LETTERS

Retrograde Filling of the Right Main Hepatic Vein on Percutaneous Splenoportography

Sir,

Splenoportography (SPG) may show a spontaneous shunt from the splenic vein into the inferior vena cava (IVC) in about 10% of cases. SPG may also be used to study the patency of a porta-systemic shunt. In this situation the shunt and the IVC can be clearly visualised. During the period 1979 to April 1983, of 357 SPG done at our institute, 150 cases had portal vein thrombosis and 32 had a patent lienorenal shunt, of whom 16 had a spontaneous shunt to the IVC. Of these 16 cases, one had non-cirrhotic portal fibrosis and all the others had portal vein thrombosis. Four cases showed retrograde flow from the IVC into the right main hepatic vein. Visualisation of the hepatic vein on an SPG has not been described previously.

These four cases described here were all boys aged 7–11 years with at least one episode of upper gastrointestinal bleed in the past. All the patients had clinical splenomegaly, palpable 2–11 cm below the left costal margin. Percutaneous SPG revealed portal vein thrombosis in all the cases. In one of these there was flow of contrast through retroperitoneal collaterals and renal vein into the IVC; there was retrograde contrast flow into the right main hepatic vein (Fig 1). In the other 3 cases, side to side lienorenal shunt was done and a shuntogram done one month to one year post-operatively showed patent shunt, visualization of IVC up to the right atrium and retrograde contrast flow into the right main hepatic vein (Fig 2).

Visualisation of the renal vein and IVC on pre-operative SPG and percutaneous transhepatic portography is well-known. After lienorenal shunt, the IVC is regularly visualised if the shunt is patent. However, retrograde flow into the hepatic vein on such occasions has not been observed.

Contrast does flow into the hepatic vein occasionally, if a pressure injection is made directly into the IVC at the level of the hepatic vein openings. Even a Valsalva manoeuvre during the injection does not consistently result in visualisation of the hepatic vein. It is therefore extremely unlikely that our patients showed retrograde flow in the hepatic vein because of transmission of pressure from the splenic pulp to the IVC during injection.

Retrograde flow may occur because of obstruction to flow in the IVC, or because of tricuspid incompetence or ateria. We have observed (unpublished data) that patients with cirrhosis of the liver may have nodules which may partially obstruct the IVC. Our patients did not show any clinical features of IVC obstruction or cardiac disease.

It is known that patients with portal vein thrombosis have a decreased hepatic blood flow. The decreased flow in the hepatic veins may theoretically make the patient more vulnerable to retrograde flow. Retrograde

Fig 1: Collaterals reduce the portal vein. Contrast flows into IVC through renal vein, clearly delineating the entire IVC and the right main hepatic vein (arrows).

Fig 2: The right main hepatic vein (arrow) and its main tributaries are still filled although contrast has cleared from the IVC.
filling of the hepatic vein should be recognised and its mechanism should be studied.

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References

Transendoscopic Needle Aspiration Cytology

Sir,

I was surprised to read the article on transendoscopic needle aspiration cytology and the statement by the authors that they have 'designed a catheter assembly' for this purpose. Actually, this technique has already been described over a year ago, using an easily available injector made by Olympus Company, Japan.

It is apparent that both the authors and the Journal's reviewers missed this earlier article, creating an erroneous impression that this technique is an invention of the authors.

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References

Reply from the Authors

Sir,

We developed the technique of transendoscopic needle aspiration cytology in 1984-85 and communicated our findings at the Annual Conference of the Indian Society of Gastroenterology, Madras, 1985. We have been using an indigenously assembled catheter for this purpose but lately have used a commercially available sclerotherapy needle (Microvase Inc., USA). We have found this technique to be especially useful in infiltrative tumors in a study of over 70 patients.

We had submitted a paper comparing the results of this technique with that of endoscopic biopsy and brush cytology in 10 patients to the journal Endoscopy in August 1985, but our manuscript was returned with the comments that we were not describing anything new, though it was the first report of its kind. The report was subsequently published in Acta Cytologica. Since the article by Lange et al was exactly similar to ours and was published later than the date of their communication to us, we protested to the editors of Endoscopy, who acknowledged that our paper had reached them a year before the one by Lange et al. Because of some reasons they could not publish it. We also wish to clarify that we had submitted our article to the Indian Journal of Gastroenterology before the March 1987 issue of Endoscopy reached here. A detailed elaboration of the described technique applied in 50 patients has been accepted for publication elsewhere.

Interestingly, the September 1987 issue of Gut carried a similar article, also submitted for publication in March 1987. A paper on the use of the technique was also read at the annual meeting of the American Society for Gastrointestinal Endoscopy in 1986. Unlike us, all these workers have described this technique in less than 15 patients each.

All these papers emphasize that endoscopic fine needle aspiration cytology may be of great diagnostic utility in submucosal and infiltrative tumors of the gut. A similar technique has been widely used to obtain transbronchial needle aspiration samples, and samples from pancreatic tumors.