British Society for Digestive Endoscopy

The third annual general meeting of the British Society for Digestive Endoscopy was held at the Medical School, University of Birmingham, on 19 September 1974. The annual business meeting preceded the scientific session and the President, Professor A. E. Read, was in the Chair. Dr K. F. R. Schiller retired as Honorary Secretary of the Society and was sincerely thanked for the hard work he had put into the Society. Dr D. G. Colin-Jones was elected to succeed him. Dr D. D. Gibbs gave the Honorary Treasurer’s report. A ballot is to be held for replacement of four members of the Executive Committee due to retire this session. The scientific session commenced with four papers, abstracts of which appear below.

The third annual Foundation Lecture was given by Dr Meinhard Classen (West Germany). Dr Classen’s lecture was entitled ‘Operative endoscopy’. Dr Classen outlined what has already been achieved in many centres with the use of fibroptic endoscopy for therapeutic purposes. He discussed the role of polypectomy from the colon and the stomach, and the removal of foreign bodies. He then looked at the future possibilities of therapeutic endoscopy and described his technique for sphincterotomy of the sphincter of Oddi through which gallstones could subsequently be removed. He demonstrated this with the aid of a film. Dr Classen’s lecture was acclaimed by a large audience.

In the afternoon the Society was invited to participate in a symposium on ‘Diagnosis of pancreatic disease’ with the British Society of Gastroenterology. Dr Sheila Waller was in the Chair and Professor Thomas Scratcherd opened the symposium with a paper on the physiology of the pancreas. Professor D. A. Dreiling (New York) then discussed his experience with pancreatic function tests in the diagnosis of pancreatic disease.

The third speaker was Dr Paul Salmon who discussed the role of ERCP in the investigation and management of patients with pancreatic disease. He gave a well-illustrated talk on his experiences with ERCP and of its value, and also the limitations of this new technique.

In the afternoon two open forums were held on ERCP and routine endoscopy. As the audience appeared to enjoy the opportunity of informal discussions on techniques and problems more open forums are planned for the future.

A randomized double-blind trial of four different premedication regimes for upper intestinal endoscopy

P. J. COOK, P. BENNETT, T. WARNES, AND J. LENNARD-JONES Patients undergoing routine upper gastrointestinal endoscopy with an ACMi forward-viewing gastroduodenoscope were allocated randomly to one of four groups, each of 30 patients. All groups received local pharyngeal anaesthesia and intravenous diazepam given in a dose sufficient to produce sedation judged adequate by the operator. Group 1 received no other medication, group 2 received atropine 0·6 mg im, group 3 received pentazocine 30 mg im, and group 4 received pethidine 100 mg im, each drug being given approximately half an hour before the procedure. Observations were made on ease of intubation, coughing, retching, salivation, apparent sedation during the procedure, the duration of sedation, and the patient’s opinion and memory of the procedure.

The dose of diazepam did not differ significantly between the four groups. There tended to be an inverse relationship between the dose of diazepam used and the degree of sedation achieved.

Analysis of the results showed that pethidine gave the greatest ease of intubation and the least salivation, coughing, and retching with the greatest apparent sedation. This group also had the least recall of events during the endoscopy and experienced the least discomfort. However, the duration of sedation was greatest in this group.

The results suggest a slight advantage from the use of atropine and pentazocine as compared with no premedication but the results are inconclusive.

Some advantage appears to be gained by using one of the three drugs as a premedication for every patient. Pethidine improves the procedure for the patient and operator but tends to prolong the recovery time; we recommend its use whenever difficulty is anticipated.

The diagnosis of duodenitis

H. THOMPSON AND G. HOLME Investigation of dyspepsia by radiology, endoscopy, and biopsy may reveal no evidence of peptic ulcer, oesophagitis, or neoplasia, and the clinical and endoscopic findings may suggest a diagnosis of x-ray negative dyspepsia possibly due to duodenitis. There is a danger that this disorder will be diagnosed too frequently and it is important that the diagnostic criteria should be sharply defined on a pathological basis. Duodenitis may exist with chronic duodenal ulcer and in certain patients it may not be possible to exclude the presence of a small or acute ulcer. The pathological criteria used for the diagnosis of duodenitis have been assessed in a series of 50 duodenal biopsies from patients with duodenal ulcer and patients with x-ray negative dyspepsia. Histological confirmation of duodenitis is necessary since it is clear that correlation between endoscopic appearances and histological interpretation is not always satisfactory. Reddening of the mucosa encountered during endoscopy may be physiological or due to the stimulus of instrumentation although it can indicate inflammatory hyperaemia. Endoscopic identification of the erosions and acute ulcers is more reliable but, especially in the case of erosions, it is again helpful to have histological confirmation.

Duodenitis is characterized by inflammatory hyperaemia, inflammatory and haemorrhagic erosions, chronic inflammatory cellular infiltration of the lamina propria, epithelial regenerative changes, and leukocytic migration through the epithelium. Small numbers of lymphocytes and IgA-producing plasma cells and eosinophils are normally present in the duodenal mucosa. Excessive numbers are present in duodenitis and there may be slight oedema of the mucosa. Cell counts using a graticule, a method in common use in the assessment of jejunal biopsies in adult coeliac disease, confirm the inflammatory element. An analysis of such cell counts will be presented. The presence of neutrophils in the lamina propria provides convincing evidence of an inflammatory reaction and microabscesses may occasionally be encountered. The surface epithelial cells become

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more cuboidal, basophilic, and regenerative in appearance, with hyperchromatic nuclei. In acute and subacute exacerbations mitoses appear and the surface epithelium may develop a papillary appearance. Emigration of neutrophils through the surface epithelium may be a prominent feature. Inflammatory erosions are commonly seen and there may be a transition stage between an acute erosion and an acute peptic ulcer.

The results of detailed histological appraisal of duodenal biopsies, including cell counts using the graticule method, will be presented and their significance especially in relation to x-ray negative dyspepsia discussed.

**The importance of the site of gastrobiopsy in ulcerating lesions of the stomach**

A. R. W. HATFIELD, G. SLAVIN, A. W. SEGAL, AND A. J. LEVI Since the introduction of the new fibre-endoscopes, gastrobiopsy has been widely used in the diagnosis of gastric carcinoma. In some Japanese centres, positive biopsies are obtained in over 90% of cancers1,2. Experience from most other centres is far less impressive3,4. Possible reasons for this include the number of biopsies taken, precise site of biopsy, and number of histological sections examined. It has been recommended that at least six biopsies should be taken from each lesion4, and that 10-20 sections be taken from each specimen5. The inside edge of the elevated wall and the rim of ulcers have been advocated as the optimum sites for gastrobiopsy4,5. It has been suggested that biopsy from the slough should be avoided as it fails to demonstrate any tissue structure6.

This study was designed to determine where best to biopsy ulcerating lesions of the stomach. Using standard Olympus GIF-D biopsy forceps, multiple biopsies were taken under direct vision from 13 freshly resected stomach specimens containing neoplastic ulcers. Five sites, including the rim and slough, were separately assessed. Carcinoma was detected with equal frequency in biopsies from the rim and slough (nine out of 13 cases). In three cases biopsies from the slough were positive when those from the other sites were negative. It appears that gastrobiopsy from the slough of ulcerating lesions does provide positive material.

In order to obtain the maximum information from a limited number of biopsies both the rim and the slough of an ulcer should be biopsied. This may improve the diagnostic accuracy of gastrobiopsy in ulcerating lesions of the stomach.

**References**

4 Segal, A. Personal communication.

**Polyposis in ulcerative colitis**

R. H. TEAGUE AND A. E. READ One hundred and fifty cases of ulcerative colitis were assessed by total fibreoptic colonoscopy. In each case a visual record was made of the extent and severity of the colitis and this was supplemented by histological sections taken at 10-cm intervals throughout the colon.

Twenty-five patients were found to have inflammatory polyposis. Adenomatous polyps were found in four patients and a carcinoma in three. Inflammatory polypos were found in association with total colitis in 20 of the 25 cases. In the remaining five cases the colitis was confined to the left colon, i.e., distal to the splenic flexure.

Six of the 25 cases had a large (>1 cm), solitary inflammatory polyp. In four of these six patients the radiological diagnosis before endoscopy was that of carcinoma of the colon. Endoscopic polypectomy was performed to establish the exact histology in two cases, and two polyps were removed at surgery, one during total colectomy. The benign nature of the remaining two polyps was proven by multiple endoscopic biopsies at the time of the initial diagnosis and at follow-up examinations.

Three of the four adenomatous polyps were found to be solitary and of these two have so far been removed and proved to be benign.

These results suggest that inflammatory polyposis may accompany colitis confined to the left colon. It is also suggested that benign solitary inflammatory and adenomatous polyps are not uncommon finding in chronic total colitis where they may give rise to diagnostic difficulty.