hands and with the right experience, is indeed safe.² I do question their approach to adding endoscopic pyloromyotomy when a patient needs an antireflux procedure, as their argument that endoscopic pyloromyotomy may be superior to an open/laparoscopic procedure has yet to be proven. Nonetheless, we all should open our minds to the skills of the interventional gastroenterologist in performing these procedures, or learn to do them skillfully ourselves. The endoscopic pyloromyotomy may well become the best option for transplant recipients with troubling delayed gastric

emptying. Thank you to the authors for recognizing this complex problem and providing such a great example of how this problem can be approached.

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Commentary: Natural orifice management of postlung transplant gastroparesis

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The outcomes of lung transplant (LTx) have been improving over the years; however, the survival of our patients still lags behind other solid-organ recipients due to the high rate of complications.¹ Previous studies found an association between delayed gastric emptying (DGE) and chronic lung allograft dysfunction (CLAD)² and acute cellular rejection.³ Multiple mechanisms can contribute to this phenomenon, including (1) microaspiration, causing direct injury or vagal stimulation; (2) reflux of gastric content, causing vagally mediated bronchoconstriction; or (3) neuroinflammatory reflexes playing a role in the release of tachykinins, which cause airway responses.⁴ Hence, managing pre- or posttransplant DGE could potentially accomplish more than just alleviating the symptoms of DGE by also reducing the risk of CLAD.

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CENTRAL MESSAGE

Managing post-lung transplant gastroparesis with the most-effective, least-invasive way.

In this issue of the *Journal*, Rappaport and colleagues⁵ reported their experience with per-oral endoscopic pyloromyotomy (POP) in managing gastroparesis after LTx. The authors measured the main outcomes subjectively by Gastroparesis Cardinal Symptom Index and objectively by gastric emptying tests. Notably, their secondary objectives, which were the incidence of gastroesophageal reflux (GERD) and allograft function (forced expiratory volume in 1 second), are harder to directly correlate with gastric emptying but are of greater significance to the LTx recipient. Their results demonstrated significant improvement in Gastroparesis Cardinal Symptom Index and gastric emptying tests. GERD improved or remained stable in most patients, and the forced expiratory volume in 1 second remained stable 1 year after POP.

The importance of this article resides in the growing number of LTx performed each year, their overall challenged quality and quantity of life, and the high incidence of gastroparesis post-LTx, which ranges from 50% to 90%.^{6,7} Ameliorating the symptoms of gastroparesis enhances the quality of life

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for our recipients, whereas the reduction in GERD potentially protects the allograft from the harm of gastric effluent and may extend life expectancy. Considering all the different ways of managing gastroparesis, the described endoscopic pyloromyotomy offers several obvious advantages for this immunocompromised population.

While sparing the patients another incision and providing an effective approach to manage this pathology serves the patient best, there are still many questions that need to be answered. For example, the patients were followed for only a median of 10.5 months. It will be important to assess the outcomes and possible complications (ie, stricture, recurrence of symptoms) over a longer period. In addition, the effect of POP on the development of CLAD and the impact on overall survival will be critical to discern. In a study done by Hirji and colleagues,⁶ there was no difference in survival between patients who had DGE post-LTx and the patients who didn't at 6 years' posttransplant. Many patients with DGE early after transplant will go on to experience improvement without definitive intervention.

Even though the number of patients included was larger than other studies that addressed similar concerns,⁸ it was still a relatively small number. We congratulate the authors for addressing such an important issue in this field.

We believe that POP will have a strong positive impact on the care of patients who undergo LTx.

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