

## Reply to Bronswijk et al



We thank Dr. Bronswijk et al. for their very astute and thoughtful comments. We read with great interest their technique to facilitate transpapillary wiring, using a 6F cystotome to enter the pancreatic duct (PD), and subsequently assist in manipulating the direction of the wire [1]. Certainly, this would be of value, as although a wire was able to be placed in the PD in 94 patients in our series (85%), only 57 of those patients were able to have the wire manipulated across the papilla. However, one of the barriers to this technique locally would be access to the instruments of interest. To our knowledge, there is no approved 6F cystotome for use in North America, thus, our current cystotome is 10F (Cook Endoscopy, United States).

As the authors pointed out, European guidelines suggest a rendezvous approach over direct transgastric stenting when possible, highlighting the reduced complication rates [2]. However, we are unsure how the adverse event (AE) rate would be affected if a cystotome (particularly a 10F cystotome) were used regularly to facilitate transpapillary rendezvous. Theoretically, so long as drainage is achieved via transpapillary or transgastric means, the risk of duct disruption or leak should be low. Currently, we have only used the cystotome in select cases to facilitate transgastric stent deployment. However, should data show favorable safety and technical success with the 10F cystotome, we would certainly consider adopting this technique in the future.

We also read with interest the authors' usage of minor transpapillary rendezvous with a non-significant increase in clinical success rates and comparable AE rate to major papilla rendezvous [1]. In our series, this was only performed on one patient (0.9%), but we agree that any transpapillary access (be it minor or major) into the duodenum would be preferable to avoid the risks of transgastric stenting.

Although not touched on in detail in our manuscript, complete ductal clearance is certainly another key piece of sustained clinical success [3]. Single-operator pancreatoscopy has been shown to be effective for clearance of stones, but we remain cautious with its use due to the AE profile [4]. Locally, patients with a significant stone burden will receive extracorporeal shockwave lithotripsy followed by attempted retrograde clearance, with variable degrees of success.

Finally, we agree with the authors regarding the necessity of comparisons to surgical interventions. With more techniques in the endoscopic toolbox, and improved operator experience, we are excited to see if endoscopic therapies can prove to be an effective and safe alternative to major surgery in benign pancreatic disease.

### Conflict of Interest

The authors declare that they have no conflict of interest.

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