better drainage than an end-to-side procedure. Anastomotic patency may depend more on whether or not a duct-to-mucosa anastomosis could be performed.

I thus cannot agree with the authors that the modification has advantages over the original procedure. In fact, there are potential disadvantages: i) the vascularity of the Roux loop is poorest at the end, and most surgeons would prefer not to anastomose the end to the pancreas; ii) in cases where an anastomosis of greater than 10 cm is required (and many require such a long anastomosis to deal with disease of the pancreatic head), it may be difficult to achieve a good tie of the opened-out jejunum over the pancreas especially at the fish-mouthed end.

Incidentally, the authors describe parenchymal calcification in 15 of 53 patients. Did these cases have hyperparathyroidism as well? Most patients with calcific pancreatitis (alcoholic or tropical) have stones confined to the ducts and the "parenchymal calcifications" have now been clearly shown to represent stones lying in the minute side-branches.2

Finally, the authors describe that the "side-to-side longitudinal pancreaticojjunostomy relieved pain in 80%...". Partington and Rochelle described the transverse pancreaticojjunostomy as opposed to the longitudinal type where the spleen and distal pancreas were removed and the constricted pancreas was sunk into the jejunum.

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References
Hepatoma cast obstructing common bile duct: not always a terminal event

Hepatocellular carcinoma (HCC) can invade the main bile ducts and present as obstructive jaundice. Intra-bile duct tumor casts with hemobilia are considered terminal events.

A 66-year-old man was admitted with biliary pain for 3 days, associated with dark urine. He was icteric. Liver was palpable 10 cm, hard, tender and smooth, with no borborygmi.

Investigations: serum bilirubin 4.5 mg/dL (direct 2.8), AST 190 IU/L, ALT 151 IU/L, alkaline phosphatase 184 IU/L (normal 59-117), GGT 245 IU/L (normal 7-50), serum albumin 3.6 g/dL. An anti-hepatitis C virus antibody was positive but markers for hepatitis B virus were negative. α-feto protein was 29 IU (normal <50).

An ill-defined lesion of heterogeneous echotexture was present in the left liver lobe on sonography: this was confirmed on CT. Endoscopic retrograde cholangiography showed a large filling defect in the common bile duct with dilatation of the left intrahepatic biliary radicles. After papillotomy, a dark grey mass protruded out; this was extracted with a Dormia basket. Histologic findings were consistent with HCC.

After endoscopic removal of the embolic bilirubin decreased to 2 mg/dL, and the patient was relieved of pain. He refused surgery, remained asymptomatic and well preserved, and was readmitted seven months later with painless jaundice and melena. He left the hospital again against medical advice, and died four days later after a massive bout of hematemesis and melena.

Intra-bile duct tumor growth from HCC is uncommon; its incidence was 9.2% in one series. Survival in these patients is short unless major hepatic resection is carried out after biliary decompression. Our report suggests the need to distinguish this condition from the other causes of jaundice in patients with HCC, as survival may be prolonged in the former.

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References

Inadvertent banding of laryngeal mucosa during endoscopic variceal band ligation

A 45-year-old man presented with abdominal distension, pain in the upper abdomen, and black stools. Clinical features and investigations established a diagnosis of cirrhosis of the liver with portal hypertension.

Fiberoptic esophagoscopy showed four grade 3+ varices extending 6-9 cm proximal to the lower esophageal sphincter. Two of these were ligated successfully with elastic 'O' rings; no overtube was used during the procedure. During insertion of the endoscope the third time, it came in contact with the posterior pharyngeal wall; the patient retched and the 'O' ring slipped on to the larynx. The third varix was ligated using another ring, the abnormal position of the previous ring was confirmed.

At direct laryngoscopy under general anesthesia, the ring was seen on the dome of the left arytenoid cartilage. It was removed after dilation with a forceps. The underlying mucosa was intact and vocal cord movements were normal. Check laryngoscopy a fortnight later showed no abnormality.

A multicenter trial reported a lower rate of complications with endoscopic variceal ligation as compared to sclerotherapy (2% vs 22%). To our knowledge, inadvertent banding of the arytenoid cartilage has not been described before.

Judicious use of local anesthetic and overtube can prevent this complication, although overtube has disadvantages of esophageal wall and mucosal tears and perforation, and rupture of varices.

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Primary biliary cirrhosis with pruritus in India

Primary biliary cirrhosis (PBC) is rare in India; pruritus, a classical symptom in the West, was conspicuously absent in the few cases reported here. We report a patient with PBC with pruritus.

A 34-year-old woman presented with complaints of pruritus...