cinoma in the middle third of the esophagus. After two
courses of cisplatinum + 5FU the patient had relief from
dysphagia for 4 months. He returned with grade III
dysphagia and was referred for dilatation.

Dilatation was attempted with short (70 cm) Savary-
Gillard dilators (Wilson-Cook Medical Inc, USA). The
guide wire was passed through the esophageal stricture
under endoscopy vision and its position was confirmed
on fluoroscopy. Dilators of size 9, 11 and 12.8 were passed
smoothly. On removal of the guide wire after the dilatation,
its spring tip noticed to be missing. Fluoroscopy and
X-ray film (Fig) demonstrated the spring tip to be inside
the abdomen. Endoscopy showed the spring tip to be
inside the stomach; it was retrieved uneventfully with the
help of a biopsy forceps.

We recommended that the guide wire be checked
after each use.

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Bifid Pancreas

Sir,

We have read with great interest a paper entitled
‘Bifid Pancreas: an endoscopic retrograde
pancreatographic curiosity’ by Agrawal et al.1

In ERCP films the authors found 4 cases in which
there was bifurcation of the main pancreatic duct: in one
case bifurcated MPD was seen only in the head, while in
the other it also extended into the body; in the third
instance bifurcation of the duct was present in the body
and in the fourth case it existed only in the tail. According
to them, bifurcation in the head was due to nonfusion of
the two ventral pancreatic buds while the last three cases,
was related to the dorsal pancreatic bud remaining bifid.

These cases cannot be called as those of bifid
pancreas. An organ is called bifid when it is ‘divided by
a deep fissure in to two parts’, e.g. bifid tongue, bifid
xiphoid process. Bifurcated MPD does not indicate that
the organ is bifid. Further unlike the ventral pancreatic
bud the dorsal bud never develops as a double bud, it is
always single.

The authors have quoted a report by Halpert et al.2
to substantiate their observations and to justify the use
of the term ‘bifid pancreas’. It is surprising that Agrawal
et al.3 did not come across a letter by Yatto and Siegel3
who denied the existence of double dorsal pancreatic bud.
They further mentioned that even ‘bifid tail’ was not two
separate masses but was a single ‘pseudomass lacking
eavage planes’.

We have dissected MPD in 130 adult pancreases
and have come across only one instance in which the duct
was double in part of its course in the body. Therefore,
a double pancreatic duct is not an anatomical curiosity.

It is further recommended that the term ‘bifid
pancreas’ be given up and replaced by the term ‘duplication’
of the pancreatic duct.

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References


2. Halpert RD, Shabot JM, Heare BR, Rogers RL. The bifid pancreas: a rare anatomical


Sir,

We have reported in our article ‘Bifid Pancreas’ only
bifurcation of MPD as seen in ERCP study. We have no
means to confirm or deny whether the concerned patients
had literally bifid pancreas or not. The term ‘bifid’ was
used only to maintain uniformity of nomenclature as first
used by Halpert et al (1990). The statement that the
bifurcation in the last three cases was related to dorsal
pancreatic bud is merely a speculation and quoting half
the sentence changes the stress unwarrantedly. Finally,
we are thankful to Dr Inderrjit Dewan for taking keen
interest in our observation.

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Perforated Acute Duodenal Ulcer Can Be Treated
Conservatively

Sir,

The article by Anandkrishnan and Angam1 prompts us
to make the following comments. While non operative
treatment is used to stabilize patients with perforated
chronic duodenal ulcer, conservative treatment is curative
for most patients with perforated acute duodenal ulcer.
Proper gastric decompression is the most important factor
that decides outcome.2

LETTERS

INdian J Gastroenterol 1995; 14 (1) 37
The concept of non-operative treatment for perforated acute ulcer is not new and has been reported in literature since 1946.\textsuperscript{2,3} We have managed 12 such patients in the last 3 years without mortality. Three of these patients were octogenarians. Surgical intervention was needed in one patient who was found to have a chronic ulcer. Another patient developed a subphrenic abscess which was drained. The diagnosis of the nature of the ulcer rests on the history, which may be fallacious. However, close monitoring will enable early operation if there is no response, or if signs of deterioration set in.

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S S BHARERA

References

Use of Indigenous and Economical Substitutes for Variceal Band Ligation Accessories

Sir,

Endoscopic band ligation of esophageal varices is now a well established method.\textsuperscript{1,2} After starting band ligation of esophageal varices in our department we faced three major difficulties. (1) The cost of imported ‘O’ ring which are available in packs of 100, is Rs 10,000/- which is not affordable by our poor patients. Hence we substituted them with bands for hemorrhoid ligation which cost just Rs 9 per band and are sold loose. (2) The introducer for slipping the ‘O’ rings on the inner cylinder was not supplied with the set hence we designed and introduced with the help of a 4" terminal piece of a glass pipette of the same diameter as the inner cylinder. (3) The trip wire knot broke often, resulting in shortening. We designed a new trip wire using the wire used for stringing tennis rackets and made the knot with the help of a soldering gun. It costs just Rs 6/- for making such a length of a trip wire.

Using these indigenously designed accessories we have performed the procedure in 19 patients without difficulty. These accessories have served as cheap alternatives to the imported ones which are for too expensive for our patients.

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References