LETTERS TO THE EDITOR

Is needle biopsy of the liver necessary to diagnose HCC?

Editor,—Schotman and colleagues (Gut 1999;45:626–7) reported a patient with subcutaneous seeding of hepato-cellular carcinoma (HCC) after percutaneous needle biopsy. Together with a review of 14 similar cases, and a comment on why it is not possible to diagnose HCC by other means (namely increased a fetoprotein (AFP) concentrations, spiral computed tomography (CT), magnetic resonance imaging); in these cases, a single pass with a large needle (18 gauge) may be preferable to multiple passes with smaller calibre needles; (ii) needle biopsies are not indicated to confirm HCC in patients suitable for liver transplantation; and (iii) the entire needle tract should be resected at surgery for the primary tumour. This has been important in other skin recurrences, namely those after laparoscopic cholecystectomy for undiagnosed gall bladder carcinoma.1,2

We agree with their conclusion, namely that needle biopsies for diagnosis of HCC are contraindicated. However, we have some questions and comments concerning the reported case. Firstly, why did the authors perform tumour biopsy in a 30 year old woman with hepatitis B liver cirrhosis and raised serum AFP, showing a 2 cm diameter subcapsular nodule in segment V and two additional satellite lesions in the same segment? Adequate imaging procedures were already available four years ago. In fact, the patient had percutaneous liver biopsy together with an informative diagnosis, in the case presented there was no deterioration in liver function or improved functional reserve after resection. The postoperative course was uneventful.

In general, we agree with the opinion to limit resection as far as possible and presently we would perform a segmentectomy. However, the long term effect of this procedure on portal haemodynamics needs to be evaluated. Although a prospective randomised study comparing B-RTO with TIPS for the prevention of bleeding or rebleeding from HCC is still needed, we hope that B-RTO will become a first line treatment for high risk liver associated with gastro-intestinal bleeding.

A MATSUMOTO
Department of Gastroenterology, Takeda General Hospital, 28-1 Ishihara Morinomi-cho, Fuchimi, Kyoto, Japan

M KAYAZAWA
Second Department of Internal Medicine, Osaka Medical College, Takatsuki, Osaka, Japan

Correspondence to: A Matsumoto, Department of Gastroenterology, Takeda General Hospital, 28-1 Ishihara Morinomi-cho, Fuchimi, Kyoto, 601-1495, Japan, akio_m@takedahp.or.jp

Management of gastric fundal varices associated with a gastroshunt

Editor,—We read with great interest the article by Jalan and colleagues (Gut 2000;46:578–81) on the clinical position of transjugular intrahepatic portosystemic shunt (TIPS) procedures. This procedure is a useful method of reducing portal pressure by creating a portosystemic shunt in the liver. They suggested that TIPS can be a successful treatment for bleeding gastric fundal varices (VF) unresponsive to pharmacological and endoscopic therapy. However, Sanayal et al reported that TIPS was ineffective for VF associated with a large gastroshunt, even when the hepatic venous pressure gradient falls below the critical bleeding threshold of 12 mm Hg.

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The behaviour of varices at different sites seems to differ. Therefore, VF should be treated on the basis of their haemodynamics.
The data in the literature do not support either of the positions that have been suggested by Matsumoto et al. Although data on the use of B-RTO for the treatment of fundal varices are exciting, we look forward to randomised controlled trials comparing TIPSS with B-RTO.

R JALAN
Institute of Hepatology,
University College London Medical School,
London, UK

FC HAYES
Liver Unit, Royal Infirmary of Edinburgh,
Lawiston Place, Edinburgh EH3 9YW, UK

Correspondence to: Dr R Jalan. r.jalan@ucl.ac.uk

The science, economics, and effectiveness of combination therapy for hepatitis C

EDITOR,—No one affected by hepatitis C virus (HCV) will question Professor Dushelko's insistence on the importance of effective therapy for HCV and the funding to meet them (Gut 2000;47:159–61). With research and clinical evidence pointing to a prevalence of HCV infection far in excess of human immuno-deficiency virus (HIV), the issue has now become urgent. Patients and clinicians alike will await the forthcoming NICE appraisal in the hope it recommends in favour of allocating sufficient resources to cover treatment costs for those most in need and best able to benefit.

However, while a positive response will be welcome it will also uncover issues that have still to be fully addressed. These centre on who will be selected for treatment and the effects of the treatment itself. Regarding the first issue there remains a debate around who will benefit most from treatment. The modern tendency is to assess outcome in terms of genotyping, age, duration of viraemia, extent of liver damage, and other complicating factors, such as continued drug and alcohol abuse. While there may be some validity to such categorisations, they are not at all absolute and can demoralise patients. Nevertheless, and leaving such considerations aside, if HCV infection is as widespread as some clinicians anticipate, it would be unrealistic to think that effective treatment will be available to treat everyone. This means that some form of treatment selection will need to be adopted. Should this occur, the question remains as to how clinicians will make choices and what criteria they will use. Furthermore, will protocols be in place to govern these criteria to ensure they are standardised nationwide?

Although Dushelko et al cite the potential priority given by the NHS to combination therapy as the salient issue, this needs to be addressed in conjunction with the equally important matter of who should receive this treatment. Which patients are offered standard combination therapy, combination therapy with pegylated interferon (PEG IFN), or PEG IFN alone is in some ways secondary to the issue of who is actually going to be given treatment. Will it be based on disease progression or expected response to treatment, or both?

Before considering this further, a factor that needs to be implicated in discussions around HCV, but which clinicians tend to underestimate, is patient tolerance and possible lingering effects of therapy. Although there seems to be a fairly clear cut case in favour of the greater efficacy of combination treatment, it is harder for patients to tolerate monotherapy with IFN, particularly when taken over 48 weeks. Despite this, we would state that the 20% (approximately) of patients who discontinue therapy before 48 weeks usually do so because of “insomnia, depression, irritability, or anaemia”. This would seem to suggest those involved with the intensity of side effects from combination therapy, which can be equally as debilitating for some patients as those of chemotherapy. In addition, the sequelae of treatment can sometimes linger for months following its cessation.

Given the potential severity of side effects, many patients with mild HCV have resisted conventional treatment methods and opted instead to try to minimise disease progression by recourse to alternative therapies. A recent nationwide trial offered to patients with mild HCV failed to recruit anywhere near its target numbers. This would suggest that those with less risk of progressive disease, and therefore less motivation to seek a cure, are more resistant to therapeutic intervention.

Notwithstanding the obvious factor of the greater and more uncomfortable side effects for patients with progressive disease following HCV infection, perhaps this trend in mild HCV sufferers might offer some insight as to how patients sometimes choose for themselves. A recent study carried out at St Mary's Hospital (Ward C, Tudor-Williams G, Cotzas T, et al. Patient preferences for treatment options in patients with HIV infection: results from the PHLs AIDS and STD Division, Scottish Centre for Infection and Environmental Health, Institute of Health, London and Oxford Haemophilia Centre—on behalf of UK Haemophilia Centre Directors Organisation). HCV infection is currently anticipated to be around 10 times higher, an estimate that would seem to be underscored by the recent study carried out at St Mary's Hospital (Ward C, Tudor-Williams G, Cotzas T, et al. Prevalence of hepatitis C virus (HCV) in women attending an inner London obstetric department: uptake and acceptability of routine antenatal testing. Gut 2000;47:277–80), which reported a prevalence of HCV infection in 0.8% of women who took part, of whom 0.6% were viranic. In the US, HCV infection is reported to be possibly four times higher than HIV with 3.5 million affected and 30 000 new cases each year (Turkington C. Hepatitis C: the silent killer. Chicago: Contemporary Books, 1998:xvi).

Screening for genetic haemochromatosis in blood samples with raised alanine aminotransferase

EDITOR,—Bhavnani et al (Gut 2000;46:707–10) claim to have identified 12 patients

www.gutjnl.com
Obtain informed consent from the 33 patients found to have a raised ALT, the cost of managing the non-responders was done by means of telephone contact and re-contacting those not responding.

Obtain informed consent from the 33 patients who did respond, and undertake genetic testing for HFE mutations.

Offer appropriate management to the 12 patients with C282Y homozygosity or compound heterozygosity.

We have some difficulty in accepting that all this can be achieved for only £1400, and would be intrigued to know how the authors arrived at their costing.

American College of Gastroenterology 2001 International GI Training Grants Programme

The ACG International GI Training (IGT) Grant Programme provides funding for clinical or research training in gastroenterology and hepatology so that an individual can acquire or develop new knowledge or a technical skill. This newly acquired knowledge or skill would then be used to improve patient care in the applicant’s geographic area. Physicians outside of the United States and Canada are eligible to apply. At least one fellowship with a maximum of $10 000 per IGT fellowship will be awarded during 2001, for a training period of not less than six months. Awards will be made by a special committee of the ACG and will be based upon the applicant’s credentials, the merit of the proposed training by the selected clinician, and included in these monies is the clinical, clerical, and nursing costs incurred in providing this service as a routine for patients in our District.

**DR M BHAVNANI
DR D LLOYD**

Department of Clinical Haematology, Wigan and Leigh NHS Trust, Royal Albert Edward Infirmary, Wigan Lane, Wigan WN1 2NN, UK

Correspondence to: M Bhavnani, manju.bhavnani@wiganlh-tr.nwest.nhs.uk

**NOTES**

**3rd European Pancreatic Club**

The meeting will take place on 13–16 June 2001 in Toulouse, France. A training course will be organised on 13 June on “Genomics and post genomics: developments in biomedical sciences”. Further information: Dr Nicole Vaysse, Inserm U531, CHU Rangueil, 31403 Toulouse, France. Tel: +33 (0)5 61 32 24 02; fax: +33 (0)5 61 32 24 03; email: nicole.vaysse@ranguel.inserm.fr; website: www.epgs.nl.

**Gastroenterology and Endotherapy: XIXth European Workshop**

This course, to introduce the experienced gastroenterologist to the growing field of therapeutic endoscopy, will be held on 15–20 June 2001 in Brussels, Belgium. Further information: Mrs Nancy Beauprez, Gastroenterology Department, Erasme Hospital, Route de Lennik 808, B-1070 Brussels. Tel: +32 02 555 49 00; fax: +32 02 555 49 01; email: beauprez@ulb.ac.be

**CORRECTION**