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Rescue gallbladder drainage in very high-risk surgical patients with acute cholecystitis: Could COVID-19 patients be best suited for the EUS-guided approach?

To the Editor:

We read with great interest the systematic review and network meta-analysis by Podboy et al,[1] comparing the efficacy of EUS-guided, endoscopic transpapillary, and percutaneous gallbladder drainage (GBD) in patients with acute cholecystitis and unfit for or with contraindications to surgical intervention.

Among the different strategies of salvage therapy proposed in this setting of nonsurgical patients,[2] many studies[3-5] and meta-analyses[6,7] have shown that the EUS-guided technique improved the outcomes in very high-risk patients, either as a bridge to surgery or as definitive therapy. Although each modality has its specific pros and cons and there was no single winner, the study by Podboy et al[1] concluded that endoscopic GBD should be preferred over percutaneous technique, choosing the EUS-guided approach in particular cases as definitive treatment, provided that adequate expertise in therapeutic EUS is available.[8]

Moreover, the clinical scenario influences the choice of a specific technique and its outcome.[1] This issue is even more relevant during the current spreading SARS-CoV2 outbreak,[9] in which some cases of acute cholecystitis in the COVID-19 setting are reported and mainly treated with percutaneous drainage.[10] Critically ill COVID-19 patients certainly fall within the high-risk and unfit-for-surgery groups. In our experience, an elderly patient admitted to the intensive care unit for severe COVID-19 disease and concomitant septic acute cholecystitis underwent EUS-guided GBD by a lumen-apposing metal stent (Hot-Axios 15 × 10 mm, Boston Scientific, Mass, USA) through a transgastric route; the procedure was performed at bedside with the use of personal protective equipment, under endoscopic and EUS guidance and without fluoroscopic assistance, and lasted 20 minutes.

High-risk surgical COVID-19 patients with concomitant acute cholecystitis could be best suited for EUS-guided GBD, in consideration of some advantages over the percutaneous approach, such as the lower rates of recurrent cholecystitis and reinterventions.[1] We suggest taking into account other pros such as the short procedure time and the absence of needing to move the patients and to equip operative and/or radiologic rooms.

DISCLOSURE

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