

ampullectomy. This is a useful technique and an addition to the repertoire of the therapeutic endoscopist.

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The endoscopic morphology of major papillae influences the selected precut technique for biliary access

To the Editor:

We read with great interest the study by Lopes et al¹ regarding the use of early or late needle-knife fistulotomy (NKF) to achieve biliary access after unsuccessful standard biliary cannulation and its related postprocedure adverse events.

The authors reported adverse event rates of 6.2% and 6.4% after early and late NKF, respectively; however, they did not consider the endoscopic morphology of the papillae, which might influence post-NKF adverse events.

The type of precut technique (needle-knife sphincterotomy, NKF, or transpancreatic sphincterotomy) selected for biliary access by most endoscopists is largely dependent on the endoscopic morphology of the major papillae. There are 3 types of major papillae: (1) papilla with no visible intramural segment of the common bile duct (CBD); (2) papilla with an intramural segment of the CBD at the limit of visibility; and (3) papilla with a long intramural segment

of the CBD that protrudes into the duodenal lumen, sometimes covering the papilla.² Experienced pancreatobiliary endoscopists are reluctant to perform NKF in types I and II papillae because of the high risk of postprocedure adverse events (ie, perforation and pancreatitis).^{3,4} We believe that the ideal indication for the performance of NKF is a type III papilla. If the endoscopist is confronted with types I and II papillae and decides to proceed with a precut technique to achieve CBD cannulation, it is preferable to perform needle-knife or transpancreatic sphincterotomy.

Therefore, it would be interesting to know whether Lopes et al¹ considered the potential impact of the endoscopic morphology of the major papillae on NKF-related adverse events.

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Response:

We appreciate Prof. Katsinelos's interest in and comments on our article. In our study we did not assess papilla morphology as a potential predictive factor for post-needle-knife fistulotomy adverse events. Although we agree on the importance of papilla morphology in tailoring the decisions undertaken during the cannulation strategy, we have a different perspective on their actual relevance for the selection of the most appropriate precut technique. In reality, the vast majority of the published data point out that experienced endoscopists tend to use the same precut technique over time, irrespective of the morphology of the papilla, based on personal

preferences.^{1,2} Furthermore, we are unaware of any randomized controlled trial or prospective cohort study comparing the success and safety of the 3 main precut techniques (needle-knife fistulotomy, classic precut, and transpancreatic sphincterotomy) in relation to papilla morphology.^{3,4} In our opinion, needle-knife fistulotomy, as long as it is performed by experienced endoscopists in an early timing, although more demanding, is highly safe and successful, irrespective of papilla types, flat papillas included.^{5,6} Their perspective on the cannulation strategy based on the papillary anatomy (an expert-based opinion), although very interesting, needs to be validated in future studies. To design better studies and compare results in this field, we urgently need a standardized and accepted nomenclature for the different precut techniques and for papilla morphology.

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Is laparoscopic Heller's myotomy superior to pneumatic dilation?

To the Editor:

Whether or not laparoscopic Heller's myotomy (LHM) is superior to pneumatic dilation (PD) in the treatment of achalasia is controversial and of great importance to clinical decision making. We read with great interest the meta-analysis conducted by Yaghoobi and colleagues,¹ who concluded that LHM was more effective than PD. We retrieved all of the published articles included in this meta-analysis and found that 1 study was not really a randomized controlled trial.² This study described the random method by saying, “Patients were randomized by order of arrival,” which indicates that this study was not really randomized. Including a nonrandomized study would weaken the power of a meta-analysis. After excluding this study from the meta-analysis, we found that there was no significant difference between LHM and PD in the treatment of achalasia (odds ratio = 1.88; 95% confidence interval, 0.95-3.74, $P = .07$) (Fig. 1). Moreover, when we searched the OVID MEDLINE, we found another study comparing LHM with PD.³ However, when we scrutinized the work, we found that this study also described the random method by saying, “Patients were included and randomly assigned for each therapy according to their order of arrival.” Therefore, we did not include this study in our meta-analysis. Because studies comparing LHM with PD are limited, we cannot come to a definite conclusion. More high-quality large sample studies are still needed. Additionally, whether PD and botulinum toxin A combination therapy is more effective than LHM also needs to be elucidated. On the basis of the available evidence, LHM and PD are both optimal therapy for achalasia.

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