Introduction

The conventional management of pancreatic fluid collections (PFC’s) involves surgery or percutaneous drainage. While surgery is associated with significant complications and mortality, percutaneous drainage is associated with prolonged hospitalization and oftentimes the need for other adjunctive treatment measures. Therefore, the use of endoscopy to drain PFC’s is becoming increasingly popular. Randomized trials have demonstrated that endoscopic ultrasound (EUS)-guided drainage is superior to conventional endoscopy in terms of technical success and potentially decreases the rates of procedural complications. While transmural drainage is usually undertaken by deployment of plastic endoprosthesis, of late, fully covered self expandable metal stents (FCSEMS) are being placed with increasing frequency. However, the benefits of this approach are unclear and require further validation in prospective trials.

Review

Endoscopic treatment outcomes are directly related to the type of PFC being treated: while the treatment success for pancreatic pseudocysts is greater than 90%, it is at best 50-65% for walled-off pancreatic necrosis. As the density of cyst contents is thin, endoscopic drainage of pancreatic pseudocysts can be accomplished by placement of few transmural plastic stents through one fistulous tract. On the other hand, necrotic contents are highly dense and hence require a larger fistulous opening or multiple tracts for effective drainage; ineffective drainage oftentimes results in infection. Also, the WOPN may extend deep into the abdominal flanks or they can be multiloculated requiring adjunctive measures such as percutaneous or surgical drainage.

Pseudocyst Drainage

In a recent study of 117 patients with pancreatic pseudocysts, the overall treatment success was 98.3% (115/117 patients): 102 (87.2%) patients required one intervention, 13 (11.1%) required > 1 intervention and 2 (1.7%) failed treatment. There was no difference in the median number of interventions required for treatment success between patients with 7 or 10Fr stents and between patients with 1 or >1 stent. On multivariate analysis,
the size and number of stents were not associated with the number of interventions required for treatment success when adjusted for pseudocyst size, drainage modality, presence or absence of pancreatic duct stent placement, luminal compression and location of pseudocyst. A recent study on the use of a lumen apposing novel metal stent for pseudocyst drainage in 15 patients demonstrated clinical outcomes similar to plastic stents: treatment success in all patients and one case of stent migration.3 In all studies, whether the endoprostheses was plastic or metal, the stents were removed, after resolution of the pseudocyst pseudocyst, within 3 months.2,3 The important question is: what are the added advantages to placing FCSEMS? FCSEMS are easier to deploy and precludes the need to place multiple plastic stents which can be technically challenging; but, for pseudocysts (not WOPN), placement of one or two plastic stents may be sufficient to facilitate effective drainage of cyst contents. Also, plastic stents are significantly cheaper than FCSEMS. While technically feasible, current evidence does NOT support a role for FCSEMS in patients with uncomplicated pancreatic pseudocysts.

**WOPN Drainage**

There are two issues that are central to treatment outcomes (a) extent of necrosis and (b) integrity of the main pancreatic duct. If the WOPN extends deeper to the flanks, patients will require “hybrid” drainage that combines endoscopy with laparoscopy or percutaneous catheter placements to facilitate better irrigation, drainage and removal of the necrotic contents. On the other, if there is only one large necrotic cavity adjacent to the stomach or the duodenum, endoscopic transmural drainage alone is sufficient. While WOPN measuring < 10-12 cm can be treated successfully with placement of multiple transluminal stents and a nasocystic drainage catheter through one transmural tract, WOPN measuring more than 12 cm benefit more from drainage via the multiple transluminal gateway technique (MTGT) that involves creation of multiple conduits into the gut lumen for effective drainage of the necrotic contents (along with nasocystic catheter placement).4 In either scenario, if the stents are to be removed within 2 months, there is no difference in outcomes between placing a FCSEMS or multiple plastic stents (single plastic stents should NOT be placed in WOPN). Additionally, if treatment is undertaken using the MTGT approach, placement of FCSEMS at multiple sites may not be cost effective.

In patients with an intact main pancreatic duct, once WOPN resolves, the transluminal stents need to be removed. In patients with a disconnected pancreatic duct syndrome, preliminary evidence suggests that indwelling permanent stents decrease the rates of PFC recurrence.5 The role of FCSEMs in such a scenario appears logical. The critical question is: can FCSEMS be left permanently? None of the current studies have addressed this important question.6-7 While technically feasible, current evidence is insufficient to support the routine placement of FCSEMS in patients with WOPN.

**Conclusions**

While current evidence suggests that placement of metal stents is technically feasible in patients with pancreatic fluid collections, there is no data to prove that metal stents are superior to plastic stents in terms of treatment efficacy, complications, recurrence rates or cost-effectiveness. Randomized trials with long-term follow-up are required comparing metal and plastic stents for drainage of PFC’s.
References