Surveillance in individuals at high risk of pancreatic cancer: too early to tell?
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We describe our experience of successfully deploying a wireless capsule endoscope (PillCam, Yqnoop, Israel) in five instances of gastric retention encountered during 205 procedures performed from October 2006 to September 2009. All patients followed standard instructions as suggested by the manufacturers. Individuals with previous history of gastric retention or failure to pass at least one capsule were included in the study. Written informed consent was obtained from all patients. Endoscopic duodenal deployment was required in five instances, including two patients with suspected Crohn’s disease and another 28-year-old female patient who required WCE on three different occasions for recurrent significant anaemia and associated persistently positive faecal occult blood test. In this patient, initial WCE failed due to excessive bowel secretions, the second examination was conducted with prior administration of simethicone suspension and mesenteric angiography, both being non-contributory.

All patients swallowed the capsule just prior to an oesophagogastroduodenoscopy under conscious sedation using midazolam. The swallowed capsule was identified in the stomach and was captured using the polyp retrieval net (RothNet-Polyp, Mentor, OH, USA, net diameter 3 cm, shaft diameter 2.5 mm) passed down the scope and advanced to the duodenum. Our modified technique involved performing 3–4 moderately forceful ‘to-and-fro’ movements of the polyp basket net towards the tip of the scope before finally pulling it out. This manoeuvre led to easy breakdown of the net threads without any difficulty, and resultant release of the capsule in the desired location. During these procedures we did not encounter any mechanical or traumatic complications. In all the patients, the capsule subsequently passed to the caecum. Using this slightly modified technique we avoided the potential complications described with the use of an over tube and the use of argon plasma coagulation for cutting the threads of the retrieval basket.

In conclusion, this simple modified technique for the direct duodenal deployment of WCE appears safe and does not influence the video quality of the procedure. This technique, however, needs further evaluation from larger cohorts.

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Authors’ response

We thank Qasim et al for their contribution.1 They comment and report on the few cases in adults, in which endoscopic capsule insertion into the duodenum is necessary in 50 of 205 patients in their letter. The problems with trauma to the gut mucosa using the Roth net are certainly encountered in children as well as adults. However, the problems in children are much more marked as the entrance to the oesophagus as well as the pylorus and duodenal lumen are considerably smaller in diameter when compared with adults, resulting in rather obvious difficulties to expel any contents out of the Roth net.

We do not believe that the technique the authors use does indeed differ from our or other experienced examiners’ procedure. Usage of the Roth net included to and fro movements to expel the contents on a routine basis. However, the actual reason for the difficulty with this device in small children is the smaller lumen of the small bowel in a 4 year old, which we reported in our paper. In some cases, to and fro movements and even relocation of the capsule into a different area of the basket did not reduce the difficulty in expelling it as opening the basket in this small space proved difficult and was sometimes very hard to achieve. In small children as we showed in our study the ‘acorn’ type of introducer whether commercially made (Advance®, Introducer, US Endoscopy, Mentor, Ohio, USA) or custom made was much easier to use with little or no trauma to the mucosa as no to and fro movements are necessary and the device has no sharp edges.

Annette Fritscher-Ravens and Peter Millar for the European Paediatric Capsule Study Group.

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Competing interests None.

REFERENCES


Surveillance in individuals at high risk of pancreatic cancer: too early to tell?

We have read with great interest the publication by Langer et al.1 Pancreatic cancer surveillance of high-risk individuals may have the potential to alter the dismal prognosis of this deadly disease. Although promising, its application is a learning experience and results of pancreatic cancer surveillance studies are eagerly awaited. Although we greatly value the efforts of Langer et al we have some comments and questions.

The title of their paper suggests a prospective cohort study with a median follow-up observation period of 5 years. Indeed, the time period in which individuals were included was 5 (and a half) years (between June 2002 and December 2007). However, as we read from the manuscript, the median number of examination visits was 2 (range 1—7), maximally 1 year apart. This is almost similar to a cross-sectional design type of study. Both endoscopic ultrasound (EUS) and MRI were part of the programme, but while 329 MRIs were performed, only 167 EUS investigations were reported. Could the authors clarify these issues to help us understand the median observation time per patient, the median number of MRI and EUS examinations per patient, as well as overall follow-up in patient-years?

The diagnostic yield of screening among 76 individuals was 1.3%, which is much lower than that in an EUS—CT based surveillance programme from the USA2 (pathologically confirmed neoplasms 10%) and an EUS based surveillance programme from the Netherlands3 (asymptomatic cancer 6.8%, IPMN Intraductal Papillary Mucinous Neoplasms-like lesions, 15.9%). This difference might be related to differences in the patient populations; the majority of the individuals included (58%) by Langer et al were at moderate risk. In addition, one might question whether some

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of the included melanoma–pancreatic cancer syndrome families were even at moderate risk, since they were non-carriers of the CDKN2A mutation. Was mutation analysis obligatory or only offered in families suspected to carry an inherited tumour syndrome? If the former is true, it might be that 50% of those individuals included were not at increased risk of pancreatic cancer.

The yield in the Langer et al study was based on the prevalence of neoplasia in patients who had surgery at their institution. Could the authors provide us with additional information regarding the number of individuals who are under close surveillance because of the detection of a potentially premalignant lesion that did not (yet) meet surgical criteria? Moreover, EUS examinations were done by a single very experienced endosonographer. Were EUS investigations and abnormalities photographed or videotaped and reassessed and confirmed by other observers?

In the abstract conclusion, it is stated that the enormous psychological stress for the tested individual should be one of the considerations that pancreatic cancer screening is not justified. We do not agree per se. The issue of psychological stress applies to all types of cancer screening and surveillance programmes. This does not withhold us from running these programmes to prevent cancer deaths. Was the level of psychological stress studied by Langer et al and can they provide additional data to substantiate their statement?

Before any discussion, we read with interest the letter by Harinck et al as a response to our paper2 and are grateful for the opportunity to respond. Harinck et al offer the criticism that the trial was not prospective as suggested by the title of our paper and the median number of examination visits was only two, with a maximum of 1 year apart. As described in our paper this was a peer-reviewed, board-approved trial that was designed as a prospective controlled study. Clin Gastroenterol Hepatol 2006;4:766–81; quiz 685.

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We recently operated two (one moderate risk, one high risk) of these 21 IAR due to the change of their lesion among multifocal PanIN 3 lesion among multifocal PanIN lesions. Intriguingly, the most dysplastic histological lesion in both cases did not correspond to the preoperatively detected lesions and were not visible in preoperative imaging (unpublished).

Harinck et al questioned the EUS-screening approach, and in particular the experience and the number of independent investigators. Indeed, all EUS examinations in our programme were performed by one very experienced endosonographer (PHK). According to the protocol standard sections and abnormalities were documented by serial photographs. All examinations were then independently re-assessed and confirmed by another experienced endosonographer (TMG).

Harinck et al also discussed the possibility that our paper carries a message that will increase the number of cancer deaths by questioning the relevance of screening for pancreatic cancer in IAR and by pointing out that IAR are exposed to significant psychological stress. Of course, both observations will not refrain us from conducting a screening programme for IAR from pancreatic cancer families in the setting of a board.
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