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Seek and ye shall find—maybe ►

▲ **Kasugai K**, Miyata M, Hashimoto T, *et al*. Assessment of miss and incidence rates of neoplastic polyps at colonoscopy. *Dig Endosc* 2005;**17**:44–9.

The authors first studied 684 patients undergoing total colonoscopy (with chromoendoscopy) twice within 30 days to calculate odds ratios of missing neoplastic polyps and the relative risk for developing new adenomas with surveillance colonoscopy. Results were compared with the number and location of polyps found at index colonoscopy. Despite meticulous technique using high quality colonoscopes, 13.9% of adenomatous polyps were missed in 22.8% of patients. No cancers were missed but, not surprisingly, flat/superficial polyps $\leqslant 5$ mm in size were most commonly missed and more so in the right colon. The odds ratio for finding polyps at the second procedure in patients with two or more polyps at the first examination was two compared with those with a normal colonoscopy.

Secondly, they examined 864 patients who had additionally undergone multiple examinations over a 10 year period for polyp surveillance to calculate the cumulative incidence rates for adenoma development. The time intervals to 50% cumulative incidence of polyps in those with 0, 1, 2, or more index polyps were 2733, 1084, 1012, and 478 days, respectively. Incidence rates at one year closely matched the calculated miss rates, so it seems likely that polyps detected one year after polypectomy are previously missed ones and not new. The number of polyps found at index colonoscopy is the strongest predictor of missed polyps *and* the incidence of new polyp formation. Therefore, slow down, keep your eyes peeled, and look hard.

Braving biliary atresia ►

▲ **Lykavieris P**, Chardot C, Sokhn M, *et al*. Outcome of adulthood biliary atresia: a study of 63 patients who survived for over 20 years with their native liver. *Hepatology* 2005;**41**:366–71.

Biliary atresia presents during the first few months of life with an obstructive cholangiopathy involving predominantly the extrahepatic biliary system. The Kasai operation, if performed early, achieves bile flow in a significant proportion of infants and delays the need for liver transplantation. Lykavieris *et al* report the long term outcome of 271 children who underwent Kasai operation in a single French centre between 1968 and 1983. Twenty years after surgery, 63 (23%) were alive with their native liver. Sixty one of 63 had cirrhosis and 44 had evidence of portal hypertension. Transplant free survival was better in those who had surgery by 90 days compared with those who had the Kasai operation after 90 days (28% *v* 13%; $p=0.006$). The 20 year survival decreased from 40% in those who had cholecystojejunostomy and cystojejunostomy (for type I and II lesions) to 35% in those who underwent hepatic portocholecystostomy (for type III) and to 19% for hepatic portoenterostomy (for type IV atresia) ($p=0.02$).

This study highlights the importance of early diagnosis of biliary atresia. Early surgery is critical not only to achieve resolution of jaundice (as has been shown previously) but also to ensure better long term survival. However, the long term transplant free survival reported in this study is lower than that reported from experienced centres in Japan. The explanation for this difference in outcome between centres in Japan and Western countries remains unresolved.

"Have a feel of the tumour"—no thanks ►

▲ **Koch M**, Kienle P, Hinz U, *et al*. Detection of hematogenous tumour cell dissemination predicts tumour relapse in patients undergoing surgical resection of colorectal liver metastases. *Ann Surg* 2005;**241**:199–205.

In patients with colorectal liver metastases, viable tumour cells can be reliably identified within the circulation by detecting mRNA using reverse transcription polymerase chain reaction (RT-PCR). In addition, these authors have previously shown that tumour cell release into the bloodstream is a frequent event in patients with liver metastases from colorectal cancer undergoing major liver resection and that intraoperative tumour manipulation increases the release of malignant cells. The prognostic significance of viable circulating tumour cells is examined in this paper.

In this study, curative resection of colorectal liver metastases was carried out in 37 patients, none of whom had extrahepatic disease. Using CK20 RT-PCR, blood samples were examined for tumour cells at three time points: preoperatively (tumour cells were present in 30%), intraoperatively (cells present in 46%), and 24 hours postoperatively (present in 22%). Bone marrow samples taken intraoperatively were also examined and found to contain tumour cells in 16% of patients. Intraoperative detection of tumour cell dissemination correlated with a significantly shorter disease free interval (median disease free survival 13 months versus 25 months). Although detection of tumour cells preoperatively did not significantly correlate with prognosis, all patients with detectable tumour cells in postoperative blood samples developed tumour recurrence. Patients with tumour cells in the bone marrow also had a significantly worse prognosis. By a multivariate analysis, intraoperative tumour cell dissemination in blood and tumour cell detection in bone marrow were shown to be independent prognostic factors. These results suggest that intraoperative tumour manipulation may cause intrahepatic or extrahepatic tumour recurrence, at least in some patients, suggesting that further steps should be carried out to prevent tumour cell dissemination, perhaps in terms of a change in surgical technique or perioperative chemotherapy.