The bottom line is this: if patients and the gastroenterology community desire higher quality evidence (ie, more reliable estimates of effect), then larger trials are needed. However, performance of additional analyses on the existing evidence base will likely not change the conclusions of our study.

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Bronchoscopic closure of tracheoesophageal fistulas

To the Editor:

We want to congratulate Dr Repici and colleagues[1] for their expertise in dealing with this difficult disease.

The use of cardiac septal occluders for closure of airway fistulae has led to an ongoing trial of closure of tracheoesophageal fistulae at our institution.[2]

Unfortunately, we must say that their article was not the first case report of the use of an occluder device to close an esophagotracheal fistula.

In 2009, our team reported a successful bronchoscopic closure in a 73-year-old male patient presenting with a tracheoesophageal fistula of approximately 5 mm in the distal trachea after prolonged intubation.[3] Alternatively, we have used a Gore Helex Septal occluder (W. L. Gore & Associates, Inc, Flagstaff, Ariz) for closing the benign tracheoesophageal fistula. After a follow-up period of 120 days, its was revealed that the esophagus was normal and that the disc placed in the esophagus had been completely incorporated. Bronchoscopy showed epithelialization of the tracheal disc, which protruded partially toward the tracheal lumen. We decided to remove the occluder, and local repair and complete closure occurred after 7 days.

This prosthesis model is not metallic, and it flattens along the organ walls, with less protrusion at the lumens of the trachea or esophagus.

Although more work is necessary to establish the best way to endoscopically treat these difficult conditions, we congratulate Dr Repici and colleagues for their valuable contribution.

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Covered biliary metal stents: which, where, when?

To the Editor:

We followed with great interest the recently published debate on the use of covered stents for malignant biliary disease based on the results of 2 recently published randomized, controlled trials comparing covered and uncovered biliary metal stents.[1-4] Part of the debate also referred to our recent work on the use of covered endoprostheses in malignant biliary disease.[5,6]

Isayama et al[3] in their comment letter raised some concerns with which to a certain extent we also agree. The key point of using covered stents is to prevent tumor ingrowth. If this can be achieved, then longer stent patency is guaranteed.

Our group performed 2 tumor-oriented prospective, randomized studies comparing expanded Polytetrafluoroethylene/Fluorinated ethylene propylene (ePTFE/FEP) covered

stents with uncovered stents in patients with cholangiocarcinoma and pancreatic cancer, which are the main cancer patients groups in which ingrowth may occur. We do not believe in using covered stents in strictures caused by lymph node enlargement because tumor ingrowth does not occur in such cases.

In both our studies, covered stents were shown to offer a statistically significant longer patency rate. There were also higher survival rates for the covered stent group with statistical significance for the cholangiocarcinoma group. Part of our selection criteria was the fact that we included patients with a life expectancy longer than 3 months. We believe that covered stents are not totally justified for placement in patients with relatively advanced disease because ingrowth usually requires 3 to 6 months to occur. The relatively lower 6-month patency of the bare stent group was mainly attributed to dysfunction caused by tumor ingrowth, which is still the main problem of bare metal stents, particularly in cases in which patients survive more than 3 months.

Migration was not noted in any of the cases included in our study. Migration used to be a serious problem for covered stents. To avoid this inadvertent event, specific stents with anchoring fins have been developed. These stents were used in our studies, and we must agree with Telford et al[4] on the fact that it is the anchoring fins that prevent migration and not the percutaneous access.

According to our studies, the indications for covered stent placement is the use in patients who are likely to survive more than 3 months and have a tumor that may cause ingrowth. In such cases, covered stents with anchoring fins and with a membrane that prevents tumor ingrowth must be used.

In our view, if the placement of covered stents follows the above-mentioned criteria, then covered stents appear to be better than uncovered stents in terms of patency and reintervention rate and need to be the first choice in the palliation of malignant jaundice.

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ERRATUM

In the article, "Second-generation colon capsule endoscopy compared with colonoscopy (Gastrointest Endosc 2011;74:581-9)," which appeared in the September 2011 issue of *Gastrointestinal Endoscopy*, the following author's name was misspelled: Leila Amininejad, MD.