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 resetable 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 2 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 after laparoscopic surgery which mostly clustered 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

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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

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Reply

Editor,—We read with interest the letter of Cetta et al (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 partial hepatectomy might have been sufficient to treat the HCC in this 30 year old woman with hepatitis B liver cirrhosis.

In the case presented there was no deterioration in liver function or impaired functional reserve after resection. The postoperative course was uneventful.

In general, we agree with the opinion to limit resection as far as possible and presently we would perform a segmentectomy.

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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 transjugaline hepaticoportosystemic 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, Sanayi 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.

The behaviour of varices at different sites seems to differ. Therefore, FV should be treated on the basis of their haemodynamics.

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

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

EDITOR,—No one affected by hepatitis C virus (HCV) will question Professor Dushikov’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 as to whether appropriate resources are available to treat everyone.

Nevertheless, and leaving aside the issue of who is actually going to benefit from the e

Figures released by the Communicable Disease Report of 26 May 2000 (Vol 10, No 21) cite 41 174 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 (Gut 2000;47:277–80), which reported a prevalence of HCV infection in 0.8% of women who took oral contraceptives and 0.6% of women who were virgins. In the US, HIV is reported to be possibly four times higher than HCV with 3.5 million affected and 30 000 new cases each year (Turkington C. Gut 2000;46:707–10) claim to have identified 12 patients

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

www.gutjnl.com
homozygous for C282Y or with compound heterozygosity at a cost of only £147 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 irons, 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 irons 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 h/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 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 research training in gastroenterology and hepatology so that an individual can acquire or develop new cognitive knowledge or a technical skill. This newly acquired knowledge or skill would then be used to improve patient care in the applicant’s geographical area. Physicians outside of the United States and Canada are eligible to apply. At least one fellowship within 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-gi.org.

Deadline for submission of applications 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 Crespi (Rome, Italy) and Professor Eamon Quigley (Cork, Ireland). Further information: Maddalena Massaro, Project Leader, AISC-AIM Group, Via A Ristori 38, 00187 Rome, Italy. Tel: +39 06 8096818; fax: +39 06 80968229; email: gastro2001@aisc.it.

3rd European Federation of Autonomic Societies (EFAS)

The third European Federation of Autonomic Societies (EFAS) meeting will take place in Toulouse, France. A training course will be held 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@rangel.uned.fr; website: www.epgs.nl.

EPSG 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, Meibergdreef 9, 1105 AZ Amsterdam, The Netherlands. Tel: +31 20 566 3926; fax: +31 20 566 6569; email: WJ.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@rangel.uned.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 Beauzep, Gastroenterology Department, Erasme Hospital, Route de Lennik 808, B-1070 Brussels. Tel: +32 02 555 49 49; fax: +32 02 555 49 01; email: beauzep@ulb.ac.be

CORRECTION
