drainage. In a subanalysis of the 2020 ESCAPE-trial, patients with symptomatic chronic pancreatitis and complete endoscopic ductal drainage were compared with early surgery, showing almost similar outcomes regarding mean Izbicki pain scores, suggesting that the claimed advantages of surgery were at least partially driven by endoscopic failure to access, clear, and stent the duct [2]. The issue is that modern advanced endoscopy should broaden its goals to achieving complete endoscopic ductal drainage using efficient access techniques, adequate stricture management and effective stone clearance using digital single-operator pancreatoscopy techniques. As the study period also covers the introduction of these dedicated devices, we wonder how this has affected the contributing endoscopists' experience and whether such techniques were considered in the current study at the index procedure.

In conclusion, EUS-PDD seems to have revolutionized the endoscopic management of symptomatic chronic pancreatitis. Besides the additional value of electrocautery-assisted pancreatic duct access, the real "burning" question that currently remains is how these improved access techniques, together with the novel concept of complete endoscopic ductal drainage, compare to surgery.

### Conflict of Interest

Michiel Bronswijk received study grants from Boston Scientific and holds consultancy agreements with Dekra and Prion Medical-

Taewoong. Roy L.J. van Wanrooij performed as a consultant for Boston Scientific. Rogier P. Voermans reports research grants from Boston Scientific and Prion Medical, performed as a consultant for Boston Scientific and Cook Medical, and received speaker's fee from Mylan and Zambon. Schalk van der Merwe holds the Cook chair in Interventional endoscopy, has consultancy agreements with Cook, Pentax and Olympus and co-chairs the Boston-Scientific Chair in Therapeutic Biliopancreatic Endoscopy. Giuseppe Vanella and Paolo G. Arcidiacono declare no conflicts of interest.

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