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Can Endoscopic Ultrasonography Prevent Unnecessary Endoscopic Retrograde Cholangiopancreatography in Patients with High and Intermediate Likelihood of Choledocholithiasis?

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See "Endoscopic Ultrasonography Can Prevent Unnecessary Diagnostic Endoscopic Retrograde Cholangiopancreatography Even in Patients with High Likelihood of Choledocholithiasis and Inconclusive Ultrasonography: Results of a Prospective Study" by Ruchir Patel, Meghraj Ingle, Dhaval Choksi, et al., on page 592-597.

It was interesting to read an original article by Patel et al., entitled "Endoscopic Ultrasonography Can Prevent Unnecessary Diagnostic Endoscopic Retrograde Cholangiopancreatography Even in Patients with High Likelihood of Choledocholithiasis and Inconclusive Ultrasonography: Results of a Prospective Study" which provided valuable prospective data for the use of endoscopic ultrasonography (EUS) in clinical practice.¹ The authors concluded that EUS is a highly accurate and safe method for detection of choledocholithiasis in patients with a high probability of developing bile duct stone. Moreover, they suggested that EUS can avoid unnecessary endoscopic retrograde cholangiopancreatography (ERCP) and ultimately reduce the medical cost and complications.

The American Society for Gastrointestinal Endoscopy practice guidelines suggest preoperative ERCP in patients with high/intermediate risk of choledocholithiasis because of a more than 50%/10%–50% probability of having choledocholithiasis.² However, recent studies have shown that the

absence of choledocholithiasis is not uncommon in patients with intermediate to high probability.^{3,4} Although great efforts have been made to identify risk factors and prophylactic measures for post-ERCP complications such as pancreatitis, no definitive methods have been proposed. Therefore, avoiding unnecessary ERCP is mandatory to reduce the incidence of complications.⁵⁻⁸ We agree that it is time to develop a new clinical consensus, which suggests that the "EUS-first" approach, rather than diagnostic ERCP, can be used in patients with possible choledocholithiasis.

Although this study indicates that the EUS-first approach can be beneficial for patients at high risk of choledocholithiasis, it has some limitations. First, despite the use of abdominal sonography, which has limited value as a screening tool for common bile duct stones, it is difficult to accept an incidence rate of 41% for common bile duct stone, which is lower than that of other studies (41% vs. 84.7%).³ The lower incidence of choledocholithiasis might overestimate the efficacy of EUS. Second, considering the possibility of false-negative results with EUS, 3 months of follow-up may be relatively short. As EUS has difficulty identifying choledocholithiasis in the far distal common bile duct area, including the ampulla of Vater, patients who did not undergo ERCP because of negative EUS results require more long-term clinical follow-up. In real-world practice, even if no evidence exists of choledocholithiasis in EUS, it is difficult for clinicians to avoid ERCP because a significant proportion of patients will develop symp-

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tomatic cholangitis. To create a new consensus among experts, we need a strong evidence that can persuade clinicians to avoid ERCP in patients with possible choledocholithiasis and negative EUS results. Further prospective studies to provide evidence for the EUS-first approach are warranted.

In summary, the EUS-first approach can be safe for patients with suspected choledocholithiasis. EUS can be the most accurate diagnostic method for detecting choledocholithiasis without radiation exposure, and the safety profile is well validated. In patients without evidence of choledocholithiasis in other imaging modalities such as transabdominal sonography or computed tomography, EUS can change the therapeutic plan. However, the above-mentioned limitations should be further validated for the EUS-first approach to be recommended as a routine practice guideline.

Conflicts of Interest

The authors have no financial conflicts of interest.

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