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 hepatocellular carcinoma (HCC) after percutaneous needle biopsy. I agree with their conclusion, namely that: (i) a needle biopsy may be indicated only if it is not possible to diagnose HCC by other means (namely increased α 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 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 diagnostic procedure such as spiral CT. In addition, subcapsular liver lesions are known to give a high rate of both subcutaneous recurrence and intraperitoneal subdiaphragmatic seeding.3 Therefore, in contrast with recurrence after laparoscopic surgery which mostly cluster around abdominal port tracts,4 simple removal of the needle tract could not be sufficient to prevent the side effects of percutaneous liver biopsy. Secondly, why did they perform right hepatectomy in a cirrhotic liver rather than segment V segmentectomy? The latter could be a similarly adequate procedure while preserving better residual liver function.

The authors should be congratulated for focusing once again on a very important question (to biopsy or not to biopsy liver nodules in suspected HCC in the present era of highly effective imaging) and for their collection of 15 cases, which is obviously an underestimation of what occurs in practice and is currently observed in many transplantation centres. However, their message for the reader should be clearer as there is an apparent contradiction between what they state and what they actually did.

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Reply

EDITOR,—We read with interest the letter of Cetta et al in which they discussed our case (Gut 1999;45:626–7) of subcutaneous seeding of a hepatocellular carcinoma (HCC) after percutaneous needle biopsy. Firstly, they state that a needle biopsy was not indicated in the case presented. It must be stated that the biopsy was performed elsewhere before the patient was admitted to our hospital. Secondly, they suggest that a smaller partial hepatectomy might have been sufficient to treat the HCC in this 30 year old woman with hepatitis B liver cirrhosis.

In the case presented there was no deterioration in liver function or impaired 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.

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Management of gastric fundal varices associated with a gastrorenal shunt

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-stenting (TIPS). 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 (FV) unresponsive to pharmacological and endoscopic therapy. However, Sanayl et al reported that TIPS was ineffective for FV associated with a large gastrorenal shunt, even when the hepatic venous pressure gradient falls below the critical bleeding threshold of 12 mm Hg.1

The behaviour of varices at different sites seems to differ: therefore, FV should be treated on the basis of their haemodynamics.

The data in the literature do not support either of the points 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 clinical trials comparing TIPSS with B-RTO.

Reply

Editor,—We thank Matsumoto and colleagues for their interest in our paper. They suggest that transjugular intrahepatic portosystemic stent-shunt (TIPSS) is ineffective for the management of bleeding from fundal varices and given the haemodynamic characteristics of fundal varices, the appropriate treatment for bleeding from them is balloon occluded retrograde transvenous obliteration (B-RTO). They quote Sanyal's paper for the management of bleeding from fundal varices. Sanyal et al reported their experience with TIPSS in 12 patients who underwent this procedure for gastric varices and in six patients these varices did not disappear on follow up. The aim of treatment of bleeding varices is firstly to control bleeding and secondly to prevent rebleeding. In the paper by Sanyal et al, no data were provided about how many patients bled from gastric varices in the follow up period compared with those who rebled with oesophageal varices.1 However, our previous study2 and that of Chau and colleagues3 clearly show that post-TIPSS bleeding from either oesophageal or gastric varices is a function of portal pressure and has little to do with whether bleeding is from oesophageal or gastric varices. Both Stanley and colleagues2 and Chau and colleagues3 compared the outcome of TIPSS insertion for varical bleeding from oesophageal or gastric varices. In the study by Stanley et al, 106 patients (oesophageal varices 74; gastric varices 32) underwent TIPSS for varical bleeding and during follow up the rates for varical rebleeding were similar in both groups and there was no difference in survival. In the study by Chau et al, 112 patients (oesophageal varices 84; gastric varices 28) underwent TIPSS for uncontrolled varical bleeding. Bleeding was controlled in all patients after TIPSS except for one in each group. Twenty four per cent of patients in the oesophageal varices group and 29% in the gastric varices group rebled during follow up. Most early rebleeding (within seven days after TIPSS) was related to oesophageal ulceration secondary to previous sclerotherapy. Rates of new varices were similar in both groups. These results suggest that emergency TIPSS is equally effective in the control of gastric fundal varical bleeding compared with oesophageal varical bleeding.

Matsumoto and colleagues also suggest that there is likely to be a place for B-RTO in the primary prophylaxis of bleeding from fundal varices and that pharmacological agents have no place in their management. Again, the data for both suggestion do not exist in the literature. We think that it is extremely difficult to suggest failure of pharmacological therapy for primary prophylaxis of fundal varices based on the assumption that portal pressure changes are unlikely to be important in the management of fundal varices.


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

Editor,—No one affected by hepatitis C virus (HCV) will question Professor Dushek's insistence on the importance of effective therapy for HCV and the funding to meet these needs (Gut 2000;47:159–61). With research and clinical evidence pointing to a prevalence of HCV infection far in excess of human immunodeficiency virus (HIV), the issue has now become urgent. Patients and clinicians alike will await the forthcoming NIACE 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 assumed key outcome in terms of genotyping, age, duration of viraemia, extent of liver damage, and other complicating factors, such as continued drug abuse, psychiatric disease, 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 and as virulent 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 Dushek 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. Both patient and the provider 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. More often than not there seems to be a fairly clear cut case in favour of the greater efficacy of combination therapy, it is harder for patients to tolerate than monotherapy with IFN, particularly when taken over 48 weeks. Due to the fact that 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 that 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 sequence 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 imply 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 urgent need of treatment 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 the type of treatment. Hopefully the healthcare of HCV patients an indicator of how best to prioritise treatment should such selection prove necessary.

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1 Figures released by the Communicable Disease Report of 26 May 2000 (Vol 10) cite 174 cases of HIV infection in the UK—that is, less than 0.07% of the population. UK data from the PHLS AIDS and STD Division, Scottish Centre for Infection and Environmental Health; Institute of Child 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 infection in women attending an inner London obstetric department: uptake and acceptability ofscreened antenatal testing. Gut 2000;47:277–80), which reported a prevalence of HCV infection in 0.8% of women who took synths 0.6% of whom were virasemic. In the US, HCV infection is reported to be possibly four times higher than HIV with 3.5 million infected 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


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homozygous for C282Y or with compound heterozygosity at a cost of only £117 per patient identified. This astonishingly low total of £1400 allowed them to:
- Select out of 35 065 blood samples 4.2% (1490) with an elevated alanine aminotransferase.
- Undertake measurement of 1490 serum iron, transferrins, and ferritin concentrations.
- Give information on haemochromatosis and offer genetic screening to the 56 patients found to have a transferrin saturation >60%, and to re-contact 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 homozygocity or compound heterozygocity.

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 costings.

**Notes**

American College of Gastroenterology 2001 International GI Training Grants Programme

The ACG International GI Training (IGT) Grant Programme provides funding for clinical or clinical research training in gastroenterology and hepatology so that an individual can acquire or develop new cognitive 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 host training centre and the potential for enhancing the field of gastroenterology in the applicant's home country. Application forms can be obtained from the ACG administrative office: 4900B South 31st Street, Arlington, Virginia 22206-1656. Tel: +1 703 820 7400; fax: +1 703 931 4520; website: www.acg.org. **Deadline for submission of application is 1 April 2001.**

Redefining Priorities in Gastroenterology

This congress will be held on 11–14 April 2001 in Monte Carlo, Italy. It will be chaired by Professor Massimo Crespi (Rome, Italy) and Professor Eamon Quigley (Cork, Ireland). Further information: Maddalena Massaro, Project Leader, AISC-AIM Group, Via A Ristori 38, 00187 Rome, Italy. Tel: +39 06 8096881; fax: +39 06 80968229; email: gastro2001@aisc.it.

33rd 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@rangueil.inserm.fr; website: www.epc.org.

Gastroenterology and Endotherapy: XIXth European Workshop

This course, to introduce the experienced gastroenterologist to the growing field of therapeutic endoscopy, will be held on 16–20 June 2001 in Brussels, Belgium. Further information: Mrs Nancy Beaufreuz, Gastroenterology Department, Eraisme Hospital, Route de Lennik 808, B-1070 Brussels. Tel: +32 02 555 49 00; fax: +32 02 555 49 01; email: beaufreuz@ulb.ac.be

**Correction**