LETTERS TO THE EDITOR

Percutaneous aspiration in the treatment of hydatid liver cysts

EDITOR,—During a survey of recent literature in preparation for the XVII International Congress on Hydatidology (held in Limassol, Cyprus, 6–10 November 1995) we have read with interest the article by Morris about liver echinococcosis (Gut 1994; 35: 1517–8). We have, however, been somewhat surprised by his misquoting of our paper.1 The two lines devoted to percutaneous aspiration ('The risks of fluid leak are high and anaphylaxis has been well reported') are not representative of what we meant.

We suggested exactly the opposite—that is, the risks of fluid leak and anaphylaxis, although real, seem rather underestimated. No such side effects were reported—by the smokers—series, nor by the authors who—inadvertently or not—had at that time aspirated a hydatid cyst.2 3 No major side effect was registered by the other groups who, at the time Morris wrote his paper, had diagnosed or treated by percutaneous aspiration more than 100 hydatid cysts and published the results of their work.4–11 We feel even more entitled to say this five years after, when our series has grown to 163 patients with 231 cysts treated this way12 and a growing number of colleagues' reports of patients treated by this or similar methods.13 14

Lately, we reported in those latest papers represent an overall population of more than 1000 patients treated with percutaneous puncture, and not in a single case anaphylactic shock or peritoneal dissemination have been reported. Both we and some of the mentioned authors reported only mild allergic reactions.

Indeed, the probability of major problems such as fluid leakage and anaphylaxis (obviously when the procedure is performed by experienced personnel, and once the correct prophyllaxis with mebendazole or albendazole has been set) is so low that the World Health Organisation recently recognised the procedure as a first choice method for treatment of hydatidosis especially in developing countries. As regards Western countries, we feel that PAIR (puncture, aspiration, injection, reaspiration) has gained a status such as to be proposed as an alternative treatment to surgery (when the patient cannot or do not want to undergo surgery). Its main advantages are greater safety, less expense, less distress for the patients.

We would therefore like to suggest that Dr Morris is more explicit in his next reviews concerning treatment of liver hydatidosis.

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Ulcerative colitis and renal cell carcinoma

EDITOR,—In addition to the patients recently reported (Gut 1996; 38: 148–50) I would like to comment that I am also aware of a patient who developed both ulcerative colitis and renal cell carcinoma. We first saw this patient in December 1984 when we suspected a prophylactic proctocolectomy because of multiple dysplastic polyps in a regularly exacerbatting ulcerative colitis.

Ulcerative colitis was diagnosed in 1991 at the age of 61 and was treated orally with ssalaminic acid with good results for 12 months. Then, computed tomography was performed for increasing abdominal pain and showed a Grawitz tumour of the left kidney, which was subsequently treated with nephrectomy. Further history revealed nephrolithiasis (1976) and a low anterior resection because of a well differentiated Duket's B, adenocarcinoma (1985). With regard to the risk factors for carcinoma of the kidney, the patient had hypertension since 1974, but was not obese and had given up smoking more than 10 years before the nephrectomy.

Unlike Dr Satssangi's patients, our patient was not treated with corticosteroids or azathioprine before the diagnosis of the renal cell tumour was established. If it were true that 5-ASA derivates do not participate in the pathogenesis of the neoplasms reported and if there were any relation between ulcerative colitis and renal cell carcinoma, our case suggests that genetic factors are more important than the effects of the drugs and that the risk is certainly higher in patients with familial adenomatous polyposis of the colon.

Although these four cases are merely anecdotal, and in no definitive proof for a relationship between the (treatment of) ulcerative colitis and renal cell carcinoma, I think they may be sufficient ground to start a case control study.

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