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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.¹ We have been using this technique since 1985 and have evaluated its role in 72 upper gastrointestinal tumors.^{2,4} 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:^{5,6} a disposable needle specially suitable for this procedure is available commercially. Apparently Ingoldby *et al* in their paper,¹ 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 1977.⁷ A number of other reports have also appeared in the literature.^{8–10}

Our technique uses a plastic syringe mounted on a suction handle, as is the practice with cytologists. This would, we feel, generate more negative pressure, thus increasing the yield. The authors have also not mentioned the type of growth in the two patients who had a negative forceps biopsy and brush cytology. In our patients such results were seen in growths which had a necrotic surface or in infiltrative tumors. It is also mentioned that stenotic lesions at the gastro-oesophageal junction may give a poor yield with biopsy and brush.¹¹ We have used a similar technique using a proctoscope to sample rectal tumors and deposits in the retrovesical pouch (unpublished data).

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