LETTERS TO THE EDITOR

Percutaneous aspiration in the treatment of hydatid liver cysts

EDITOR,—During a survey of recent literature in preparation for the XVII International Congress on Hydatidology (held in Limassol, Cyprus, 6–10 November 1995) we have read with interest the article by Morris about liver echinoccosis (*Gut* 1994, **35:** 1517–8). We have, however, been somewhat surprised by his misquoting of our paper.[1] The two lines devoted to percutaneous aspiration ('The risks of fluid leakage are high and anaphylaxis has been well reported') are not representative of what we meant.

We suggested exactly the opposite – that is, the risks of fluid leakage and anaphylaxis, although real, seem rather overestimated. No such side effects were reported in our – by then rather small – series, nor by the authors who – inadvertently or not – had at that time aspirated a hydatid cysts.[2 3] No major side effect was registered by the other groups who, at the time Morris wrote his paper, had diagnosed or treated by percutaneous aspiration more than 100 hydatid cysts and published the results of their work.[4–11] We feel even more entitled to say this five years after, when our series has grown to 163 patients with 231 cysts treated this way[12] and a growing number of colleagues' reports of patients treated by this or similar methods.[13]

The series reported in those latest papers represent an overall population of more than 1000 patients treated with percutaneous puncture, and not in a single case anaphylactic shock or peritoneal dissemination have been reported. Both we and some of the mentioned authors reported only mild allergic reactions.

Indeed, the probability of major problems such as fluid leakage and anaphylaxis (obviously when the procedure is performed by experienced personnel, and once the correct prophylaxis with mebendazole or albendazole has been set) is so low that the World Health Organisation recently recognised the procedure as a first choice method for treatment of hydatidosis especially in developing countries. As regards Western countries, we feel that PAIR (puncture, aspiration, injection, reaspiration) has gained a status such as to be proposed as an alternative treatment to surgery (when the patients cannot or do not want to undergo surgery). Its main advantages are greater safety, less expense, less distress for the patients.

We would therefore like to suggest that Dr Morris is more explicit in his next reviews concerning treatment of liver hydatidosis.

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Reply

EDITOR,—Growing old can indeed be a painful business but let's consider this carefully, our opinions clearly differ – I do think it matters! Can the facts help us? Brunetti and Filice acknowledge 'mild allergic reactions' – to what? If this is to parasite protein rather than the needle or the local anaesthetic, then spillage has occurred and it is (in my opinion) very likely that the other consequence of spillage – dissemination will occur. The short-term, and often very poor quality, follow up offered by the current literature (of which I am well acquainted) does not reassure me. Recurrence is likely to take many years, and will probably be encountered in the peritoneum, the needle track, and elsewhere. The 'minor allergic' reactions don't reassure me much either – what determines the difference between minor, major, and fatal allergic reaction to hydatid fluid spillage? – they certainly all occur.

Hydatid cysts (*E granulosus*) if viable are often under considerable pressure and contain up to 10^6 protoscoleces/ml each capable of forming a new cyst if spilled and contain large lumps of debris in the form of daughter cysts and collapsed laminar layer. Even at surgery using a large diameter suction device, blockage frequently occurs – the likelihood of spillage during percutaneous aspiration, even if done through liver, is in my view very high. Spillage has two risks: one immediate in the form of an aphylactic reaction and the other long term in the form of dissemination. A large proportion (in my experience) of hepatic hydatid cysts communicate with the biliary tree – the injection of scolicide into the biliary tree can produce fatal sclerosing cholangitis.

I certainly do not accept that it is established or likely that the safety of percutaneous aspiration is greater than medical or surgical treatment (I have not yet lost a patient with *E granulosus* treated by either medical or surgical means) whether it is less expensive and whether it causes more or less distress to patients will clearly depend again on longterm outcome.

If the WHO regards this technique as optimal I am surprised, and if it believes that it should be used as a first choice in developing countries, I am concerned and disappointed – quality of follow up is likely to be even more of a problem in such circumstances and while the economics of health care can place very real restraints on treatment, the issue is what is best practice?

I challenge the writer to do some good animal work with viable liver cysts and demonstrate clearly the safety of this technique, my view at present remains unchanged that this technique is most inadvisable.

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Ulcerative colitis and renal cell carcinoma

EDITOR,—In addition to the patients recently reported (*Gut* 1996; **38:** 148–50) I would like to comment that I am also aware of a patient who developed both ulcerative colitis and renal cell carcinoma. We first saw this patient in December 1994 when we performed a prophylactic proctocolectomy because of multiple dysplastic polyps in a regularly exacerbating ulcerative colitis.

Ulcerative colitis was diagnosed in 1991 at the age of 61 and was treated only with orally administered 5-aminosalicylic acid with good results for 12 months. Then, computed tomography was performed for increasing abdominal pain and showed a Grawitz tumour of the left kidney, which was subsequently treated with nephrectomy. Further history revealed nephrolithiasis (1976) and a low anterior resection because of a well differentiated Dukes's B_1 adenocarcinoma (1985). With regard to the risk factors for carcinoma of the kidney, the patient had hypertension since 1974, but was not obese and had given up smoking more than 10 years before the nephrectomy.

Unlike Dr Satsangi's patients, our patient was not treated with corticosteroids or azathioprine before the diagnosis of the renal cell tumour was established. If it were true that 5-ASA derivates do not participate in the pathogenesis of the neoplasms reported and if there were any relation between ulcerative colitis and renal cell carcinoma, our case suggests that genetic factors are more important than the effects of drug therapy.

Although these four cases are merely anecdotal, and in no way definitive proof for a relation between (the treatment of) ulcerative colitis and renal cell carcinoma, I think they may be sufficient ground to start a case control study.

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