



Correspondence

Author's reply: Outcomes of minor versus major papilla rendez-vous: All we have for now!


Dear Editor:

The endoscopic management of chronic pancreatitis has undergone revolutionary changes in the last decade. Where tools to achieve adequate ductal decompression used to be limited, both therapeutic endoscopic ultrasound (EUS) and digital single-operated pancreatoscopy (DSOP) have changed our approach in radical fashion, by improving ductal access and guiding stone clearance respectively. These novel approaches not only bring forth new research questions, as discussed in our January 2024 article [1], but also spark discussion within our own field [2–5]. We sincerely thank Dr. Saad Hassan and colleagues for their interest in our study and would like to take this opportunity to respond to their observations.

The our study was conceived following our observation that in many patients undergoing EUS-guided rendez-vous preferential non-intentional guidewire advancement through the minor papilla occurred. We wondered whether the outcomes following minor papilla rendez-vous led to similar outcomes when compared to major papilla rendez-vous. To date, no other studies have focused on this topic. This retrospective design inherently brings forth a certain degree of bias, as eluded to by our esteemed colleagues. We attempted to reduce this risk by including all consecutive EUS-guided pancreatic duct drainage (EUS-PDD) cases and using our widely accessible nation-wide health database to minimize missing data or recall bias. Although we agree that we should transition to randomized trials to minimize bias and other confounding factors, the colleagues will concur that first observational data should be obtained, with all of their intrinsic disadvantages, to guide any future randomized study design. We do think that it is unlikely that any randomized comparisons between minor and major papilla rendez-vous will become available, as this falsely suggests that we actively choose between both papillae whilst performing these challenging procedures.

Regarding the adverse event (AE) reporting, we believe that we delivered sufficient information to adequately assess the nature and severity of the complications (see Table 3). In the safety section we even elaborate on AE management, which should enable the readers to fully understand the safety considerations following such procedures.

As for the long-term outcomes, we have to acknowledge that only limited data are available with the field of EUS-PDD. The available studies are mostly retrospective, often include fewer than 30 cases and exhibit a relatively short follow-up duration

[6–8]. Only very recently, a Spanish study was published focusing specifically on long-term outcomes [9]. After a median follow-up of 58 months, 21 % of patients required endoscopic revision, whereas 14 % of patients eventually required surgery following endoscopic failure. This study underlines our current 'endoscopy first'-approach, where surgery is offered to patients who experience persistent symptoms despite endoscopic treatment, patients with tail-predominant disease or following technical failure of endoscopic ductal clearance. For now, specifically designed randomized comparisons between maximum endoscopic therapy and surgery are lacking [10,11].

Despite the abovementioned shortcomings, we believe that the current study does suggest that in patients where preferential guidewire advancement through the minor papilla has occurred, similar outcomes can be expected when compared to major papilla rendez-vous. In short, how to achieve adequate ductal clearance seems more important than the question through which route it should be provided. As randomized confirmations of these findings are unlikely to become available in the future, these results may aid in unraveling a small portion of the residual knowledge gap within EUS-guided pancreatic duct drainage.

Conflict of interest

Michiel Bronswijk received trial support from Boston Scientific and holds consultancy agreements with Dekra, Ovesco and Prion Medical-Taewoong. 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.

Funding

None.

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DOIs of original articles: [10.1016/j.dld.2023.07.027](https://doi.org/10.1016/j.dld.2023.07.027), [10.1016/j.dld.2024.06.014](https://doi.org/10.1016/j.dld.2024.06.014)

<https://doi.org/10.1016/j.dld.2024.07.021>

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