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Self-expanding metallic esophageal stents: A long way to go before a particular stent can be recommended

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Abstract

We agree that the covered self-expanding metal stents (SEMSs) fare better than the uncovered stents as recurrent dysphagia due to tumor ingrowth is common with uncovered stent. Recent American College of Gastroenterology Practice Guideline on the Role of Esophageal Stents in Benign and Malignant Diseases concludes that SEMSs cannot be routinely recommended in conjunction with chemo-radiation. The comparison of ultraflex and choostent in the Italian study found no difference in the palliation of dysphagia, rate of complications and survival rate.

Key word: Self-expanding metallic esophageal stents; Dysphagia; Esophageal stents

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TO THE EDITOR

We read with interest the article "Covered nitinol stents for the treatment of esophageal stricture and leaks" by Bona *et al*[1] in the May 14, 2010 issue of *World Journal of Gastroenterology*. We agree that covered self-expanding metal stents (SEMSs) fare better than uncovered stents as recurrent dysphagia due to tumor ingrowth is common with uncovered stent[2]. Partially covered SEMSs are superior to uncovered SEMSs in the palliation of dysphagia due to unresectable esophageal tumor[3].

Although the study discussed the positive role of temporary stent placement in patients undergoing neoadjuvant therapy, recent American College of Gastroenterology Practice Guideline on the Role of Esophageal Stents in Benign and Malignant Disease concludes that SEMSs cannot be routinely recommended in conjunction with chemo-radiation[4]. The data on use of SEMSs for gastroesophageal junction cancers with concomitant radiation are retrospective, discordant and limited[5,6].

The self-expanding plastic stents are preferable over SEMSs as temporary stent insertion in case of anastomotic complications or post-radiotherapeutic stricture because the option of retrieval is better, there is limited local tissue reaction and is of lower costs[7].

SEMSs are useful in patients with poor functional status who cannot tolerate chemotherapy or radiotherapy, who have advanced metastatic disease or in whom previous therapy has failed[8]. This data was lacking in the study, and it would have given a better way to compare ultraflex and choostent.

Bona *et al*[9] in their study of comparison of ultraflex and choostent found no difference in the palliation of dysphagia, rate of complications and survival rates. Both stents were safely removable in short term follow-up. The benefit of temporary insertion of both types of stents was documented in patients with esophageal carcinoma prior to chemotherapy or chemoradiotherapy and in those with anastomotic strictures or leaks. The ideal timing for metallic stent removal is not well defined and varies from

2 wk to 4 mo. However, it is safe to remove within 2 mo after stent placement[10].

So, further studies are required before firm recommendation regarding the choostent can be made.

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