The third spring meeting of the British Society for Digestive Endoscopy was held at Bristol from 14 to 15 March, 1974, under the presidency of Professor A. E. Read. The general theme of the meeting was ‘An evaluation of gastrointestinal fibre-endoscopy’. The following symposia constituted the main programme: ‘Mucosal cancer’ (Moderator: Dr B. C. Morson), ‘Haematemesis and melena’ (Dr Geoffrey Watkinson), ‘Disorders of the duodenal bulb’ (Professor M. J. S. Langman), ‘Obstructive jaundice’ (Professor A. E. Read), and ‘Inflammatory disorders of the large bowel’ (Dr S. C. Truelove). In addition there was a free paper session and the abstracts of the papers presented appear below.

On this occasion the meeting was not held in a hospital or university environment but in a local hotel. The attendance at the meeting was excellent, and having all facilities, including a large exhibition of instruments, pharmaceuticals, and books on the same premises, made for a pleasant and informal atmosphere. It was generally agreed that the hon. Local Secretary, Dr Paul Salmon, had done an excellent job.

K.F.R.S.

Endoscopy and Histological Findings in the Asymptomatic Patient after Vagotomy and Pyloroplasty

M. T. ROSENBERG and D. FINNIS Twenty patients asymptomatic for two to five years after vagotomy and pyloroplasty for duodenal ulceration underwent endoscopy. The purpose of the investigation was to assess the visual changes of gastritis and duodenitis in asymptomatic patients without ulceration, and also to compare the histological appearances of endoscopic specimens obtained from certain fixed sites. In all patients the size of the gastro-duodenal channel (the pyloroplasty) was measured against a steel marker passed through the biopsy channel, and biopsies were taken from the duodenum, the pyloroplasty site, the antral lesser curve, and the lower oesophagus. Five of the 20 patients had visual evidence of gastritis and two of oesophagitis. In all, the pyloroplasty size was in excess of 1.5 cm at its maximum diameter, but in none of the 20 patients was an ulcer found. Histological specimens showed duodenitis to be present in six, inflammatory changes at the edge of the pyloroplasty in all patients, varying degrees of gastritis in all but one of the 20 patients, and oesophagitis in four. An additional patient had severe atrophic gastritis in the specimen taken from the oesophagus. It is clear from these data that there are no grounds for attributing symptoms to inflammatory changes in the duodenum, stomach, or oesophagus, as these changes are frequently found in patients without symptoms. Similar findings had previously been reported after partial gastrectomy. This is not unexpected as there is no block to biliary reflux into the stomach after pyloroplasty and partial gastrectomy.

Evaluation of Retrograde Cholangio-pancreaticography (RCP) and Selective Pancreatic Angiography (SPA) for the Differentiation between Benign and Malignant Biliary and Pancreatic Diseases: Results of a Prospective Study

F. HALTER, L. WITZEL, F. WANGER, J. TRILLER, AND E. VÖGELI Both SPA and RCP have their limitations in differentiating inflammatory from malignant biliary-pancreatic disease. In order to investigate whether the combination of both techniques would improve the diagnostic accuracy, 21 patients aged 29 to 75 years with clinically suspected inflammatory or malignant pancreatic diseases (16) and obstructive biliary syndromes (5) were submitted to both RCP and SPA. The results of each investigation were initially evaluated by two independent groups. Final diagnosis was obtained by laparotomy or necropsy in 10 patients and by clinical follow up in 11. The correct diagnosis (chronic pancreatitis eight, pancreatic carcinoma two, biliary carcinoma three, papillary carcinoma one, normal seven) was achieved in 15/21 by SPA alone, in 14/21 by RCP alone, and in 20/21 by using both methods together. The problems using RCP were: unsuccessful cannulation (three), inability to differentiate between malignant and benign pancreatic diseases (three), and misinterpretation of pancreatitis as carcinoma (one). SPA failed to outline two biliary and one papillary carcinoma and three cases of pancreatitis were misinterpreted as cancer. By integration of the results of both methods only one false result was obtained, by considering one case of chronic pancreatitis as pancreatic carcinoma. A further important contribution of SPA was the demonstration of splenic vein thrombosis in 5/8 cases of chronic pancreatitis. The results of this study suggest that the combined approach of SPA and RCP does not only increase the diagnostic accuracy in biliary-pancreatic diseases but gives more precise information to the surgeon as to the extent of inflammatory and neoplastic lesions than either of the two methods alone.

A Comparison of Endoscopy and Radiology in the Early Diagnosis of Acute Gastrointestinal Haemorrhage

B. J. WILKEN, F. P. MCGINN, H. STEER, AND P. B. GUYER Early investigation of patients admitted with acute upper gastrointestinal haemorrhage is receiving increasing attention. Emergency barium studies can be safely conducted in this group of patients but the difficulties of interpreting the results have so far limited its usefulness. The value of endoscopy in the assessment of these patients has been clearly demonstrated, but few comparative studies of radiology and endoscopy have been reported. The present study was designed to compare the results of emergency endoscopy, carried out within 12 to 24 hours of admission, with those of an emergency barium meal performed within the same time limits. All patients were assessed within hours of admission and both investigations arranged to suit the resuscitation requirements of the patient, and the commitments of ourselves and the radiologists. Both end- and side-viewing instruments were employed and the majority of the endoscopic examinations carried out in a modified area of a ward. The emergency radiology was undertaken by a number of radiologists, but all films were later reviewed by one of us (PGB) without prior knowledge of the clinical or gastroscopic findings. One hundred and thirty-two patients have been studied by emergency endoscopy and 126 of these have also been examined radiologically. In 106 patients (80%), the source of bleeding was identified on endoscopy, but only in 48 patients (38%) was a lesion correctly reported by the emergency radiologist. In 13 patients (10%) endoscopy failed to reveal a source of haemorrhage, while negative findings were obtained in 44 (35%) of the x-ray examinations. A greater number of positive radiological findings were, however, reported when the emergency films were reviewed, blindly, by a consultant radi-
A Study of the Effect of Emergency Endoscopy or Radiology on the Mortality and Morbidity in Acute Upper Gastrointestinal Bleeding

A. M. HOARE All patients admitted with acute upper gastrointestinal bleeding during a two-year period have been studied. Fifty-three patients admitted under consultants with a policy of emergency endoscopy have been compared with the remaining 105 patients. There was no statistical difference in age or sex between the two groups. The cause of bleeding was found in 96.2% of the endoscopy group (all the patients on whom endoscopy was successfully performed), and 41.9% of the control group. The overall mortality was 5.9% in the endoscopy group and 15.2% in the controls, but the numbers are not large enough for this to be statistically significant. In the endoscopy group the correct preoperative diagnosis was made in all patients who required an operation. The median delay before operation was two days in the endoscopy group and five days in the control group, the difference being statistically significant \((p < 0.05)\). In the control group 18.5% had no diagnosis before operation, the preoperative diagnosis was wrong in 33.3% and in 18.5% no cause of the bleeding was found at laparotomy. The operative mortality was 14.3% in the endoscopy group and 25.9% in the controls. Two patients in the control group had a carcinoma of the stomach diagnosed within six months of a normal barium meal following haematemesis. None developed in the endoscopy group, but two carcinomas were found in patients who had normal barium meals. The average length of stay in hospital in the endoscopy group (11.2 days) was significantly less than the controls (19.6 days).

The Mallory-Weiss Syndrome: A Study of 76 Cases

M. DELTENRE, M. CREMER, A. GULBIS, and J. P. PEETERS The Mallory-Weiss syndrome (MWS) was described in 1929 as a clinical and morphological entity comprising laceration of the cardia with haematemesis preceded by non-blood vomitting, occurring mainly in alcoholics. Our study deals with 76 cases investigated by endoscopy during the last 22 years in Brugmann's Hospital, Brussels. The incidence of the MWS was 3.9% of all cases of upper gastrointestinal bleeding during the period 1952 to 1969, when some side-viewing gastroscopes were in use, and rose to 7.1% since we have been using forward-viewing endoscopes (1970 to 1973). The male: female ratio in the MWS is 3:8:1; in our total series of 1600 cases with acute upper gastrointestinal bleeding of any origin the ratio is 1:9:1. In our series of patients with the MWS the average age was 56 years. A history of chronic or acute alcohol abuse was observed in 46%. Haematemesis was the presenting symptom in 67 cases (88%), while in four cases melena alone was observed and in five cases no symptom of bleeding was found. Twenty-six patients had repeated episodes of haematemesis. Although it is usually said that a large meal or alcoholic overindulgence is the precipitating cause, we found this factor in only 22% of our cases. The classic prodrome of a traumatic tear of the cardia, due to food vomiting preceding haematemesis, occurred in 33 cases only. In seven patients the precipitating cause may have been severe coughing. In 53 cases the haemorrhage was not of great severity. The remaining 23 patients had massive bleeding with clinical evidence of shock, haematocrit values of 30% or less, and required blood transfusions of 1 to 5 litres.

The main diagnostic criteria of MWS are morphological. The laceration is usually linear (75%) and is often surrounded by a thin reddish border (60%). The base of the laceration is commonly partly or completely hidden by blood clot when endoscopy is performed early in the history of the disease (40%) or may be covered by a yellowish-green slough. A whitish-grey scar is observed in later examinations. In 18 patients several lacerations were present. The tear appeared in the gastric cardia in 63%. Serial endoscopy shows that the healing process may be complete within four to 14 days. Surgery was employed in two patients only.

Endoscopic Diagnosis in Advanced Carcinoma of the Stomach

B. STERRY ASHBY In 561 upper gastrointestinal endoscopies performed in a district general hospital by one observer, there were 61 cases of carcinoma of the stomach (11%); five of these were early carcinomata, i.e., confined to the mucosa and submucosae, and detected by repeated examination and biopsy of unhealing gastric ulcers. Forty-seven patients were submitted to laparotomy, 31 proved to have unresectable advanced carcinoma of the stomach, and 14 (45%) of these had negative biopsies at endoscopy. Five also had negative barium meal radiographs, and two had no radiographs (one pregnant and one with previous gastric surgery), so that in seven cases radiology was also unhelpful. It emerges from this series that nearly half the patients with proven advanced carcinoma of the stomach had negative biopsies at endoscopic examination. It is important that beginners in upper gastrointestinal tract endoscopy realize the limitations of the small endoscopic biopsy, especially when there is an intact gastric mucosa, such as may occur in the infiltrating limits platsica-type of tumour. Other observations made during endoscopy, such as unexplained mucosal oedema, rigidity of the gastric wall, and inability to distend the stomach with air, must be considered. Tissue diagnosis is an important part of an endoscopic examination, but so is detailed observation, and a negative biopsy is not infallible in the presence of other signs suggesting carcinoma of the stomach.