
Reply
Sir,—Thank you for letting me see the letter from Drs Dilawari and Chawla in response to my recent editorial. The only comment that I would wish to make is that my editorial was concerned with the whole problem of extra hepatic portal venous obstruction rather than the specific experience in India. I have indeed suggested in the paper (midway down page 1194) that there may indeed be features which distinguish EHPO in different parts of the world. The picture described in Chandigarh is not typical or representative of that found in the West.

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Dilatation of ‘impossible’ malignant oesophageal strictures using angiographic techniques
Sir,—Bown et al recently reported in Gut that in seven of the 37 patients in their series with advanced oesophageal carcinoma, it was impossible to insert a guide wire through the lumen.7 They suggest that this finding is a good indication for laser therapy because it renders dilatation and intubation impossible. Prograde laser therapy, however, is more hazardous in the situation where there is no visible lumen to guide application. We have successfully used a new method to pass a guide wire and dilate such carcinomas by using angiographic techniques, where it was impossible or unsafe to pass a standard endoscopic guide wire.2 This has now been done under sedation in nine patients on 12 occasions.

The technique used was as follows: a 16 French nasogastric (NG) tube was placed in the proximal oesophagus via the oral route. Dilute barium was then injected into the NG tube to confirm proximal oesophageal location. With the patient in the left lateral position, a Cook 15 mm J (TSCF) 0·96 mm guide wire was then passed through the NG tube into the proximal oesophagus with the tip of the guide wire exiting through the distal side port of the tube. The guide wire with its floppy end was then coiled in the proximal oesophagus. The NG tube was removed and a 5·3 French multipurpose torque control catheter was exchanged over the guide wire. The guide wire was then removed. Small amounts of contrast (water soluble may now be used) were injected to outline the lumen if present. One of a variety of wires was then used in an attempt to cross the stenotic lesion. For a moderate to severe stenosis a very floppy straight wire (TSFNB 0·965 mm) was used. Through the torque control catheter, the TSFNB wire was advanced at small increments into the patent lumen of the stricture. The catheter then followed the TSFNB at small intervals, providing stiffness and mild steerability. This procedure continued until the lesion has been completely crossed by both wire and catheter.

If unsuccessful or for higher grade stenosis, a steerable wire such as a Lunderquist torque guide (Cook THG 0·965 mm) or a Waltman (Cook SMG 0·63 mm) wire was used to cross the lesion. These wires offer maximal steering capacity and safety.

When the wire and catheter were safely in the stomach, the steerable wire was removed and water soluble contrast was once again injected to confirm the intraluminal position. A heavy duty exchange wire (Cook Teflon-coated Lunderquist exchange wire 0·965 mm) was then passed through the catheter and the distal tip coiled safely in the stomach. The stiffening catheter was then removed.

At this point we used either Savary-Guilland dilators, a high pressure balloon angioplasty catheter (USCI PE Plus II) or Olbert fascial balloon dilator to dilate the stricture. All of these devices easily pass over the exchange wire. After dilatation, either the balloon catheter itself or the torque control catheter originally used was passed into the gastric lumen. The stiff exchange wire was then removed and a softer wire (Cook 15 mm J TSCF 0·965 mm) was placed through the catheter with its tip coiled in the stomach. This wire facilitates passage of the endoscope through the stricture.3 Laser cautery or endoscopic intubation could then be carried out.

We have seen no complications as a result of this dilatation technique apart from one patient who developed a transient tachyarrhythmia without hypotension during the procedure.

We describe a simple technique to dilate difficult oesophageal carcinomas. It can readily be done in the radiology department without major equipment purchases. We suggest that angiographic techniques have a role in the dilatation of such ‘impossible’ malignant oesophageal strictures prior to treatment with laser or intubation.

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References

Reply
Sir,—Murray et al describe an elegant and simple technique for getting a guide wire through the ‘impossible’ malignant oesophageal stricture. This sounds a very useful device and it would certainly be helpful to be able to dilate oesophageal tumours before laser therapy in all cases. I agree that prograde laser therapy is ‘potentially’ more hazardous in a situation where there is no visible lumen. As long as one sticks to the basic rules of endoscopic laser treatment, however, and only fires the laser at exophytic tumour, the risk of perforation is extremely small. It may well not be possible to recanalise a difficult tumour in one session, however, so making it necessary for necrosed tumour to slough before a further attempt can be made to pass a guide wire or the endoscope and so a technique as described in this letter, which would make dilatation possible at the first session, would be a useful advance.

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Endoscopic needle aspiration cytology
Sir,—Ingoldby et al in a recent report have highlighted the usefulness of endoscopic needle aspiration cytology in the diagnosis of upper gastrointestinal cancer. We have been using this technique since 1985 and have evaluated its role in 72 upper gastrointestinal tumors. We had initially used an indigenously manufactured aspiration needle, but now we use a 23 gauge sclerotherapy needle (Microvasive Inc. USA). We have kept the length of the retractable needle to 4–5 mm for fear of perforation with a larger length. So far we have had no complications. The overall positivity rate of this technique is 92%. Our results show that this technique is especially useful in infiltrative tumors and we feel that with modifications in the retractable needle, sampling of submucosal tumors will be made easy. The idea of using this technique had come from the routine application of needle aspiration cytology for abdominal tumors. A literature review showed that this technique has been used through a bronchoscope for many years: a disposable needle specially suitable for this procedure is available commercially. Apparently Ingoldby et al in their paper, claiming endoscopic needle aspiration cytology to be a new method, have also overlooked an earlier report by Tsuchiya et al who had used endoscopic needle aspiration biopsy for detecting carcinoma of pancreas with an accuracy of 84%, way back in 1977. A number of other reports have also appeared in the literature.

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