

Brasil en la literatura internacional

En este número la revista Acta publica los resúmenes de los trabajos editados por autores de ese país en revistas internacionales de la especialidad, lo cual permitirá, sin lugar a dudas, un más amplio conocimiento de los esfuerzos realizados por los investigadores. Los Editores agradecen profundamente el esfuerzo realizado por el Dr José C Ardengh, el haberse hecho cargo de esta revisión.

Los Editores

José Celso Ardengh

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Cost-effectiveness of palliation of unresectable esophageal cancer

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Dig Dis Sci 2008;53:3103-3111

This paper compared different palliative treatment modalities for obstructive symptoms in patients with unresectable esophageal cancer (EC). The therapeutic alternatives differed significantly in costs and effectiveness. A Markov model was created to compare the cost-effectiveness (CE) of self-expandable stent (SES), brachytherapy, and laser treatment. Patients were assigned to one of the three treatments. The improvement in swallowing function, probability of survival, and risks of complications were used for effectiveness comparison.

The authors found that laser treatment produced the lowest CE ratio, followed by brachytherapy at an incremental cost-effectiveness ratio (ICER) of \$4,400.00, and SES was the treatment with the highest CE ratio. Laser treatment had the highest probability of cost-effectiveness when the willingness-to-pay (WTP) values were lower than \$3,201, and brachytherapy was the most cost-effective at any WTP value with a positive net health benefit (NHB) (threshold \$4,440). The authors concluded that, depending on the WTP and current US Medicare costs, with brachytherapy provided the largest amount of NHB as a palliative treatment for unresectable esophageal cancers and the most cost-effective.

However, some level of uncertainty remained and additional research was needed.

Treatment of achalasia: lessons learned with chagas' disease

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Dis Esophagus 2008;21:461-467

This paper described the valuable lessons learned by surgeons and gastroenterologists in Brazil from their experience in treating patients with Chagas' disease. The authors reviewed the treatment of achalasia at different medical centers with expertise in treating Chagas' disease. Preoperative evaluation, endoscopic treatment (forceful dilatation and botulinum toxin injection), Heller's myotomy, esophagectomy, conservative techniques such as myotomy, and reoperation are discussed on the basis of personal experiences and literature reviews. The authors focused on treatment approaches not frequently adopted by North American and European surgeons and suggested that nonadvanced achalasia is often treated with Heller's myotomy while the endoscopic treatment is reserved for limited cases. There is no consensus on the treatment for end-stage achalasia. Esophagectomy was the most popular treatment in advanced disease, but the morbidity and mortality associated with the procedure caused some clinicians to choose alternatives such as Heller's myotomy and cardioplasties. Minimally invasive esophageal resection may change the guidelines of treating the disease, but few centers currently perform the procedure routinely.

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Endoscopic ultrasound-guided ureterosigmoidostomy in malignant ureteral obstruction: description of a new method

Artifon EL, da Silveira EB, Lopes RI, Kumar A, Bhutani MS, Mesquita JL, Souza T, Dall'oglio M, Lucon AM, Couto D, Sakai P, Srougi M

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Endoscopy 2008;40:769-772

The authors described a new technique of using endoscopic ultrasound (EUS)-guided ureterosigmoidostomy to relieve a malignant ureteral obstruction in a patient who was a poor candidate for surgery because of a previously failed uroendoscopic stent insertion. This is a new indication for EUS-guided therapy in urology which opens a new frontier of endoscopic procedures in urological diseases.

Endoscopic resolution of pseudocyst infection and necrosis as a complication of endoscopic pseudocyst drainage: a case report

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JOP 2008;9:499-503

Endoscopic therapy has recently gained importance as an option for the treatment of pancreatic necrosis. The authors reported a case of transgastric endoscopic resolution of pseudocyst infection and necrosis as complications of endoscopic pseudocyst drainage. Most notably, the patient remained asymptomatic with no radiographic signs of pseudocyst recurrence after the procedure. This paper showed that transmural endoscopic therapy followed by continuous drainage and necrosectomy is a reasonable treatment for pancreatic pseudocyst secondary to infection.

Early pancreatic cancer: can currently available methods identify it?

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Arq Gastroenterol 2008;45:169-177

This paper recommended that gastroenterologists and surgeons pay more attention to patients at high risks of developing pancreatic carcinoma and examined whether and how surveillance and prevention strategies can be applied to routine clinical practice. The authors reviewed recent publications for risk factors, biochemical tests, and imaging methods used to uncover small tumors in the pancreas. The survival rate of carcinoma of the pancreas remains negligible even after significant advances made in diagnosis, treatment, and molecular pathophysiology. Surveillance and prevention in the embryonic stage for people with high risk of pancreatic cancer has developed. This publication summarized the risk factors for developing this disease, state-of-the-art genetic screening, and imaging technology currently available. The authors described a small number of the cases with a PaNin diagnosed by EUS-FNA and confirmed by surgery.

Endoscopic ultrasound for preoperative staging of gastric cancer: correlation with surgical and pathological findings

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Arq Gastroenterol 2008;45:22-27

Gastric adenocarcinoma is a major cause of cancer death in Brazil. To reach a prognosis and devise a treatment plan, the preoperative staging according to the TNM classification of Malignant Tumors is critical. The authors analyzed endoscopic ultrasound findings for T and N staging. They evaluated the lymph node stations 16, 13, 12, 6, 5, 4, 3, 8, 7, 9, 10, 11, 1, and 2 using a frequency of 7.5 MHz. The T and N staging results from the ultrasound were compared with the conclusive findings. In the unresectable cases, the correlation with macroscopic findings was studied.

The accuracy for the T staging was 83.3%, and the other 16.7% were all overestimated by the endoscopic ultrasound. For the N staging, the accuracy was 76.7%. Among the other cases, 16.6% were underestimated and 6.7% were overestimated. The authors concluded that there was a clear corre-

lation between the results by endoscopic ultrasound and the surgical and pathological findings in the evaluation of T and N categories in patients with gastric adenocarcinoma. EUS is the best method to analyze the depth of a malignant gastric tumor and identify affected lymph nodes. However, the authors concluded that EUS should not be adopted as a therapeutic modality.

Endoscopic sphincterotomy before deployment of covered metal stent is associated with greater complication rate: a prospective randomized controlled trial

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J Clin Gastroenterol 2008;42:815-819

Endoscopic sphincterotomy (ES) may facilitate insertion of self-expandable metal stent (SEMS). ES is also independently associated with the risk of pancreatitis, bleeding, and perforation. This paper examined whether ES before SEMS placement was associated with a greater likelihood of stent migration and other complications in patients with malignant obstruction of the distal common bile duct. Seventy-four patients with unresectable distal bile duct obstruction were prospectively randomized to biliary stenting following ES (group 1) or without ES (group 2).

In both groups the covered SEMS were successfully deployed in all patients. Overall, complications occurred in 18 patients in group 1 and 4 in group 2, and the difference was statistically significant ($P=0.006$). The authors concluded that the deployment of covered SEMS without prior ES in patients with distal common bile duct obstruction due to pancreatic cancer is feasible and can prevent complications such as stent migration, bleeding, and perforation.

Self-expandable metallic stents for palliative treatment of digestive cancer

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J Clin Gastroenterol 2008;42:991-996

This was a very interesting article, because the authors assessed the role of SEMS in reestablishing luminal continuity in patients with malignancy of the esophagus, gastric outlet, or colon who are at high risk for surgical intervention. The authors evaluated the feasibility and complications of endoscopic stenting in esophageal, gastroduodenal, and colonic malignancies. The mortality was 73.9% (113 patients), including 105 patients who died between 1 and 60 weeks after the procedure (median survival, 17 wk), but none was directly related to the stent placement.

A quarter (75%) of the patients required a single stent, and 24.2% patients needed an overlapping stent. The procedure was unsuccessful in only 1 case of colonic obstruction. A quarter (26%) of the patients developed 52 complications, of which 9.4% were procedure related (perforation, 5; migration, 5; obstruction, 3; misplacement, 2; and hemorrhage, 1) and 21.3% were late complications (obstruction, 20; migration, 9; fistula, 6; and perforation, 1). In 5.6% patients experienced more than 1 complication and 3.5% required surgery (colon: 2 perforations, 1 fistula, and 1 obstruction; esophagus: 1 perforation). No significant difference in the complication rate was found among the sites in which a metallic stent was inserted. The authors concluded that the endoscopic stenting for palliation of digestive cancer is feasible in most patients and leads to a reasonably low complication rate. Most of the complications were not life-threatening and could be managed with endoscopy.

Endoscopic resection of superficial gastrointestinal tumors

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World J Gastroenterol 2008;14:4600-4606

This paper suggested that therapeutic endoscopy plays a major role in the management of gastrointestinal neoplasia. Its indications can be classified in four broad categories: to remove or obliterate neoplastic lesion, to palliate malignant obstruction, to

treat bleeding, and to allow complete histological staging of the cancer by endoscopic resection. The final indication is critical because it helps the clinician to better stratify and define further treatment. Although other endoscopic techniques, such as ablation therapy may also cure early gastrointestinal cancer, they do not provide pathological specimens for definitive diagnosis. Early-stage lesions have a low frequency of lymph node metastasis, which allows for less invasive treatments and improve the patient's quality of life compared with surgery. Endoscopic mucosal resection (EMR) and endoscopic submucosal dissection (ESD) are now accepted worldwide as treatment modalities for early cancers of the gastrointestinal tract.

Endoscopic ultrasound-guided endoscopic transmural drainage of pancreatic pseudocysts

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Arq Gastroenterol 2008;45:17-21

The authors analyze the efficacy of EUS-guided endoscopic transmural drainage of pancreatic pseudocysts. Surgery is the traditional treatment for symptomatic pancreatic pseudocysts, but the morbidity is high. Minimally invasive endoscopic approaches have been encouraged by experts. In this study, the medical records of 31 consecutive symptomatic patients who had received 37 procedures at an endoscopic unit were retrospectively reviewed.

Chronic and acute pancreatitis was found in 54.8% and 10 32.3% cases, respectively. Bulging was presented in 14 (37.8%) cases. Cystogastrotomy or cystoduodenostomy were performed with an interventional linear echoendoscope under endosonographic and fluoroscopic control. According to the protocol, only a single plastic stent without nasocystic drain was used. Straight and double pigtail stents were used in 59.5% and 40.5% procedures, respectively. EUS-guided transmural drainage was successful in 93.5% of the reviewed patients. Two cases needed surgery, both of whom were due to

procedure-related complications. There was no mortality related to the procedure. During follow-up with a mean duration of 12.6 months, 25% of the patients had symptomatic recurrences due to stent clogging or migration, and 2 had secondary infections. The median time to complications and recurrence of the collections was 3 weeks. These patients were successfully managed with new stents. Complications were more frequent in patients treated with straight stents and in those with a recent episode of acute pancreatitis.

Endoscopic dilation of benign esophageal strictures without fluoroscopy: experience of 2750 procedures

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Hepatogastroenterology 2008;55:1342-1348

The authors analyzed 2750 dilation sessions in patients with strictures due to different etiologies who underwent dilation without fluoroscopy. Each patient's dysphagia score, the cause and location of the stricture, and the diameter of the bougies were recorded at every session. Clinical response was achieved in 92% of the postsurgical patients, 84% of the patients with caustic injuries, 81% of the peptic patients; and 58% of the patients with radiation injuries ($p < 0.05$). Absence of dysphagia was achieved in 68%, 38%, 67%, and 27% of the above classes of patients, respectively ($p < 0.05$). All groups had a significant improvement in mean dysphagia score, and 98% of the patients with a 45F catheter inserted, achieved clinical response.

There were 6 perforations, including 2 deaths. The authors concluded that endoscopic dilation for benign esophageal strictures without fluoroscopy is safe and effective. Postsurgical patients had excellent results for dilation, and caustic and post-radiotherapy strictures had the worst clinical response. A diameter of 45F is a satisfactory end-point for therapy in the majority of cases.

Clinical and laboratory predictors of esophageal varices in children and adolescents with portal hypertension syndrome

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J Pediatr Gastroenterol Nutr 2008;46:178-183

This study investigated the clinical and laboratory parameters that may predict the presence of esophageal varices in children and adolescents with portal hypertension. A total of 111 patients with portal hypertension and no history of digestive bleeding underwent esophagogastroduodenoscopy for the detection of esophageal varices. A univariate analysis was carried out, followed by a logistic regression analysis to identify independent variables associated with esophageal varices. The esophagogastroduodenoscopy was the reference test.

Sixty percent of patients had esophageal varices on

the first esophagogastroduodenoscopy. Patients with portal vein thrombosis and congenital hepatic fibrosis were 6.15 times more likely to have esophageal varices than cirrhotic patients. In the 85 cirrhotic patients, splenomegaly and hypoalbuminemia were significant indicators of esophageal varices. Only spleen enlargement had a high enough sensitivity and negative predictive value (97.7% and 91.7%, respectively) to be used as a screening test for esophageal varices among cirrhotic patients. The authors concluded that, in standard services and research protocols, endoscopic screening should be performed in all patients with portal vein thrombosis and congenital hepatic fibrosis. Among cirrhotic patients, the use of endoscopy should depend on clinical evidence of splenomegaly or hypoalbuminemia. Clinicians should discuss the risk of bleeding with the parents or guardians of children and adolescents with portal vein thrombosis and congenital hepatic fibrosis. Cirrhotic patients with hypoalbuminemia and splenomegaly should receive the information.

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