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Abbreviations: GOO, gastric outlet obstruction; LAMS, lumen-apposing metal stent.

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**Response:**

We thank Bronswijk et al<sup>1</sup> for the interesting commentary on our clinical case regarding an EUS-guided choledo-

choduodenostomy and gastric outlet obstruction (GOO).<sup>2</sup> In their letter, the authors rightly underlined the complexity and issues of biliary drainage in patients with GOO, supported by data from their recent “CABRIOLET Study.”<sup>3</sup> In this retrospective analysis involving patients affected by both biliary and duodenal obstruction, a significant trend toward higher biliary stent dysfunction in patients treated with EUS-guided choledochoduodenostomy (EUS-CDS) and duodenal stenting was found, compared to other combinations, that is, hepaticogastrostomy (EUS-HGS), EUS-guided gastroenterostomy (EUS-GE), and transpapillary biliary stenting. On the contrary, EUS-GE+HGS resulted in the best combination in patients with both biliary and duodenal obstruction. According to these data, the authors discourage the use of EUS-CDS in the setting of GOO. Although we sincerely agree with the messages emerging from the literature and highlighted by Bronswijk et al, we would like to clarify some points regarding our clinical case. First of all, at the time of the biliary drainage (EUS-CDS), the patient had already undergone a successful surgical gastroenterostomy, and since the patient’s urgent problem was jaundice, we opted for the quickest and easiest way to obtain a full biliary drainage; EUS-HGS could have been an option, but as pointed out by our colleagues—as well as by other studies—this approach may be associated with longer procedure time, higher rates of failure, and adverse events.<sup>4</sup> Even the latest European guideline on therapeutic EUS suggests to perform EUS-HGS only for malignant inoperable hilar biliary obstruction, supporting the use of EUS-CDS over EUS-HGS in distal biliary obstruction owing to its lower rate of adverse events.<sup>5</sup> Secondly, the problem of stent dysfunction in EUS-CDS is well known: there are numerous case reports about it, suggesting that many interventions are possible to solve this issue in most cases.<sup>6-10</sup> It is most important to continue to accumulate evidence to clarify what is the best treatment in the different scenarios, weighing risks and benefits; we should also keep in mind how these procedures regard, in the vast majority of cases, patients with a reduced life expectancy. This does not mean that we should not offer the best possible treatment, but that we should also consider the “real” effectiveness of our intervention, which should be tailored according to the patient’s overall status, the extent of disease, and, not least, the center’s expertise regarding the different endoscopic procedures. In conclusion, it is important to always remember how each case and each patient is a different story, and one—or more—therapeutic algorithm may not be suitable for every situation: in our case, if the patient had not previously had surgery, the best approach would probably have been EUS-GE in combination with another biliary drainage. Once again, we thank our colleagues for the constructive discussion raised, which we believe will be useful for all endoscopists who perform therapeutic procedures.

## DISCLOSURE

*The authors disclosed no financial relationships.*

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*Abbreviations: EUS-CDS, EUS-guided choledochoduodenostomy; EUS-GE, EUS-guided gastroenterostomy; EUS-HGS, hepaticogastrostomy; GOO, gastric outlet obstruction.*

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