

Double EUS bypass: same sequence, different reasons



To the Editor:

In December, the video case report by Kevin D. Platt et al¹ was published online, describing the successful EUS-guided palliation of a metastatic ovarian cancer with biliary and duodenal obstruction. We agree with the authors that simultaneous creation of a double EUS bypass is feasible, and we think that this is a crucial addition to the endoscopic armamentarium in patients with a bifocal stenosis.^{2,3} In the current case report, the authors mention performing the EUS-guided gastrojejunostomy (EUS-GJ) first, followed by the EUS-guided hepaticogastrostomy. In our opinion, aside from preventing EUS-guided hepaticogastrostomy dislodgement after EUS-GJ, there are 2 other important reasons to perform these procedures in the described order.

Recently, we assessed the use of EUS-guided biliary drainage in the context of failed ERCP and postsurgical anatomy.⁴ This series included 9 patients in whom a double EUS bypass was performed. Analysis of these procedures revealed that in 6 of 9 combined procedures, significant contrast extravasation or free air surrounding the stomach was seen after successful intrahepatic biliary drainage,⁴ which may compromise visualization during EUS-GJ. Furthermore, in situations where biliary drainage has been performed first, additional insufflation of CO₂ during EUS endoscope insertion or while placing a nasojejunal catheter in preparation for EUS-GJ will keep the transgastric tract patent. This may allow for gas to egress into the peritoneal cavity, resulting in a capnoperitoneum with the potential of significantly complicating subsequent EUS-GJ. However, the most compelling reason to perform EUS-GJ first is the fact that successful EUS-guided biliary drainage is dependent on a functioning gastrojejunal transit. If creation of an EUS-GJ is not possible, EUS-guided biliary drainage is futile and will only result in cholangitis.

In summary, we concur that the development of EUS-guided double bypass procedures has evolved as a potentially crucial step forward in the management of patients with both gastroduodenal and biliary stenosis. Furthermore, we strongly recommend that EUS-GJ be performed

first, followed by EUS-guided biliary drainage, albeit for reasons other than those stated by the current authors.

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Abbreviation: EUS-GJ, EUS-guided gastrojejunostomy.

REFERENCES

1. Platt KD, Bhalla S, Sondhi AR, et al. EUS-guided gastrojejunostomy and hepaticogastrostomy for malignant duodenal and biliary obstruction. *VideoGIE* 2021;6:95-7.
2. Irani S, Itoi T, Baron TH, et al. EUS-guided gastroenterostomy: techniques from East to West. *VideoGIE* 2019;5:48-50.
3. Brewer Gutierrez OI, Nieto J, Irani S, et al. Double endoscopic bypass for gastric outlet obstruction and biliary obstruction. *Endosc Int Open* 2017;5:E893-9.
4. Vanella G, Bronswijk M, Maleux G, et al. EUS-guided intrahepatic biliary drainage: a large retrospective series and subgroup comparison between percutaneous drainage in hilar stenoses or postsurgical anatomy. *Endosc Int Open* 2020;8:E1782-94.

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