Foreword

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Dear colleagues and friends,

For the second time, I am happy to comment the new EIO issue.

This issue features 6 studies on 6 very different topics and from different continents.

The first study is from UK and raises many questions, despite some limitations (single center and retrospective study). It is a case-control study of patients with venous thromboembolism (VTE). The risk to present with VTE is higher (O.R. 3.58) following endoscopy than for the controls. When patients at risk for VTE are excluded, the risk is the same with or without previous endoscopy. Causes to explain this higher risk of VTE related to endoscopy could be dehydration, long-lasting fixed position or increased intraabdominal pressure.

Endoscopic treatment has become over the years the standard treatment of ulcerative gastrointestinal bleeding, but still failures are not uncommon and could lead to situations which are difficult to manage. The study from Singapore and Hong-Kong is the first meta-analysis comparing surgical arterial embolization treatment. The problem is that comparative studies are few and retrospective. Conclusions of this meta-analysis should be interpreted with caution, as the authors point out. Embolized patients were older and had more comorbidities, but a post hoc sensitivity analysis did not show age or comorbidities as confounding factors. Analysis of embolization is penalized by using very different techniques in the different studies, and it seems that surgery still plays a major role.

Another study from Osaka, Japan deals with ESD at the level of the esogastric junction. The respective roles of ESD and EMR are still debated for cancers arising from Barrett's mucosa and ESD itself is challenging in this location, especially for non Asiatic operators. This study is a plea for ESD due to the high R0 resection rates. Furthermore, this study emphasizes the need to get a 1 cm safety lateral margin because of the risk of submucosal lateral extension.

The fourth study (from the Netherlands) evaluated the role of a novel endoscopic bariatric technique (duodeno-jejunal bypass liner) to induce remission of type 2 diabetes mellitus. Twelve obese patients were followed-up 24 weeks after the liner placement. Significant weight loss, decrease in fat mass, and early remission of type 2 diabetes, were observed for bypass surgery. Accompanying gut hormone responses were also analyzed. Unexpected increase in fasting ghrelin should be analysed further.

A meta-analysis has been conducted in the USA about the role of age on ERCP-related side-effects. This paper, the first of this kind, shows that increasing age seems to protect against post-ERCP pancreatitis and that ERCP is safe in the elderly when it is defined by age > 65. However, above the age of 80 or 90, cardiopulmonary adverse events (maybe explained by more severe comorbidities) and bleedings (maybe due to more frequent medications, more frequent diverticulum or larger stones) are more frequently observed and mortality increased by 2 to 4-fold.

The last paper is very appealing as it reports another application of the OTS clips. These clips already changed the landscape of iatrogenic perforation as it is a very effective rescue therapy in this case. In these series from the USA, OTS clips have been used also as a rescue therapy for different acute severe upper GI bleeding in case of failure of previous endoscopic treatment. The clips appear very effective. More studies are needed first to observe some limits and to test the method also as first line method.

Good reading and best regards,

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