particularly of their endogastric ultrasonographic assessment. Furthermore, in terms of the avoidance of a formal laparotomy in patients who are subsequently deemed inoperable, diagnostic laparoscopy may well have a significant part to play, and we would also be interested in any data the authors have that specifically compare laparoscopy with the modalities described in their paper.

R S KIFF
B A TAYLOR
Warrington Hospital, Warrington, Cheshire WA5 1QG

Bile duct injury after laparoscopic cholocystectomy

EDITOR,—I read with interest the report of Davids *et al* (*Gut* 1993; **34**: 1250–4) describing their experience of ERCP in the management of patients with bile duct injuries after laparoscopic cholecystectomy. We too have found an increasing incidence of such injuries after laparoscopic cholecystectomy, compared with open cholecystectomy, as the first procedure becomes more widely performed. I agree that early ERCP is the investigation of choice and like Davids *et al* have found that bile duct dilatation has not always been detected by abdominal ultrasound.

In my opinion the authors failed to mention the most probable cause for strictures in the mid common bile duct. I believe these are caused by thermal damage produced by the diathermy hook during dissection. There is a risk of such injury when an L shaped hook is used. While dissecting with the tip of the hook, the heel can cause unnoticed damage possibly due to conduction of electricity along a previously placed metal clip. The delayed necrosis of the bile duct and the resultant very localised inflammatory reaction would, I think, explain the initial 'silent' anicteric period to which the authors refer. It would also explain the very localised area of dense fibrosis, which I have personally found surrounding the bile duct stricture.

I have treated two such patients, who have been referred to me, by hepaticojejunostomy. Although I accept that endoscopic stenting will be possible in many of these patients, I disagree that it should be used preferentially in young patients simply because 'a proximal hepaticojejunostomy seems unattractive' and endoscopic stenting seems 'less invasive'. Longterm efficacy should be the yardstick by which any treatment is judged rather than the degree of therapeutic 'invasion' necessary. The authors at present are in no position to recommend endoscopic stenting after such a short follow up. Successfully performed hepaticojejunostomy has been shown to be effective in the long term and not associated with significant morbidity. I would suggest that the effects of chronic culminative low grade sepsis, which are associated with the longterm use of indwelling endoprostheses mitigate against its use in the young. An admittedly difficult operation when performed by someone experienced in the field, offers the best chance of a longterm cure particularly if performed early and before infection has been introduced into the area.

A R BERRY
Northampton General Hospital, Cliftonville, Northampton, NN1 5BD

NOTES

Gut 1993; **34**: 1297–9. The editor would like to make clear that the recommendations in this paper apply to adults and are not relevant to children.

Budd-Chiari Syndrome

The Third International Symposium on Budd-Chiari Syndrome will be held in London on 11–13 April 1994. Further information from Professor K E F Hobbs, University Department of Surgery, Royal Free Hospital, Pond Street, London NW3 2QG. Tel: 44 71 435 6121; fax: 44 71 431 4528.

Gastrointestinal motility

The 7th European Symposium on Gastrointestinal Motility, will be held in Toulouse, France on 7–9 July 1994. Further information from: Lionel Bueno, Europa Organisation, 40 Boulevard des Récollets, BP 4406, F-31405 Toulouse, France. Tel: 33 61 32 66 99; fax: 33 61 32 66 00.

Digestive endoscopy course

The European Postgraduate Gastro-Surgical School is organising this course at the Academic Medical Center of the University of Amsterdam, Amsterdam, The Netherlands on 8–9 September 1994. For information contact: Helma Stockmann, Managing Director European Postgraduate Gastro-Surgical School, Room G4–109.3, Academic Medical Center, Meibergdreef 9, 1105 AZ Amsterdam, The Netherlands. Tel: 31 20 5663926; fax: 31 20 6914858.

European Pancreatic Association

The 26th meeting of the European Pancreatic Association will be held in Bologna, Italy on 8–10 September 1994. Further information from: Professor Lucio Gullo, Institute of Medicine and Gastroenterology, St Orsola Hospital, 40138 Bologna, Italy. Fax: 39 51 392538; tel: 39 51 6364129.

Bile acids in gastroenterology

The XIIIth International Bile Acid Meeting: Bile Acids in Gastroenterology will be held in San Diego, California on 30 September–2 October, 1994. Further information from: Cass Jones, Professional Conference Management, Inc, 7916 Convoy Court, San Diego, CA 92111 USA. Tel: 619 565 9921; fax: 619 565 9954.

Endoscopic Surgery

The 2nd Asian Pacific Congress of Endoscopic Surgery will be held in Hong Kong from 19–23 June 1995. Further information to Dr Sydney Chung, Department of Surgery, The Chinese University of Hong Kong, Prince of Wales Hospital, Shatin, Hong Kong. Tel: 852 636 2627; fax: 852 645 3602.