Correspondence

Endoscopic treatment of bile duct stones: (apples and oranges) – and lychees?

Sir,—We read Dr Peter Cotton’s well balanced editorial on endoscopic sphincterotomy for common bile duct stones with interest.1 While we agree that there is no place for any surgical complacency with the nationwide incidence of retained stones remaining in the region of 10%, the benefit of operative choledochoscopy is perhaps less than fairly treated. He quotes Rattner2 with an incidence of 6% and Feliciano3 with an incidence of 8-9% retained stones. Do these two series represent some lychees among his apples and oranges?

Rattner reported eight retained stones in 144 patients – 5-6, not 6%. In two of these patients, however, the stones were visualised with the choledochoscope but were not removed; the failure rate of choledochoscopy was thus six of 144 patients – 4-2%. Feliciano found seven patients with retained stones in 79 patients – 8-9%. We have recently reviewed the published literature on choledochoscopy, with clarification of the number of stone positive bile duct explorations by correspondence with the authors where necessary. In a total of 37 reports on operative choledochoscopy retained stones occurred in 99 of 3159 patients – less than 3-1%. Feliciano’s report was one of only five papers in which the incidence of retained stones exceeded 5%.4

Few surgeons resent the contribution that endoscopic sphincterotomy has made to the care of patients with common bile duct stones and the early experience of dealing with symptomatic common duct stones endoscopically in patients with gall bladders in situ is of great interest. Although these patients may now represent 50% of patients undergoing endoscopic sphincterotomy they do, of course, represent only a proportion of the 12% patients with gall stone disease who have stones in the bile duct as well as the gall bladder.

We entirely agree that endoscopic treatment should be used more widely. The weight of evidence that has amassed in favour of choledochoscopy compared with conventional bile duct exploration indicates the pressing need for routine endoscopy – at the time of common bile duct exploration – rather than afterwards.

R W MOTSON
B S ASHBY

The London Hospital, London, and Southend General Hospital, Southend on Sea, Essex.

References


Oesophageal stricture after endoscopic sclerotherapy

Sir,—We are alarmed at the very high incidence of oesophageal stricture after endoscopic sclerotherapy as reported by Dr Sorensen and his colleagues (Gut 1984; 25: 473–7) and we cannot agree with their conclusions that ‘stricture and dysphagia constitute a continuing and prominent clinical problem among patients with oesophageal varices treated by sclerosing injections’.

Over a four year period we have treated 104 patients with sclerotherapy without a single case of stricture and only eight cases of transient dysphagia. If we exclude 19 patients who died within one month, 85 patients had a mean number of 3-8 treatments (range 1–14) during a mean follow up period of 14 months (range two months to four years).

We inject intravariceally, however, and stop the injection when any blanching of the mucosa occurs. It is not surprising that the paravasal technique produces strictures as it has its effect on the varices by producing surrounding fibrosis. Intravariceal injection produces thrombosis of the vessels and the mucosa is affected only when inadvertent extra-variceal injection occurs.

Intravariceal injections can be made without giving a high risk of variceal rebleeding (our risk being 0-065 bleeds per patient month of follow up). As the authors suggest, a controlled trial might be indicated, but this would not seem justified if aggressive paravasal injections give such a high incidence of complications.

T MCCORMACK AND A G JOHNSON

University Surgical Unit,
Royal Hallamshire Hospital,
Sheffield S10 2JF.

Reply

Sir,—We agree with McCormack and Johnson that the incidence of dysphagia and oesophageal stricture