

Best Practice Advice Statements

1. Intervention decisions should involve oncologists, surgeons, and endoscopists



2. Esophageal cancer obstruction



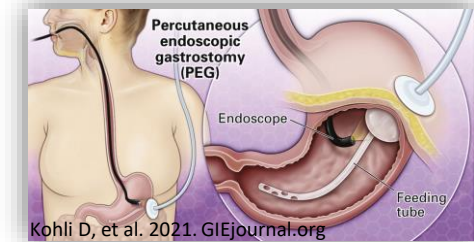
Avoid routine self-expanding metal stents (SEMS)



3. Esophageal cancer obstruction + malnutrition



Consider PEG placement



4. Esophageal cancer + Ineligible for resection



Consider SEMS or brachytherapy or combination

5. Esophageal cancer + SEMS placement



Place a fully-covered or partially-covered SEMS

6. Malignant gastric outlet obstruction (GOO)

+

**Life expectancy > 2 months +
✓ Functional status + Surgically fit**



Surgical gastrojejunostomy (GJ) > Enteral stent



**7. Surgical GJ for malignant GOO:
Laparoscopic approach > Open approach**

8. Malignant GOO

+

Ineligible for surgical or EUS-guided GJ



Consider enteral stent placement

Best Practice Advice Statements

9. Multiple malignant luminal obstructions or severely impaired gastric motility



Avoid enteral stenting and consider venting gastrostomy



10. Depending on endoscopist experience, EUS-guided GJ is an acceptable alternative to surgical GJ and enteral stenting

11. Malignant colonic obstruction + Eligible for resection



SEMS insertion is a reasonable choice as a bridge to surgery

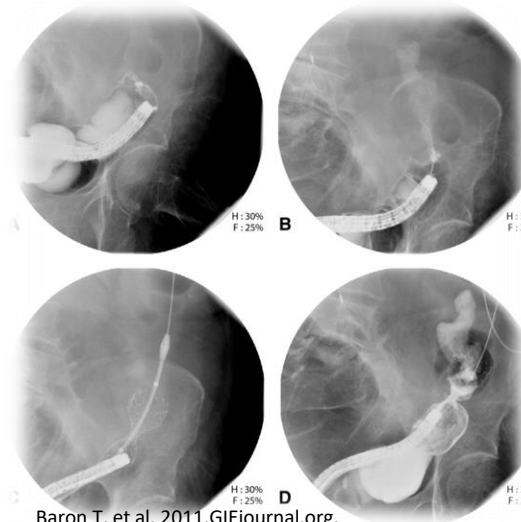
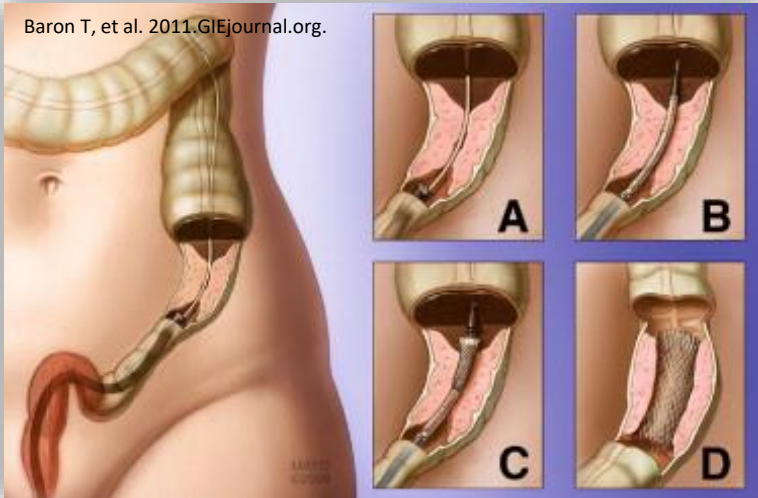
12. Malignant colonic obstruction + Ineligible for resection



SEM insertion or Diverting colostomy

13. Right-sided colonic obstruction: SEMS insertion is reasonable as a bridge to surgery or as palliative therapy

Baron T, et al. 2011.GIEjournal.org.



Baron T, et al. 2011.GIEjournal.org.

14. Extra-colonic malignancy

+

Ineligible for resection

↓

SEMS insertion is an option

BUT

-Technically challenging

-Variable clinical success rate

- ↑ Complications (e.g. stent migration)