British Society for Digestive Endoscopy

The first meeting of the British Society for Digestive Endoscopy was held on 11 March in the Royal College of Physicians, London, following the Spring Meeting of the British Society of Gastroenterology. Over 150 members of the BSDE and BSG and their guests attended.

Side-viewing Olympus Duodeno-fibrescope JF-B

A. W. DELLIPIANI (with H. B. DEVLIN) reported their experience with this instrument in a district general hospital. Like other observers they found it particularly useful in the diagnosis of suspected lesions after gastric surgery. It is an excellent gastroscope but examination of the duodenal bulb can be difficult and ulcers can be missed. It was pointed out in discussion that using an end-viewing duodenoscope first, followed by a side-viewing instrument, gave a greater success rate in detecting duodenal ulcers.

Early Endoscopy for Upper Gastrointestinal Bleeding

J. S. KIRKHAM reviewed his experience of early endoscopy in patients admitted to St James' Hospital, Balham, with upper gastrointestinal bleeding. Patients were examined the morning after admission, if necessary after gastric lavage with cold saline. In 113 patients 97 satisfactory examinations were achieved. Only three of the 16 failures were due to the stomach being totally obscured by blood. Early gastroscopy was considered valuable as it avoided the need for gastrotomy at the time of emergency surgery, enabled a radical operation to be carried out if a bleeding carcinoma was diagnosed, and allowed exclusion of other lesions. The duodenum was not examined in this series and, as was pointed out in the discussion, the presence of a lesion in the stomach did not exclude the possibility of bleeding from some other site such as a duodenal ulcer, emphasizing the benefit of using an end-viewing instrument capable of inspecting the oesophagus, stomach, and duodenal bulb in patients with haematemesis.

Gastroduodenoscopy at Operation

R. M. KIRK discussed gastroduodenoscopy at operation using the irrigating cystoscope. He expressed dissatisfaction with peroral duodenoscopy, and admitted to a substantial rate of failure to enter the duodenum. The exclusion of an ulcer is

sometimes uncertain. The instrument may not pass through the pylorus. At operation for the cure of an expected ulcer, or when searching for a suspected ulcer, no scar may be found. The lumen must always be examined: in 900 laparotomies nine active ulcers (four bulbar, two postbulbar and three gastric) were found that were undetectable by external inspection of the bowel. However, a gastroduodenotomy closed as a pyloroplasty irrevocably destroys the pylorus and may add to the patient's disability. The lumen can be inspected by introducing an irrigating cystoscope through a small gastrotomy. Water from a reservoir placed 10 cm above the stomach is run in after applying non-crushing clamps across the gastric cardia and proximal jejunum. The stomach, duodenal bulb, ampulla, and distal duodenum may be inspected. Large biopsy specimens may be removed from gastric ulcers or other lesions.

Examination of Duodenal Bulb

P. BROWN (with P. R. SALMON and A. E. READ) reported on a series of 400 examinations of the duodenal bulb. The forward-viewing instrument is always used first and in 278 cases it allowed a complete examination of the bulb. In 64 patients the examination was incomplete so a side-viewing instrument was also passed. In 58 patients a side-viewing instrument only was used either because it was a follow-up examination, or in order to cannulate the ampulla of Vater, or because the patient was a child. The examination was unsatisfactory in only 2.5% of cases. Of 112 patients with x-ray negative dyspepsia abnormalities were found in 38, of which 17 were duodenal ulcers and four scars in the bulb. The disagreement between radiological and endoscopic findings was greatest in the patients who had had gastric surgery—a notoriously difficult area for the radiologist. The disagreement was least in patients with duodenal ulcer.

Long Colonoscopy CF-LB

C. B. WILLIAMS and T. MUTO (St Mark's, London) reviewed the examination of 50 patients with the long colonoscopy CF-LB. In 47 the caecum was reached and in some the terminal ileum was examined. The patients were examined under heavy sedation with diazepam. A complete examination took an average of 90 minutes and in some cases up to three hours. Screening is essential to check the part

of the colon which has been reached. Patients were selected for total colonoscopy on the basis of an abnormal appearance in the terminal ileum or right side of the colon on barium examination (40% were found to have some abnormality), or of unexplained rectal bleeding, or if three or more polyps were found in the left side of the colon.

Complications of Endoscopic Examination

K. F. R. SCHILLER (with P. B. COTTON) reviewed five major complications from a combined series of 1 700 endoscopic examinations of the upper gastrointestinal tract. Two were cases of aspiration pneumonitis and three were perforations. They asked members to answer the questionnaire requesting information on the incidence of complications such as perforation, haemorrhage, aspiration pneumonitis, cardiovascular complications, and problems relating to premedication and local anaesthesia to the pharynx.

Dr Bernardo drew attention to the risk of serum hepatitis by contamination of endoscopes and biopsy forceps. Mr Dean suggested that cleansing and soaking in Cidex was the best available means of preventing this risk and would not harm the endoscope.

Symposium on Basic Aspects of Digestive Endoscopy

The second part of the morning was devoted to a symposium on basic aspects of digestive endoscopy,

concentrating attention on the diagnosis of lesions of the stomach. P. R. SALMON reviewed the instruments available, and the technique for complete examination of the stomach and duodenal bulb, emphasizing the importance of conducting the examination to a set routine.

R. WHITEHEAD emphasized the great importance of getting the biopsy specimens into fixative quickly. Orientation was not a problem provided the specimen was of adequate size. He reviewed the appearance of normal gastric mucosa from different parts of the stomach and of the different stages of atrophic gastritis. S. C. TRUELOVE and R. WHITEHEAD then performed a beautifully illustrated duet showing a wide range of gastroscopic appearances and the corresponding histology.

A. I. SPRIGGS reviewed the scope of gastric cytology and strongly recommended obtaining samples by brushing suspicious areas of gastric mucosa under direct vision rather than by gastric lavage. Smears obtained should not be allowed to dry but should be immersed at once in fixative. He illustrated the appearances of normal gastric epithelial cells, cells from gastritic areas, and malignant cells, showing how in a small proportion of cases it could be extremely difficult to distinguish gastritis from carcinoma. In spite of the problems of interpretation he had a very small proportion of false negatives, only five carcinomas being missed in 378 negative cytology reports and, more important, there were no false positives.

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