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Summary

Malignant gastric outlet obstruction: Should it be treated surgically?

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The speaker presented evidence from three randomised controlled trials arguing that EUS-guided gastroenterostomy with lumen-apposing metal stents should replace surgery as the primary palliative treatment for malignant gastric outlet obstruction, while a surgical discussant maintained that surgery remains important in complex cases and when endoscopic expertise is unavailable.

KEY POINTS

- The speaker reported results from the Dutch Enduro trial (98 patients) stating that EUS-guided gastroenterostomy with 20mm lumen-apposing metal stents achieved shorter time to oral intake (1 day vs 3 days), noninferior reintervention rates (10% vs 12%), higher clinical success (96% vs 80%), and shorter hospital stay (1 day vs 4 days) compared to laparoscopic surgical gastrojejunostomy, with no difference in adverse events.
- The speaker cited the DeGroot trial (nearly 100 patients, 2020–2022) stating that EUS-guided gastroenterostomy showed lower six-month reintervention rates (4% vs 29%) and shorter hospital stay (4 days vs 6 days) compared to duodenal stent placement.
- The speaker stated that cost analysis from the Enduro study found EUS-guided gastroenterostomy was more than 4000 less expensive than surgery with a small gain in quality-adjusted life years.
- The speaker acknowledged uncertainties regarding long-term effectiveness and patency in survivors beyond six months and extrapolation to non-expert settings.
- The surgical discussant argued that surgery remains necessary when EUS-guided gastroenterostomy is not feasible, after endoscopic failure or complications, in complex tumour situations with major bleeding or perforation, when local expertise is lacking, and in curative intent cases.

– The surgical discussant stated that surgical gastrojejunostomy is a basic established operation available in almost every surgical department, whereas EUS-guided gastroenterostomy remains concentrated in approximately ten expert centres in Germany, and recommended interdisciplinary case discussion with immediate surgical backup for endoscopic procedures.

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