

Endobiliary ablation before stenting in malignant biliary obstruction: the importance of patient selection “about”

Malign biliyer obstrüksiyonda stentleme öncesi endobiliyer ablasyon: hasta seçiminin önemi "hakkında"

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Received:09.05.2026

Accepted:08.06.2026

Dear Editor,

We read with great interest the article by Demirci et al., entitled “Percutaneous endobiliary ablation (RFA and MWA) prior to stenting: assessing feasibility and outcomes in malignant biliary obstruction,” recently published in Pamukkale Medical Journal [1]. The authors should be congratulated for addressing a clinically relevant issue in the palliative management of unresectable malignant biliary obstruction, where durable biliary drainage and avoidance of procedure-related morbidity are central therapeutic goals.

The most important message of this study is that technical feasibility does not necessarily translate into clinical benefit. In their retrospective cohort of 122 patients, pre-stenting ablation did not significantly improve stent patency or overall survival, while the complication rate was significantly higher in the ablation group.¹ This finding is valuable because endobiliary ablation is increasingly discussed as an adjunct to metallic stenting, particularly in patients with malignant strictures; however, its benefit is unlikely to be uniform across all patients with malignant biliary obstruction [2-4].

In this context, we believe that the practical interpretation of the study would be strengthened by further clarification of patient selection. Specifically, it would be useful to know whether outcomes differed according to the underlying malignancy, such as pancreatic cancer, cholangiocarcinoma, gallbladder cancer, or metastatic disease; the anatomical level of obstruction; baseline cholangitis; bilirubin burden; performance status; and anticipated oncologic treatment after biliary

drainage. These variables may influence both the probability of stent occlusion and the risk of post-procedural complications. Therefore, subgroup-based reporting, even if exploratory, could help clinicians determine whether ablation should be avoided broadly or reserved for a narrower group of patients with longer expected survival and higher risk of tumor ingrowth.

Another clinically relevant issue is whether radiofrequency ablation and microwave ablation should be interpreted together. Although both techniques aim to provide local tumor control within the biliary tract, their thermal characteristics, tissue effects, and potential complication profiles may differ. In a relatively small ablation cohort, separate descriptive reporting of RFA and MWA outcomes may help readers better understand whether the observed complication signal reflects ablation in general or a technique-specific pattern.

Recent evidence suggests that endobiliary radiofrequency ablation may improve stent patency or survival in selected patients, but the literature remains heterogeneous and is influenced by study design, route of intervention, tumor type, and stent characteristics [2-4]. For this reason, the negative findings reported by Demirci et al. are clinically important. They remind clinicians that additional local treatment should not be adopted solely on the basis of feasibility, especially in a palliative setting where the threshold for added intervention should depend on a favorable balance between expected benefit and complication risk.

Clarification of patient selection criteria and subgroup outcomes would further enhance the practical value of this important article.

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Declaration on the use of artificial intelligence: AI tools were used for text editing, language correction, literature assistance, and manuscript formatting support. The author reviewed and approved the final content and accepts full responsibility for the manuscript

Conflicts of interest: The author declares no conflicts of interest in relation to this article.

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