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## Usefulness of the Hook knife in flexible endoscopic myotomy for Zenker's diverticulum

Olivier Rouquette, Armando Abergel, Aurélien Mulliez, Laurent Poincloux

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Xiu-Xia Song, Director  
*World Journal of Gastrointestinal Endoscopy*  
Baishideng Publishing Group Inc  
7901 Stoneridge Drive, Suite 501, Pleasanton, CA 94588, USA  
Telephone: +1-925-2238242  
Fax: +1-925-2238243  
E-mail: [editorialoffice@wjgnet.com](mailto:editorialoffice@wjgnet.com)  
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## Retrospective Study

**Usefulness of the Hook knife in flexible endoscopic myotomy for Zenker's diverticulum**

Olivier Rouquette, Armando Abergel, Aurélien Mulliez, Laurent Poincloux

Olivier Rouquette, Armando Abergel, Laurent Poincloux, Department of Digestive and Hepatobiliary Diseases, CHU Estaing Clermont-Ferrand, 63003 Clermont-Ferrand, France

Armando Abergel, Laurent Poincloux, ISIT, UMR 6284 CNRS Université d'Auvergne, 63003 Clermont-Ferrand, France

Aurélien Mulliez, Biostatistics Unit, DRCI, CHU Gabriel Montpied Clermont-Ferrand, 63003 Clermont-Ferrand, France

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**Correspondence to:** Olivier Rouquette, MD, Department of Digestive and Hepatobiliary Diseases, CHU Estaing Clermont-Ferrand, 1, place Lucie et Raymond Aubrac, 63003 Clermont-

Ferrand, France. [orouquette@chu-clermontferrand.fr](mailto:orouquette@chu-clermontferrand.fr)  
Telephone: +33-4-73750523  
Fax: +33-4-73750524

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**Abstract****AIM**

To investigate the outcome of flexible endoscopic myotomy performed with the Hook knife in patients with symptomatic Zenker's diverticulum (ZD).

**METHODS**

All consecutive patients treated for ZD at our institution between 7/2012 and 12/2016 were included. The flexible endoscopic soft diverticuloscope-assisted technique with endoclips placement and Hook knife myotomy were performed in all patients. Here we report a retrospective review of prospectively collected data. Demographics, dysphagia score (Dakkak and Bennett), associated symptoms and adverse events were collected pre-procedure, at 2 and 6 mo post-procedure, and at the end of the follow-up period. Clinical success was defined as at least 1-point improvement in dysphagia score and a residual dysphagia score  $\leq 1$ , with no need for reintervention. Dysphagia scores were compared before treatment and at end-of-follow-up using the Wilcoxon test.

**RESULTS**

Twenty-four patients were included. Mean size of ZD was 3.0 cm (range 2-8 cm). Mean number of sessions

was 1.17/patient (range 1-3 sessions). Overall clinical success was 91.7%. Two adverse events (8.3%) occurred, and both were managed conservatively. No bleeding or perforation was reported. Mild pain was reported by 9 patients (37.5%). Median hospital stay was 1 d (range 1-6). Median follow-up was 19.5 mo (range 6-53). Mean  $\pm$  SD dysphagia score was  $2.25 \pm 0.89$  before treatment and decreased to  $0.41 \pm 0.92$  at end-of-follow-up ( $P < 0.001$ ). Regurgitation and cough dropped from 91.7% and 50% to 12.5% and 0% at the end of follow-up, respectively. Recurrence was observed in 3 patients, and all 3 were symptom-free after one more session.

### CONCLUSION

The Hook knife, used in the soft diverticuloscope-assisted technique setting, is efficient and safe for treatment of ZD.

**Key words:** Zenker's diverticulum; Flexible endoscopy

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**Core tip:** Zenker's diverticulum can cause uncomfortable symptoms such as dysphagia, regurgitation and cough, and sometimes weight loss or aspiration pneumonia. Soft diverticuloscope-assisted flexible myotomy is used worldwide and has proven to be safe and efficient. In terms of adverse events, perforation remains the major concern. The most effective tool for performing myotomy in this setting has yet to be determined. Here we treated 24 patients with the Hook knife, resulting in 91.7% overall success, a 13% recurrence rate, and only 2 mild adverse events reported.

Rouquette O, Abergel A, Mulliez A, Poincloux L. Usefulness of the Hook knife in flexible endoscopic myotomy for Zenker's diverticulum. *World J Gastrointest Endosc* 2017; 9(8): 411-416 Available from: URL: <http://www.wjgnet.com/1948-5190/full/v9/i8/411.htm> DOI: <http://dx.doi.org/10.4253/wjge.v9.i8.411>

## INTRODUCTION

Zenker's diverticulum (ZD), an acquired rare condition that typically occurs in the elderly<sup>[1]</sup>, is a pulsion diverticulum developing on the posterior wall of the esophagus through Killian's triangle. ZD development is thought to be caused by dysfunction of the cricopharyngeal muscle resulting in increased intraesophageal pressure<sup>[2]</sup>. ZD can cause symptoms such as dysphagia, regurgitations, or chronic cough. Weight loss and aspiration pneumonia are potentially severe complications. Treatment basically consists in myotomy of the cricopharyngeal muscle. Endoscopic myotomy was introduced decades ago, has been widely evaluated since, and is now considered a first-line treatment option<sup>[3]</sup>. In Europe, the mini-invasive flexible endoscopic soft diverticuloscope-

**Table 1** The Dakkak and Bennett score of dysphagia<sup>[7]</sup>

Grade 0	No dysphagia
Grade 1	Solids
Grade 2	Semi-solids
Grade 3	Liquids
Grade 4	Aphagia

assisted technique with endoclip(s) placement, as described by Huberty *et al.*<sup>[4]</sup>, is common practice and has proven safe and effective. However, various tools are used to perform the myotomy. Submucosal dissection knives have been described in this indication, and appear to be safe and effective<sup>[5]</sup>. Myotomy must be continued deep enough to improve clinical symptoms, but dissection must be limited to muscle fibers to avoid perforation. The key issue is where to stop the myotomy<sup>[6]</sup>. The Hook knife (Olympus endotherapy, Tokyo, Japan) is designed with a distal tip consisting in a 5 mm-long, rotatable, hook-shaped knife, allowing pulling tissues before cutting. We posit that the Hook knife is the most appropriate tool for this intervention. Here we report short and mid-term outcome and adverse events of soft diverticuloscope-assisted flexible endoscopic myotomy with the Hook knife.

## MATERIALS AND METHODS

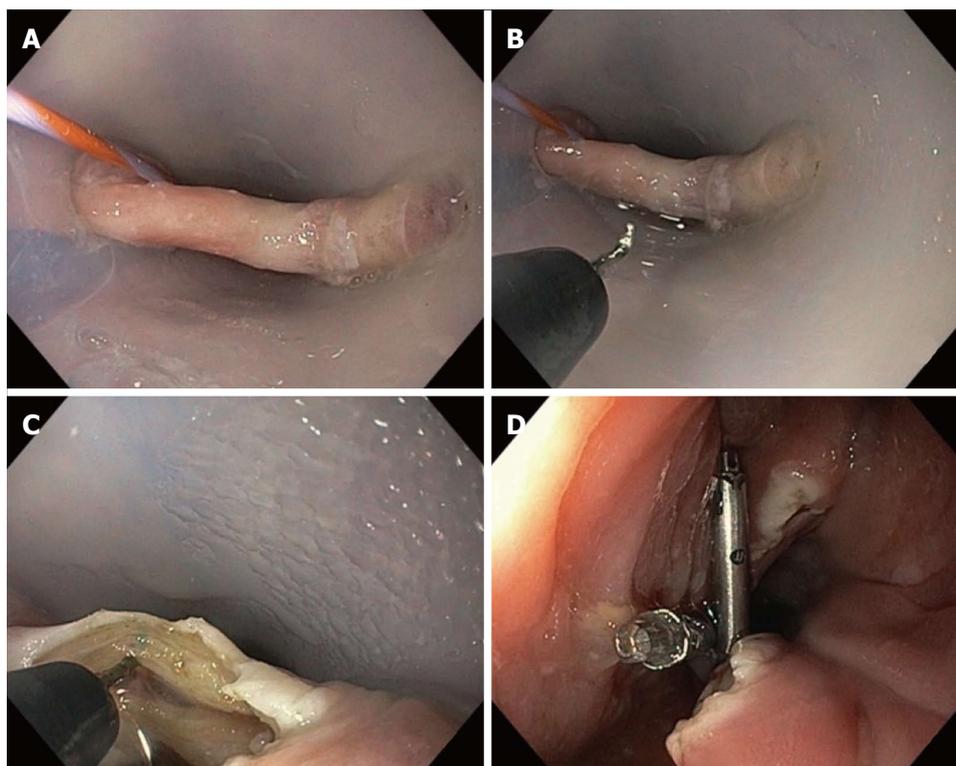
### Population

All consecutive patients treated at our institution by flexible endoscopy for symptomatic ZD between July 2012 and December 2016, and with at least 6 mo of follow-up at December 2016, were included in the study. We performed a retrospective review of prospectively collected data. Demographics, dysphagia score, symptoms, outcome, and adverse events were recorded. The Dakkak and Bennett dysphagia score was used (Table 1)<sup>[7]</sup>. All patients were seen as outpatients before and at 2 and 6 mo after the procedure, and were asked to phone anytime in case of recurrence. At the end of the follow-up period, all patients were interviewed by phonecall.

This study was conducted according to the ethical principles of the Declaration of Helsinki and in compliance with good clinical practice. Informed consent was obtained from all patients. This study was reviewed and approved by our center's Institutional Review Board, reference 2016/CE 91.

### Endoscopic treatment

All patients were treated by a single endoscopist (Olivier Rouquette). All procedures were performed under general anesthesia, with orotracheal intubation, in supine position. All patients were administered amoxicillin-clavulanic acid prophylaxis beforehand. Anticoagulant therapy was discontinued 5 d before procedure and bridged with low molecular-weight heparin. Low-dose aspirin was continued. Other antiplatelet agents were



**Figure 1 Endoscopic procedure.** A: Soft diverticuloscope in place, affording optimal exposure. Esophageal lumen is identified by the guidewire; B: The Hook knife is locked in 12 o'clock position; C: After initial incision, myotomy is performed, pulling the muscle fibers up before cutting; D: End of procedure, with 2 endoclips in place.

discontinued 5 d before procedure and replaced with low-dose aspirin. Anticoagulant and antiplatelet therapies were resumed on the day after the procedure.

Figure 1 describes the endoscopic procedure. First, a complete upper endoscopy, using a standard gastroscope (GIF H180, GIF H190; Olympus, Tokyo, Japan), is performed to rule out any other esophageal or gastric disorder that could explain dysphagia. A 0.035-inch guidewire is advanced in the gastric lumen and left in place for later identification of the esophageal lumen. Then, the soft diverticuloscope (ZDO-22-30, Cook Endoscopy, Winston-Salem, NC) is fitted over the gastroscope and advanced gently, after lubrication, as far as the black mark is located roughly near the incisor line. The endoscope is then slowly withdrawn to allow visualization of the diverticulum and adjust diverticuloscope position across the septum, which is then seen as a bridge, and optimal exposure of the operative site. Once septum exposure is good, myotomy of the cricopharyngeal muscle is performed with the Hook knife (Endocut Q mode, effect 3, 120 W cutting, 40 W soft coagulation; VIO 300; ERBE, Tübingen, Germany). The hook is locked in 12 o'clock position. The initial incision is performed at the top of the bridge. Then, the cricopharyngeal myotomy is continued progressively downward, using the hook to gently pull the muscle fibers before cutting, allowing precise dissection. Myotomy is stopped when the muscle fibers are completely cut. Finally, anterior ZD and posterior esophageal walls are cut up to 5 mm above the bottom of the diverticulum, and one or more

endoclips are placed to prevent delayed perforation or bleeding. If no complication is suspected, oral semi-liquid diet is resumed and patients are discharged from hospital on day one post-surgery.

Primary endpoint was clinical success. Recurrence and adverse event rates were also investigated. Clinical success was defined as at least a 1-point improvement in dysphagia score and a residual dysphagia score  $\leq 1$ , with no need for reintervention. Recurrence was defined as dysphagia score  $> 1$  after initial clinical success. Any event resulting in readmission or unexpected length of hospital stay post-surgery ( $> 1$  d) was regarded as an adverse event. Bleeding was considered an adverse event if any medical or endoscopic reintervention was needed. Perforation was defined as presence of cervical subcutaneous crepitus, cervical abscess, or free air on computed tomography.

### Statistical analysis

The statistical review of the study was performed by a biomedical statistician. Characteristics of the study population are expressed as proportion and means  $\pm$  SD. The Wilcoxon matched-pairs signed-rank test was used to compare pre- vs post-treatment dysphagia scores comparison. Statistical significance was set at  $P < 0.05$  (two-sided). Statistics were computed using Stata12 (Stata Corp, College Station, TX).

## RESULTS

The study included 24 consecutive patients [18 men

**Table 2 Patient characteristics n (%)**

Characteristics	
Variable	n = 24
Male	18 (75)
Median age (yr)	77
Mean time from onset of symptoms (mo)	18.5
Dysphagia score before treatment	
Grade 1	6 (25)
Grade 2	7 (29)
Grade 3	10 (42)
Grade 4	1 (4)
Weight loss	11 (46)
Mean size of diverticula (cm ± SD)	3.0 ± 1.63

(75%), median age 77 years (range 44-90 years)]. Before procedure, seven patients were treated with anticoagulant therapy and 6 with antiplatelet agents. ZD diagnosis was based on esophagogastrosocopy in 12 (50%) patients, and/or barium swallow in 18 (75%) patients or computed tomography in 3 patients. Mean size of ZD was 3.0 cm (2-8 cm). Mean time from onset of symptoms was 18.5 mo. Four patients had a previous rigid endoscopic treatment (CO<sub>2</sub> laser). All patients presented with dysphagia. Other symptoms included regurgitation (n = 22, 91.7%), chronic cough (n = 12, 50%) and aspiration pneumonia (n = 2, 8.3%). Patient characteristics are reported in Table 2.

A total of 28 endoscopic procedures were performed in our 24 patients (mean 1.17 procedures per patient): One procedure in 21 patients, two procedures in two patients and three procedures in one patient. Diverticuloscope insertion and good septum exposition were achieved in all patients. One or two endoclips were placed in all patients. Median follow-up was 19.5 mo (6-53).

Clinical success was obtained in 21 (87.5%) patients after the first procedure. Two patients developed recurrence, at 4 and 8 mo post-procedure, respectively: One was successfully treated with a second session, the other declined any reintervention. Initial failure was observed in 3 (12.5%) patients: One patient with an 8-cm ZD was contraindicated for general anesthesia for a second session, and two patients with ≤ 3 cm ZD underwent a second procedure. Symptoms resolved in both patients, but one experienced recurrence 6 mo later, which was successfully treated by a third session. Overall clinical success was obtained in 22/24 patients (91.7%). Overall recurrence rate was 13% (3/23). Mean ± SD dysphagia score was 2.25 ± 0.89 before treatment and decreased to 0.25 ± 0.74 at end-of-follow-up (P < 0.001). At end-of-follow-up, 19/22 (86.4%) and 12/12 patients were free from regurgitation and cough, respectively. Among 11 patients with preoperative weight loss, 10 (90.9%) regained weight (mean +4.2 kg) at two months post-treatment. Median time to recurrence was 6 mo. Figure 2 and Table 3 summarize treatment outcome. Overall adverse effect rate was 8.3%: Two patients developed

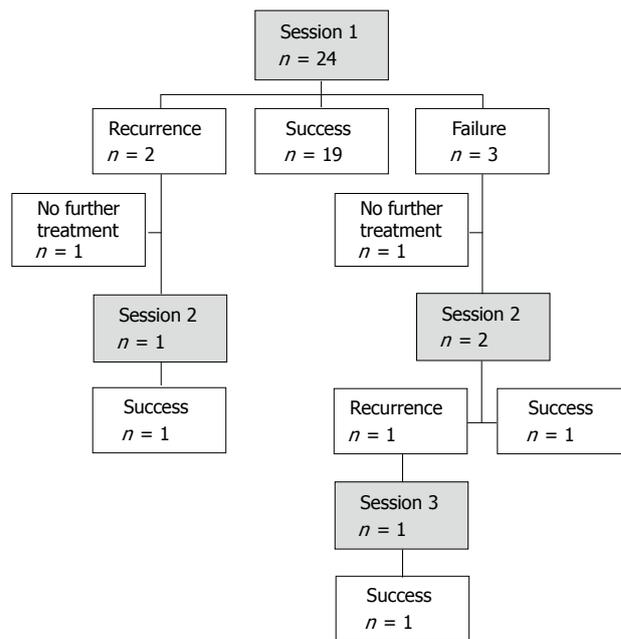


Figure 2 Clinical outcome of endoscopic myotomy.

fever with elevated CRP, without evidence of perforation on CT scan with contrast agent ingestion. Conservative management with antibiotics was successful in both patients, who were discharged from hospital on day 4 and day 6 post-procedure, respectively. No perforation or post-procedural bleeding was recorded. Nine patients (37.5%) reported mild pain, lasting a median 3 d. All of them were treated with acetaminophen as outpatients. Mild bleeding during myotomy occurred in two (8.3%) patients and was treated by soft coagulation applied with a Coagrasper (Olympus endotherapy, Tokyo, Japan). These two patients were not treated with anticoagulant or antiplatelet agents, and both were discharged from hospital on day 1 post-procedure. One asymptomatic patient died of unrelated cause during follow-up, at 29 mo after myotomy. Median hospital stay was 1 d (1-6).

## DISCUSSION

Open surgery is mainly considered after endotherapy failure or for large diverticula<sup>[2,8]</sup>. Along with endoscopic stapling, flexible endoscopic myotomy is a first-line treatment option for symptomatic ZD. The use of a soft diverticuloscope stabilizes the endoscope and provides better exposure of the septum, resulting in a lower adverse events rate<sup>[9]</sup>. We perform diverticulotomy in supine position in order to increase the stability of the gastroscope, which may slip out of the diverticuloscope if the patient is lying in left lateral position. Most authors agree with placing endoclips at the end of the procedure to prevent delayed complications<sup>[4]</sup>. Nevertheless, various tools are used to perform the myotomy: Argon plasma coagulation has been practically abandoned as it needs multiple procedures and carries a high complication rate<sup>[10]</sup>, whereas favorable outcome is

**Table 3** Dysphagia score before treatment and at end-of-follow-up

Before treatment	End of the follow-up period			
	0	1	2	3
1	<i>n</i> = 6	<i>n</i> = 0	<i>n</i> = 0	<i>n</i> = 0
2	<i>n</i> = 7	<i>n</i> = 0	<i>n</i> = 0	<i>n</i> = 0
3	<i>n</i> = 7	<i>n</i> = 1	<i>n</i> = 1	<i>n</i> = 1
4	<i>n</i> = 1	<i>n</i> = 0	<i>n</i> = 0	<i>n</i> = 0
Total	21	1	1	1

reported with the use of needle-knife<sup>[11]</sup>, submucosal dissection knives<sup>[5]</sup>, a Zimmon needle (Cook endoscopy, Winston-Salem, NC)<sup>[4]</sup>, or endoscopic scissors<sup>[12,13]</sup>. The SB-knife<sup>®</sup> (Sumimoto Bakelite Ltd, Tokyo, Japan), an endoscopic scissor, seems to be safe, fast and effective<sup>[13]</sup>. Myotomy with the SB-knife consists in cutting the full thickness of the septum without individualization of muscle fibers, anterior and posterior walls of the diverticulum. It remains unclear where dissection should be stopped in this setting. The most reliable device for diverticulotomy has yet to be determined<sup>[14]</sup>. A major concern is perforation risk if dissection extends too deeply. The Hook knife provides advantages for this purpose, as its design allows pulling the muscle fibers upward before cutting. Extensive myotomy can be achieved with complete visual control, and the risk of coagulation-induced injury risk may be reduced by pulling tissues upward instead of pushing downward with most other tools. Unlike previous series on submucosal dissection knives<sup>[5]</sup>, we believe that these devices-but not the Hook knife-do not confer an optimal visualization, especially in the final steps of the myotomy, before cutting the posterior ZD and anterior esophageal walls, whereas pulling with the hook is helpful to assess the nature and amount of tissue before cutting.

Our 91.7% overall clinical success rate is in line previous papers. A 95% overall success rate was reported in a series of 46 patients treated with the Hook knife<sup>[15]</sup>. However, in this series, initial clinical success was 100%, but recurrence rate was high at 30%, leading to frequent retreatment (mean 1.39 sessions/patient). This might be explained by the interruption of the myotomy 5 to 10 mm above the bottom of the diverticulum, regardless of complete cut of muscle fibers and diverticulum size. Indeed, post-treatment size  $\geq 10$  mm is suspected to be a risk factor for recurrence at 48 mo<sup>[8]</sup>. Moreover, diverticula were larger (median size 42 mm) than in our series. Although diverticulum size was not significantly associated with recurrence rate, pre-treatment size  $\geq 50$  mm may be an independent factor for clinical failure at 6 mo<sup>[8]</sup>, and this could also explain such a high recurrence rate. Lower (from 50%) or higher (to 100%) success rates have been reported before<sup>[8,16,17]</sup>. With the Zimmon needle, overall success, recurrence and complication rates were respectively 84%, 23.1% and 2.2%<sup>[4]</sup>. With a needle knife, overall

success rates ranged from 69%<sup>[8]</sup> to 84%<sup>[17]</sup> at 6 mo, recurrence rates from 15%<sup>[8]</sup> to 30%<sup>[17]</sup>, and adverse event rates from 3%<sup>[8]</sup> to 23%<sup>[17]</sup>. Laquière *et al.*<sup>[5]</sup> described the use of the Dual-knife<sup>®</sup> (Olympus endotherapy, Tokyo, Japan) and the HybridKnife<sup>®</sup> (Erbe elektromedizin GmbH, Tuebingen, Germany), with an overall success rate, recurrence rate and complication rate of respectively 91.7%, 14% and 7.1%. Endoscopic myotomy with the SB-knife<sup>®</sup> resulted in a 87.1% overall success rate, a 6.5% recurrence rate, and a 3.2% complication rate, with a limited median follow-up of 7 mo<sup>[13]</sup>. These variations might be related to how tightly clinical success was defined: Dysphagia score  $\leq 1$ <sup>[4]</sup>, or  $< 1$ <sup>[8]</sup> have been proposed. Moreover, composite scores investigating respiratory symptoms or hoarseness and their weekly frequency have been included in clinical success definition by some authors<sup>[9]</sup>, resulting in lower success rates. Here however, in our definition of clinical success, no further intervention was needed, which means patients were satisfied with the functional result on the ZD-related symptoms. The initial failure rate of 12.5% and the recurrence rate of 13% are consistent with previous studies given the small mean size of ZD in our series; septotomy length  $\leq 25$  mm is suspected to be an independent prognostic factor for clinical failure and recurrence (HR = 6.34 at 6 mo and 2.20 at 48 mo)<sup>[8]</sup>.

Only two patients experienced mild adverse events. No bleeding was reported, when anticoagulant or antiplatelet therapy was resumed the day post-procedure in more than half of patients. No perforation occurred. Moreover, after all but two procedures, patients were discharged from hospital on day 1, demonstrating the safety of this technique.

Retrospective analysis, single-center design, and lack of comparison with other devices are limitations to this study. Even with a minimal follow-up of 6 mo, our median follow-up of 19.5 mo might still be too short to investigate long-term recurrences: Even though another study reported a mean time to recurrence after diverticulotomy with the Hook knife of 4.4 mo<sup>[15]</sup>, recurrence rate may be underestimated, as success rate for dysphagia decreased between 6 and 48 mo in a large study including 89 patients with a 24-mo minimum follow-up<sup>[8]</sup>.

### Conclusion

The Hook knife is a reliable tool for flexible endoscopic soft diverticuloscope-assisted myotomy in patients with symptomatic Zenker's diverticula. It is safe and efficient and could therefore be considered a device of choice in this indication. Larger comparative studies, with extended follow-up, are needed to determine which tool is the best.

## COMMENTS

### Background

Zenker's diverticulum can cause dysphagia, regurgitations, and sometimes life-

threatening complications. Endoscopic treatment is a first line option.

### Research frontier

Flexible endoscopic myotomy can be performed with various tools. Safety (perforation risk) and efficacy are major concerns. The ideal tool has yet to be determined.

### Innovations and breakthroughs

The Hook knife allows precise dissection of muscle fibers and complete myotomy in a safe way, by pulling up tissues before cutting. It results in high clinical success rate and low complication and recurrence rates.

### Applications

The Hook knife may be a device of choice for flexible endoscopic diverticulotomy.

### Peer-review

The manuscript was well written and helpful.

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