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*Gut* 2010 59: 288
doi: 10.1136/gut.2009.196139

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Long-term value of endoscopic dilatation for Crohn’s strictures

Walter A Koltun

In this issue of Gut, Thienpoint and colleagues' (see page 320) present one of the largest reported studies to date with the longest follow-up, evaluating the technique of endoscopic balloon dilatation of symptomatic Crohn’s disease strictures. The authors should be commended for, first, technically refining this endoscopic technique which is increasingly being used in patients with Crohn’s disease and, second, providing this very relevant longer term data that allows an assessment of its safety and success. Without a doubt, balloon dilatation of Crohn’s disease strictures is becoming another valuable tool in the armamentarium of the clinician caring for the patient with Crohn’s disease.

The authors report on 138 patients undergoing 257 dilatations with a mean 5.8-year follow-up. Forty-four per cent of patients required no further therapy during the follow-up period, but 46% required further dilatation and 24% required surgery. The serious complication rate based on patients treated was 12/138 or approximately 9%, including six perforations. The success rate did not appear to be affected by the presence of disease at the stricture or medical therapies utilised. Though valuable for its presentation of objective data, this article, like all others in the literature describing this technique, is based on subjective data, this article, like all others in the literature describing this technique, is based on subjective data, this article, like all others in the literature describing this technique, is based on subjective data, this article, like all others in the literature describing this technique, is based on subjective data, this article, like all others in the literature describing this technique, is based on subjective data, this article, like all others in the literature describing this technique, is based on subjective data, this article, like all others in the literature describing this technique, is based on subjective data.

The second, less ideal comparison group, could have been those who had been refused for endoscopic balloon dilatation, presumably due to exclusionary features such as associated abscess, complex or longer fistulae, concurrent symptomatic disease elsewhere or other contraindications. This group would have also been interesting to document since it would give the inexperienced reader/endoscopist a perspective on when not to perform endoscopic dilatation. Unfortunately, the retrospective method of chart review in this paper did not recruit this group of patients who presumably went on to surgery. It may very well have been the case that such refused patients represented an even larger group than the one who underwent dilatation reported here. Or put another way, the patients in the present article are a highly selected group, chosen for their ideal anatomy with no other factors complicating their management. And the highly selected nature of this patient group is important to recognise in the overall assessment of this technique. To the relatively uninitiated patient or caregiver, endoscopic dilatation may be a very attractive option. However, criteria predicting success are relatively strict. These include a relatively short, straight stricture, without associated fistulae or abscess or evidence for cancer and one that is easily reachable by the scope. It should be a single dominant stricture, identified as being responsible for the patient’s symptoms. In addition, sophisticated facilities including fluoroscopy, anaesthesia and surgical back-up should be readily available. Satisfying these multiple criteria will very probably, in experienced hands, result in outcomes comparable to those reported here. However, these should be balanced against the option of a laparoscopic resection which will likely have a more durable benefit and even possibly a lower major complication rate.

Without a doubt, for the properly selected and symptomatic patient an endoscopic balloon dilatation can provide significant benefit with acceptable risk.7 It provides the clinician caring for these sometimes difficult patients one more option in disease management that frequently needs to be carefully customised to the specific circumstances of the individual patient. Such care more importantly, however, needs to be multi-disciplinary, recognising the respective indications and relative value of medical versus surgical versus endoscopic intervention.

Competing interests None to declare.

Provenance and peer review Commissioned; not externally peer reviewed.

Gut 2010;59:288. doi:10.1136/gut.2009.196139

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