LETTERS

Ultrasound Guided Pancreatic Ductography

Sir,

We appreciate the high success rate (92%) of pancreatic duct opacification achieved without any complications by ultrasound guided pancreatic ductography by Dr Das and colleagues. However, we have the following observations to make.

In 66% of 13 patients, the diagnosis had already been established by either endoscopic biopsy, brush cytology or fine needle aspiration cytology (in 3 patients with pancreatic carcinoma) and by ultrasound directed aspiration cytology (in 3 patients with periampullary carcinoma). Further delineation of pancreatic duct by contrast agent was not necessary as it would not have changed the management of the patients. Moreover, in patients with malignant obstruction of the pancreatic duct or common bile duct there is always an increased incidence of complications following introduction of contrast in the dilated ducts.

Ultrasound directed pancreatography should, however, be very helpful and fully justified in the delineation of the pancreatic duct prior to surgery in patients with chronic pancreatitis, since it may alter the nature of surgical intervention. And if the same degree of accuracy and safety can be achieved by other workers, this procedure can indeed replace endoscopic retrograde cholangiopancreatography in such patients.

This novel technique is welcome, but in our opinion it should be utilized more purposefully, such as in selected patients with chronic pancreatitis prior to surgery, and should be avoided in cases with periampullary carcinoma and carcinoma of the pancreas where delineation of the pancreatic duct system may not help substantially in the management and may also be hazardous.

No 11 AF Hospital
Alief Field Hospital
Glasgow, U.K.

WG CDR BALVINDER SINGH
ANIL ARORA, RAKISH TANDON

*Department of Gastroenterology
All India Institute of Medical Sciences
New Delhi 110 029

Reference


Role of Enteroclysis in Acquired Small Bowel Diverticula

Sir,

The diagnosis of small bowel diverticula is made by radiological methods, surgery or at autopsy. The efficacy of barium meal follow through, the most commonly used radiographic technique to diagnose small bowel diverticulosis, is very low. We therefore evaluated the technique of enteroclysis which is considered to be more specific and reliable for detecting acquired diverticulosis.

Over a period of two years enteroclysis was performed in 150 patients who presented with clinical features of malabsorption syndrome, subacute intestinal obstruction, and inflammatory or neoplastic diseases of the small bowel. Intubation was done with Bilbao-Dotter tube which was placed beyond the duodeno-jejunal flexure. Thirty percent w w barium was infused at the rate of 75 ml/min and serial radiographs of the small bowel were taken as the barium flowed, applying intermittent compression on all segments of the small bowel during infusion. The total amount of barium used varied from 800-1000 ml.

Of the 150 patients, 11 patients (8 males, 3 females, aged 38-55 years) were found to have acquired diverticula of the jejunum and ileum. Patients with pseudo-diverticula resulting from scleroderma or previous surgery were excluded from this study. One patient had solitary diverticulum in the proximal jejunum (Fig 1), whereas the rest had multiple diverticula in the jejunum (Fig 2). Associated ileal diverticula were seen in only two cases. The size of the jejunal diverticula measured 2-3 cm, and in the ileum their size varied from 1-2 cm. One patient showed a giant cauliflower-like diverticulum in the jejunum, measuring 5-3 cm, in addition to multiple diverticula in the rest of the jejunum. In all the cases, no associated abnormality was detected radiologically.

The frequency of detection of small bowel diverticula by barium meal follow through ranges from 0.073% to 1.9%. In the present study the detection rate by enteroclysis was 7%, indicating that enteroclysis is a reliable method for the demonstration of small bowel diverticula. The intraluminal bowel ostension with continuous barium infusion and intermittent compres-
Variceal Sclerotherapy with 3% Aqueous Phenol

Sir,

In the article by Dr Mathur et al\(^1\) about the comparative trial of three different schedules for endoscopic esophageal variceal sclerotherapy (EVS), the number of EVS sessions taken to obliterate the varices on the weekly schedule was reported to be 4.75 ± 2.436; this means that in some patients the varices were obliterated by 2-3 or lesser sclerotherapy sessions. The authors have not mentioned the grade of varices, but since all cases had bled, I assume that they had grade II or larger varices and were undergoing sclerotherapy for the first time.

The incidence of esophageal ulcers reported also appears to be very low, ranging from 7.1% to 17.64% except in group IIa where it is 51.1%. A more efficacious sclerosant is also more damaging.\(^2\) Therefore, if phenol was so efficient as to eradicate the varices with such small number of injections, a higher incidence of esophageal ulcers should have been expected.

Also, when patients are seen at shorter intervals one is likely to encounter higher incidence of ulcerations.\(^3,4\) This may be for two reasons: (a) a real increase in the ulcers due to shorter intervals; (b) detection of more ulcers at shorter intervals because superficial ulcers may heal before the next sessions if they follow at long intervals.

KITANO ET AL\(^5\) using weekly injections of polidocanol or sodium tetracycl sulphate eradicated varices in 4.5 ± 1.1 sessions, but found esophageal ulcerations in 60% to 100% of their patients. We also used 1% polidocanol or 1% sodium tetracycl sulphate at weekly intervals.\(^6\) The varices were eradicated in 5-7 ± 1.6 sessions and the incidence of ulceration was 68% and 88% respectively. Thus it is surprising that Dr Mathur et al could eradicate varices so quickly with such a low rate of esophageal ulcers.

No 11, Air Force Hospital
Hindan, Ghaziabad, UP.

References

Reply from the Authors

Sir,

We are grateful to Wg Cdr Balwinder Singh for his interest in the findings reported by us. He has raised two questions. The first concerns the grades of varices in different groups of our patients. These data are given in Table 1 of our paper.

The second point relates to the author’s surprise over the very low incidence of mucosal ulcers with phenol despite its high efficacy as compared to that with other agents like sodium tetracycl sulphate, ethyoxycarol and sodium morrhuate. The explanation may lie in the differences in the mechanisms of action of these other agents and of phenol. All these former agents have been shown in autopsy studies to produce destruction of varices with esophageal wall fibrosis rather than mere thrombosis of varices.\(^3,4\) In contrast, phenol has been shown by us through initial experimental\(^5\) and subsequent autopsy\(^6\) studies to produce initial damage to variceal intima leading to