LETTERS TO THE EDITOR

Is needle biopsy of the liver necessary to diagnose HCC?

EDITOR,—Schotman and colleagues (Gut 1999;45:626–7) reported a patient with subcutaneous seeding of hepatocellular carcinoma (HCC) after percutaneous needle biopsy together with a review of 14 similar cases and correctly outlined the necessity for a critical evaluation of the role of needle biopsy in resectable HCC.1,2 We agree with their conclusion, namely that if it is not possible to diagnose HCC by other means (namely increased a fetoprotein (AFP) concentrations, spiral computed tomography (CT), magnetic resonance imaging); in these cases, a single pass with a large needle (18 gauge) may be preferable to multiple passes with smaller calibre needles; (ii) needle biopsies are not indicated to confirm HCC in patients suitable for liver transplantation; and (iii) the entire needle tract should be resected at surgery for the primary tumour. This has been important in other skin recurrences, namely those after laparoscopic cholecystectomy for undiagnosed gall bladder carcinoma.3,4 However, we have some questions and comments concerning the reported case. Firstly, why did the authors perform tumour biopsy in a 30 year old woman with hepatitis B liver cirrhosis and raised serum AFP, showing a 2 cm diameter subcapsular nodule in segment V and two additional satellite lesions in the same segment? Adequate imaging procedures were already available four years ago. In fact, the patient had percutaneous liver biopsy together with an informative diagnostic procedure such as spiral CT. In addition, subcapsular liver lesions are known to give a higher rate of both subcutaneous recurrence and intrahepatic subdiaphragmatic seed- ing.5 Therefore, in contrast with recurrence after laparoscopic surgery which mostly cluster around abdominal port tracts,6 simple removal of the needle tract could not be sufficient to prevent the side effects of percutaneous liver biopsy. Secondly, why did they perform right hemihepatectomy in a cirrhotic liver rather than segment V segmentectomy? The latter could be a similarly adequate procedure while preserving better residual liver function. The authors should be congratulated for focusing on once again on a very important question (to biopsy or not to biopsy liver nodules in suspected HCC in the present era of highly effective imaging) and for their collection of 15 cases, which is obviously an underestimation of what occurs in practice and is currently observed in many transplantation centres. However, their message for the reader should be clearer as there is an apparent contradiction between what they state and what they actually did. F CETTA M ZUCKERMANN Institute of Surgical Clinics, University of Siena, Italy Correspondence to: Professor F Cetta, Institute of Surgical Clinics-University of Siena, Nuovo Polichinico-Viale Bracci-53100, Siena, Italy. cetta@uni.s.it

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Reply

EDITOR,—We read with interest the letter of Cetta et al in which they discussed our case (Gut 1999;45:626–7) of subcutaneous seeding of a hepatocellular carcinoma (HCC) after percutaneous needle biopsy.

Firstly, they state that a needle biopsy was not indicated in the case presented. It must be stated that the biopsy was performed elsewhere before the patient was admitted to our hospital. Secondly, they suggest that a smaller needle biopsy may be preferable to multiple passes with a large needle (18 gauge) may be preferable to multiple passes with smaller calibre needles; (ii) needle biopsies are not indicated to confirm HCC in patients suitable for liver transplantation; and (iii) the entire needle tract should be resected at surgery for the primary tumour. This has been important in other skin recurrences, namely those after laparoscopic cholecystectomy for undiagnosed gall bladder carcinoma.1,2

However, we have some questions and comments concerning the reported case. Firstly, why did the authors perform tumour biopsy in a 30 year old woman with hepatitis B liver cirrhosis and raised serum AFP, showing a 2 cm diameter subcapsular nodule in segment V and two additional satellite lesions in the same segment? Adequate imaging procedures were already available four years ago. In fact, the patient had percutaneous liver biopsy together with an informative diagnostic procedure such as spiral CT. In addition, subcapsular liver lesions are known to give a higher rate of both subcutaneous recurrence and intrahepatic subdiaphragmatic seeding.3 Therefore, in contrast with recurrence after laparoscopic surgery which mostly cluster around abdominal port tracts,4 simple removal of the needle tract could not be sufficient to prevent the side effects of percutaneous liver biopsy. Secondly, why did they perform right hemihepatectomy in a cirrhotic liver rather than segment V segmentectomy? The latter could be a similarly adequate procedure while preserving better residual liver function. The authors should be congratulated for focusing on once again on a very important question (to biopsy or not to biopsy liver nodules in suspected HCC in the present era of highly effective imaging) and for their collection of 15 cases, which is obviously an underestimation of what occurs in practice and is currently observed in many transplantation centres. However, their message for the reader should be clearer as there is an apparent contradiction between what they state and what they actually did.

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Management of gastric fundal varices associated with a gastrorenal shunt

EDITOR,—We read with great interest the article by Jalan and colleagues (Gut 2000;46:578–81) on the clinical position of transjugular intrahepatic portosystemic stent-shunt (TIPSS). This procedure is a useful method of reducing portal pressure by creating a portosystemic shunt in the liver. They suggested that TIPSS can be a successful treatment for controlling gastric fundal varices (FV) unresponsive to pharmacological and endoscopic therapy. However, Sanayl et al reported that TIPSS was ineffective for FV associated with a large gastrorenal shunt, even when the hepatic venous pressure gradient falls below the critical bleeding threshold of 12 mm Hg.1 The behaviour of varices at different sites seems to differ. Therefore, FV should be treated on the basis of their haemodynamics.

The data in the literature do not support either of the points that have been suggested by Matsumoto et al. Although data on the use of B-RTO for the treatment of varical bleeding are exciting, we look forward to randomised controlled clinical trials comparing TIPSS with B-RTO.

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Letters, Notes, Correction


Reply

EDITOR,—We thank Matsumoto and colleagues for their interest in our paper. They suggest that transjugular intrahepatic portosystemic stent-shunt (TIPSS) is ineffective for the management of bleeding from fundal varices and given the haemodynamic characteristics of fundal varices, the appropriate treatment for bleeding from them is balloon oedusculated retrograde transvenous obliteration (B-RTO). They quote Sanyal’s paper as evidence in support of their suggestion that TIPSS is unlikely to be useful in the setting of fundal varices. Sanyal et al reported their experience of TIPSS in 12 patients who underwent this procedure for gastric varices and in six patients these varices did not disappear on follow up. The aim of treatment of bleeding varices is firstly to control bleeding and secondly to prevent rebleeding. In the paper by Sanyal et al, no data were provided about how many patients bled from gastric varices in the follow up period compared with those who rebled with oesophageal varices.1 However, our previous study2 and that of Chau and colleagues3 clearly show that post-TIPSS bleeding from either oesophageal or gastric varices is a function of portal pressure and has little to do with whether bleeding is from oesophageal or gastric varices. Both Stanley and colleagues2 and Chau and colleagues3 compared the outcome of TIPSS insertion for varical bleeding from oesophageal or gastric varices. In the study by Stanley et al, 106 patients (oesophageal varices 74; gastric varices 32) underwent TIPSS for varical bleeding and during follow up, the rates for varical rebleeding were similar in both groups and there was no difference in survival. In the study by Chau et al, 112 patients (oesophageal varices 84; gastric varices 28) with varical bleeding underwent TIPSS for uncontrolled varical bleeding. Bleeding was controlled in all patients after TIPSS except for one in each group. Twenty four per cent of patients in the oesophageal varices group and 29% in the gastric varices group rebled during follow up. Most early rebleeing (within seven days after TIPSS) was related to oesophageal ulceration secondary to previous sclerotherapy. Rates of mortality varied in both groups. These results suggest that emergency TIPSS is equally effective in the control of gastric fundal varical bleeding compared with oesophageal varical bleeding.4

Matsumoto et al suggest that there is likely to be a place for B-RTO in the primary prophylaxis of bleeding from fundal varices and that pharmaceutical agents have no place in their management. Again, the data for both suggestion do not exist in the literature. We think that it is extremely difficult to suggest failure of pharmaceutical therapy for primary prophylaxis of fundal varices based on the assumption that portal pressure changes are unlikely to be important in the management of fundal varices.

The science, economics, and effectiveness of combination therapy for hepatitis C

EDITOR,—No one affected by hepatitis C virus (HCV) will question Professor Dush- elko’s insistence on the importance of effective therapy for HCV and the funding to meet them (Gut 2000;47:159-61). With research and clinical evidence pointing to a prevalence of HCV infection far in excess of human immunodeficiency virus (HIV), the issue has now become urgent. Patients and clinicians alike will await the forthcoming NICE appraisal in the hope it recommends in favour of allocating sufficient resources to cover treatment costs for those most in need and best able to benefit.

However, while a positive response will be welcome it will also uncover issues that have still to be fully addressed. These centre on who will be selected for treatment and the effects of the treatment itself.

Regarding the first issue there remains a debate around who will benefit most from treatment. The best way to assess outcome in terms of genotype, age, duration of viremia, extent of liver damage, and other complicating factors, such as continued drug abuse and alcohol abuse. While there may be some validity to such categorisations, they are not at all absolute and can demoralise patients. Nevertheless, and leaving such considerations aside, if HCV infection is as widespread as some clinicians anticipate, it would be unrealistic to assume that effective therapy will be available to treat everyone. This means that some form of treatment selection will need to be adopted. Should this occur, the question remains as to how clinicians will make choices and what criteria they will use. Furthermore, will protocols be in place to govern these criteria to ensure they are standardised nationwide?

1 Figures released by the Communicable Disease Report of 26 May 2000 (Wvd 171) cite 173 cases of HIV infection in the UK—that is, less than 0.07% of the population. UK data from the PHLS AIDS and STD Division, Scottish Centre for Infection and Environmental Health; Institute of Child Health; London and Oxford Haemophilia Centre—on behalf of UK Haemophilia Centre Directors Organisation. HIV infection is currently anticipated to be around 10 times higher, an estimate that would seem to be underscored by the recent study carried out at St Mary’s Hospital, (Ward C, Tudor-Williams G, Cottaza T, et al. Prevalence of hepatitis C virus among young women attending an inner London obstetric department: uptake and acceptability of checked antenatal testing. Gut 2000;47:277-80), which reported a prevalence of HCV infection in 0.8% of women who took part in the study. It was Figure 2 that were women who tested positive, 90% of whom were viramic. In the US, the HCV infection is reported to be possibly four times higher than HIV with 3.5 million affected and 30 000 new cases each year (Turkington C. Hepatitis C: the silent killer. Chicago: Contemporary Books, 1998) xiii.

Screening for genetic haemochromatosis in blood samples with raised alanine aminotransferase

EDITOR,—Bhavnani et al (Gut 2000;46:707-10) claim to have identified 12 patients

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homozygous for C282Y or with compound heterozygosity at a cost of only £117 per patient identified. This astonishingly low total of £1400 allowed them to:

- Select out of 35 065 blood samples 4.2% (1490) with an elevated alanine aminotransferase.
- Undertake measurement of 1490 serum iron, transferrins, and ferritin concentrations.
- Give information on haemochromatosis and offer genetic screening to the 56 patients found to have a transferrin saturation >60%, and to re-contact those not responding.
- Obtain informed consent from the 33 patients who did respond, and undertake genetic testing for HFE mutations.
- Offer appropriate management to the 12 patients with C282Y homozygosity or compound heterozygosity.

We have some difficulty in accepting that all this can be achieved for only £1400, and would be intrigued to know how the authors arrived at their costings.

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Reply

Editor—Our preliminary study set out to examine the clinical usefulness of screening a targeted population for genetic haemochromatosis. The costing given in our paper was as stated, based solely on laboratory costs, a summary of which is given below. Costs of the clinician, nursing, and clerical time were not included in the paper, and are detailed below.

Laboratory costs:
- Screening for blood samples with elevated ALT incurred no additional costs as these samples were processed routinely as part of the normal hospital and GP biochemistry requests.
- The marginal costs for the measurement of 1490 serum iron and transferrins, £1085; 33 serum ferritins, £51; and genetic testing: £264 (total £1400).
- Although serum ferritins were performed on all 1490 specimens as part of the study, at a cost of £1788, we felt that they did not help in the screening process.

Thus we advocated “In those patients found to have a raised ALT, the cost of screening with iron saturation and follow up when appropriate with ferritin and gene testing would be £1400”.

Other costs:
We were awarded a research grant of £5000 from the Health Authority, and the rest of the money was used for employing a medical laboratory assistant, (8 hours/week) who picked out the relevant specimens and batched them for future testing. Information on haemochromatosis, plus offering genetic screening to the 56 patients found to have a transferrin saturation >60% and re-contacting the non-responders was done by means of a standard letter to the clinicians who had requested the original liver function tests. Consent for genetic testing was obtained by employing these clinicians. Management of the 12 patients (homozygotes and compound heterozygotes) was undertaken (with no extra funding) by one of the authors (MB) as part of the routine Clinical Haematology service.

Since then, the Health Authority has awarded us continuing revenue for this targeted screening, and included in these monies are the clinical, clerical, and nursing monies incurred in providing this service as a routine for patients in our District.

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NOTES

American College of Gastroenterology 2001 International GI Training Grants Programme
The ACG International GI Training (IGT) Grant Programme provides funding for clinical or clinical research training in gastroenterology and hepatology so that an individual can acquire or develop new cognitive knowledge or skill. This newly acquired knowledge or skill would then be used to improve patient care in the applicant’s geographic area. Physicians outside of the United States and Canada are eligible to apply. At least one fellowship with a maximum of $10 000 per IGT fellowship will be awarded during 2001, for a training period of not less than six months. Awards will be made by a special committee of the ACG and will be based upon the applicant’s credentials, the merit of the proposed training by the selected host training centre and the potential for enhancing the field of gastroenterology in the applicant’s home country. Application forms can be obtained from the ACG administrative office: 4900B South 31st Street, Arlington, Virginia 22206-1656. Tel: +1 703 820 7400; fax: +1 703 931 4520; website: www.acg.org. Deadline for submission of application is 1 April 2001.

Redefining Priorities in Gastroenterology
This congress will be held on 11–14 April 2001 in Monte Carlo, Italy. It will be chaired by Professor Massimo Crepni (Rome, Italy) and Professor Eammon Quigley (Cork, Ireland). Further information: Maddalena Massaro, Project Leader, AISC-AIM Group, Via A Ristori 38, 00187 Rome, Italy. Tel: +39 06 809681; fax: +39 06 80968229; email: gastro2001@aisc.it.

3rd European Federation of Autonomic Societies (EFAS)
The third European Federation of Autonomic Societies (EFAS) meeting in conjunction with the annual meeting of the sections “Autonomic nervous system” of the German Neurological Society, “Diabetes and Nervous System” of the German Neurological Society, and “Autonomic Nervous System” at the University of Erlangen-Nuremberg, Germany, will be held in Erlangen, Germany on 26–28 April 2001. Further information: Professor Dr M J Hild, Department of Neurology, University or Erlangen-Nuremberg, Schwabachanlage 6, D-91054 Erlangen, Germany. Tel: +49 9131 8534444; fax: +49 9131 8534328; website: www.neurologie.med.uni-erlangen.de/ oeffentliche_Veranstaltungen.html

Falk Workshop
The workshop entitled Update in Inflammatory Bowel Diseases will be held in Ljubljana, Slovenia, on 5 May 2001. Further information: Prof Dr S Markovic, University Medical Center Ljubljana, Division of Internal Medicine, Jalepova 2, 1525 Ljubljana, Slovenia. Tel: +386 (1) 231 6925; fax: +386 (1) 433 4190; email: sasa.markovic@kclj.si

EPGS Endosonography Live in Amsterdam
This European Postgraduate Gastro-Surgical School congress will take place on 31 May and 1 June 2001 in Amsterdam, the Netherlands. Further information: Mrs Helma Stockmann/Mrs Joy Goedkoop, European Postgraduate Gastro-Surgical School, Melibergdreef 9, 1105 AZ Amsterdam, The Netherlands. Tel: +31 20 566 3926; fax: +31 20 566 6569; email: W.J.Stockmann@amc.uva.nl; website: www.epgs.nl.

33rd European Pancreatic Club
The meeting will take place on 13–16 June 2001 in Toulouse, France. A training course will be organised on 13 June on “Genomics and post genomics: developments in biomedical sciences”. Further information: Dr Nicole Vaysse, Inserm U531, CHU Rangueil, 31403 Toulouse, France. Tel: +33 (0)5 61 32 24 02; fax: +33 (0)5 61 32 24 03; email: nicole.vaysse@ranguelig.inserm.fr; website: www.epc.org.

Gastroenterology and Endotherapy: XIXth European Workshop
This course, to introduce the experienced gastroenterologist to the growing field of therapeutic endoscopy, will be held on 18–20 June 2001 in Brussels, Belgium. Further information: Mrs Nancy Beauprez, Gastroenterology Department, Erasme Hospital, Route de Lennik 808, B-1070 Brussels. Tel: +32 02 555 49 00; fax: +32 02 555 49 01; email: beauprez@ulb.ac.be

CORRECTION

Management of gastric fundal varices associated with a gastrorenal shunt

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