

## Is there any tip that makes performing EUS-guided drainage easier and safer?



Endoscopic ultrasound (EUS)-guided drainage is evolving and no standardized technique for it has been established yet. Availability of dedicated devices and accessories also are lacking. Anderloni et al. described a new technique of stent deployment named Intra Channel Stent Release Technique (ICSRT) in EUS-guided drainage [1], which is summarized as follows: deployment of the proximal part of the stent within the working channel of the echoendoscope and then gentle withdrawal of the scope. As the authors has emphasized, the core of this technique is maintaining stable and secure positioning of the scope during the procedure, thus decreasing the chance of failure.

We totally agree, however, in 2017 we introduced a similar technique called the “modified stent deployment maneuver” [2]. In our previous study about EUS-guided hepaticogastrostomy, to stabilize positioning/attachment of the echoendoscope in the high body of the stomach or the cardia during stent placement, we deployed the front half of the dual-flap metal stent, and next the remainder of the stent within the channel of echoendoscope, and then gently pulled out the echoendoscope, leaving the stent. Because stabilization of the scope is most difficult during hepaticogastrostomy, we introduced this technique with a conventional stent deployment system during EUS-guided hepaticogastrostomy.

The concept of our modified stent deployment maneuver and intra-channel stent release technique (ICSRT) is the same, the only difference between the 2 techniques being that ICSRT is performed under complete EUS control using a novel dedicated EUS-guided drainage device (Hot AXIOS™, Boston Scientific Corp., Marlborough, MA, USA). However, fluoroscopic guidance is mandatory during hepaticogastrostomy. Even during EUS-guided choledochoduodenostomy, we recommend doing the procedure under fluoroscopic guidance because it is not possible to anticipate what problems may develop during EUS-guided drainage.

Finally, according to this study, the role of black marker in the catheter for endoscopic deployment of the proximal flange in the AXIOS stent is questionable. Given the high cost of the AXIOS stent with dedicated endoscopic deployment system, a dedicated lumen-apposing stent with conventional deployment system may be more attractive. EUS-guided drainage is a challenging procedure and formal training dedicated to EUS-guided drainage is difficult. To develop and establish a standardized protocol for EUS-guided drainage, sharing technical tips and information development of dedicated devices is important.

### Competing interests

None

### The authors

Woo Hyun Paik<sup>1</sup>, Do Hyun Park<sup>2</sup>

- 1 Department of Internal Medicine and Liver Research Institute, Seoul National University Hospital, Seoul National University College of Medicine, Seoul, Korea
- 2 Division of Gastroenterology, Department of Internal Medicine, University of Ulsan College of Medicine, Asan Medical Center, Seoul, Korea

### Corresponding author

**Do Hyun Park, MD, PhD, Associate Professor of Internal Medicine**

University of Ulsan College of Medicine, Asan Medical Center, 88 Olympic-Ro 43-Gil, Songpa-gu, Seoul 05505, Korea  
Fax: +82-2-3010-8043  
dhpark@amc.seoul.kr

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