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Feasibility of endoscopic management of anastomotic leakage after minimally invasive esophagectomy in the critically ill patient

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Score	Reviewer	Reject Comment	Overall Comment
6	Martin Barrios		
5	Sarah Billmeier		
6	Ezra Teitelbaum		
5	Rich Pierce		This Abstract appears to be non-identical, although VERY similar, to Abstract #88000 I am concerned about possible “salami-slicing” and might accept one of the abstracts, but not both.

Introduction: Anastomotic leakage (AL) is a life threatening complication after minimally invasive Ivor Lewis esophagectomy (tMIE ILE). Several treatment strategies such as conservative treatment, endoscopic treatment and surgery are used. In the case of critical illness due to AL, treatment tends to be more aggressive, often leading to re-operation. The aim of this study was to explore the role of endoscopic treatment for critically ill patients caused by AL after MIE.

Methods and procedures: All patients underwent tMIE ILE for esophageal cancer in three high-volume hospitals. Patients included in this study developed critical illness after AL, defined as readmission to the ICU for treatment of the AL. Endoscopic treatment (stenting, clipping or suction-drainage) and its success-rate was compared with a surgical approach. Success was defined as clinical improvement after primary treatment. Primary endpoint was the time until oral feeding was resumed. Secondary endpoints were hospital stay and total amount of surgical, endoscopic and radiologic re-interventions.

Results: In this cohort, 83 patients developed AL; 57 of these patients had to be readmitted to the ICU before treatment of the AL. In this group of 57 patients, endoscopic approach was performed as primary treatment in 22 patients (39%) and surgical treatment was used in 35 patients (61%). Baseline variables were similar in both groups. Incidence of empyema and mediastinal fluid collections were similar in both groups (p=0.448 and p=0.502 respectively).

Both in the endoscopic-group and the surgical-group, anastomotic leak was diagnosed on median postoperative day 5 (p=0.604). Median ICU-stay and the success-rate of the primary treatment were similar; median ICU-stay was 16 days and 14 days respectively (p=0.371), success-rate of the treatment 59% and 71% respectively (p=0.336)

Primary and secondary endpoints were comparable for both groups; median time until oral feeding was resumed was 33 days and 31 days respectively (p=0.406), median total hospital stay 45 days and 43 days respectively (p=0.900) and the median amount of re-interventions was 5 in both groups (p=0.326). There was no significant difference in mortality (2 versus 3 patients) (p=0.364).

Conclusion: In this cohort, endoscopic treatment for AL in the critically ill patient appears to be feasible, with comparable outcomes as a surgical approach. Naturally, treatment of AL requires an individual and patient-tailored approach based on the extend of the AL and the condition of the patient. However, if possible, an endoscopic-approach should be considered, given the minimally invasive character of this treatment and the satisfying outcomes.