LETTERS TO THE EDITOR

Is needle biopsy of the liver necessary to diagnose HCC?

Editor,—Schotman and colleagues (Gut 1999;45:626–7) reported a patient with subcutaneous seeding of hepatocellular carcinoma (HCC) after percutaneous needle biopsy together with a review of 14 similar cases and correctly outlined the necessity for biopsy together with a review of 14 similar cases and correctly outlined the necessity for biopsy and recurrence at trocar sites after laparoscopic cholecystectomy for unsuspected carcinoma. Is it partly preventable? Gastroenterology 1997; 112:A500.

Reply

Editor,—We read with interest the letter of Cetta et al in which they discussed our case (Gut 1999;45:626–7) of subcutaneous seeding of a hepatocellular carcinoma (HCC) after percutaneous needle biopsy. Firstly, they state that a needle biopsy was not indicated in the case presented. It must be stated that the biopsy was performed elsewhere before the patient was admitted to our hospital. Secondly, they suggest that a smaller partial hepatectomy might have been sufficient to treat the HCC in this 30 year old woman with hepatitis B liver cirrhosis. In the case presented there was no deterioration in liver function or impaired functional reserve after resection. The postoperative course was uneventful.

In general, we agree with the opinion to limit resection as far as possible and presently we would perform a segmentectomy.

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Management of gastric fundal varices associated with a gastrorenal shunt

Editor,—We read with great interest the article by Jalan and colleagues (Gut 2000;46:578–81) on the clinical position of transjugular intrahepatic portosystemic stent-shunt (TIPSS). This procedure is a useful method of reducing portal pressure by creating a portosystemic shunt in the liver. They suggested that TIPSS can be a successful treatment for bleeding gastric fundal varices (FV) unresponsive to pharmacological and endoscopic therapy. However, Santal et al reported that TIPSS was ineffective for FV associated with a large gastrorenal shunt, even when the hepatic venous pressure gradient falls below the critical bleeding threshold of 12 mm Hg.

The behaviour of varices at different sites seems to differ. Therefore, FV should be treated on the basis of their haemodynamics.

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5 Baldi C, Zuckermann M, Montalto G, et al. Factors influencing seeding of tumoral cells and recurrence at trocar sites after laparoscopic cholecystectomy for Kupffer cell hypervascular carcinoma of the gallbladder. Hepatogastroenterology 1998; 45(suppl2):240.
6 Cetta F, Montalto G, Pachiarotti MC, et al. Abdominal wall recurrence after laparoscopic cholecystectomy for hepatocellular carcinoma. Is it partly preventable? Gastroenterology 1997; 112:A500.

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4 Kanagawa H, Mima S, Kouyama H, et al. Treatment of gastric fundal varices occluded retrograde transvenous obliteration. J Gastroenterol Hepatol 1996;11:51–8.
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The data in the literature do not support either of the points that have been suggested by Matsumoto et al. Although data on the use of B-RTO for the treatment of fundal varices are exciting, we look forward to randomised controlled clinical trials comparing TIPSS with B-RTO.

The science, economics, and effectiveness of combination therapy for hepatitis C

EDITOR,—No one affected by hepatitis C virus (HCV) will question Professor Dusheiko's insistence on the importance of effective therapy for HCV and the funding to meet them (Gut 2000;49:159–61). With research and clinical evidence pointing to a prevalence of HCV infection far in excess of human immunodeficiency virus (HIV), the issue has now become urgent. Patients and clinicians alike will await the forthcoming NICE appraisal in the hope it recommends in favour of allocating sufficient resources to cover treatment costs for those most in need and best able to benefit. However, while a positive response will be welcome it will also uncover issues that have still to be fully addressed. These centre on who will be selected for treatment and the effects of the treatment itself.

Regarding the first issue there remains a debate around who will benefit most from treatment. The aim is to assess outcome in terms of genotyping, age, duration of viraemia, extent of liver damage, and other complications, such as continued drug and alcohol abuse. While there may be some validity to such categorisations, they are not at all absolute and can demoralise patients. Nevertheless, and leaving such considerations aside, if HCV infection is as widespread as some clinicians anticipate, it would be unrealistic to assume that a cure will be available to treat everyone. This means that some form of treatment selection will need to be adopted. Should this occur, the question remains as to how clinicians will make choices and what criteria they will use. Furthermore, will protocols be in place to govern these criteria to ensure they are standardised nationwide?

Although the Dusheiko et al. cite the potential priority given by the NHS to combination treatment as the salient issue, this needs to be addressed in conjunction with the equally important matter of who should receive this treatment. Notwithstanding the fact that patients are offered standard combination therapy, combination therapy with pegylated interferon (PEG IFN), or PEG IFN alone is in some ways secondary to the issue of who is actually going to be given treatment. Will it be based on disease progression or expected response to treatment, or both?

Before considering this further, a factor that needs to be implicated in discussions around HCV infection. Although clinicians tend to underestimate, is patient tolerance and possible lingering effects of therapy. Although there seems to be a fairly clear cut case in favour of the greater efficacy of combination treatment, it is harder for patients to tolerate monotherapy with IFN, particularly when taken over 48 weeks. Doubt must also be cast on the 20% of patients who continue to suffer disease progression or expected response to treatment, or both?

Given the potential severity of side effects, many patients with mild HCV have resisted conventional treatment methods and opted instead to try to minimise disease progression by recourse to alternative therapies. A recent nationwide trial offered to patients with mild HCV failed to recruit anywhere near its target numbers. This would suggest that those with less risk of progressive disease, and therefore less motivation to seek a cure, are more resistant to therapeutic intervention.

Notwithstanding the obvious factor of the greater and more urgent need for treatment particularly for patients with progressive disease following HCV infection, perhaps this trend in mild HCV sufferers might offer some insight as to how patients sometimes choose for themselves—suggesting to those involved in the healthcare of HCV patients an indicator of how best to prioritise treatment should such selection prove necessary.

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1 Figures released by the Communicable Disease Report of 26 May 2000 (Vol 23, No 19, 1173) of HIV infection in the UK—that is, less than 0.07% of the population—data from the PHLS AIDS and STD Division, Scottish Centre for Infection and Environmental Health, Institute of Child Health, London and Oxford Haemophilia Centre—on behalf of UK Haemophilia Centre Directors Organisation. HCV infection is currently anticipated to be around 10 times higher, an estimate that would seem to be underscored by the recent study carried out at St Mary's Hospital (Ward C, Tudor-Williams G, Cottaza T, et al. Prevalence of hepatitis C virus infection in women attending an inner London obstetric department: uptake and acceptability of a routine antenatal testing. Gut 2000;47:277–80), which reported a prevalence of HCV infection in 0.8% of women who took aspirin (over 0.6% were virasemic). In the US, the HCV infection is reported to be possibly four times higher than HIV with 3.5 million affected and 30 000 new cases each year (Turkington C. Hepatitis C: the silent killer. Chicago: Contemporary Books, 1998:xvi).

Screening for genetic haemochromatosis in blood samples with raised alanine aminotransferase

EDITOR.—Bhavnani et al (Gut 2000;46:707–10) claim to have identified 12 patients
homozygous for C282Y or with compound heterozygosity at a cost of only £1400 per patient identified. This astonishingly low total of £1400 allowed them to:

- Select out of 35 065 blood samples 4.2% (1490) with an elevated alanine aminotransferase.
- Undertake measurement of 1490 serum iron, transferrins, and ferritin concentrations.
- Give information on haemochromatosis and offer genetic screening to the 56 patients found to have a transferrin saturation >60%, and to re-contact those not responding.
- Obtain informed consent from the 33 patients who did respond, and undertake genetic testing for HFE mutations.
- Offer appropriate management to the 12 patients with C282Y homozygosity or compound heterozygosity.

We have some difficulty in accepting that all this can be achieved for only £1400, and would be intrigued to know how the authors arrived at their costs.

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Reply

EDITOR,—Our preliminary study set out to examine the clinical usefulness of screening a targeted population for genetic haemochromatosis. The costing given in our paper was as stated, based solely on laboratory costs, a summary of which is given below. Costs of the clinician, nursing, and clerical time were not included in the paper, and are detailed below.

Laboratory costs:

- Screening for blood samples with elevated ALT incurred no additional costs as these samples were processed routinely as part of the normal hospital and GP biochemistry requests.
- The marginal costs for the measurement of 1490 serum iron and transferrins, £1085; 33 serum ferritins, £51; and genetic testing: £264 (total £1400).
- Although serum ferritins were performed on all 1490 specimens as part of the study, at a cost of £1788, we felt that they did not help in the screening process. Thus we advocated “In those patients found to have a raised ALT, the cost of screening with iron saturation and follow up when appropriate with ferritin and gene testing would be £1400”.

Other costs:

- We were awarded a research grant of £5000 from the Health Authority, and the rest of the money was used for employing a medical laboratory assistant, (8 h/week) who picked out the relevant specimens and batched them for future testing. Information on haemochromatosis, plus offering genetic screening to the 56 patients found to have a transferrin saturation >60% and re-contacting the non-responders was done by means of a standard letter to the clinicians who had requested the original liver function tests. Consent for genetic testing was obtained by these clinicians. Management of the 12 patients (homozygotes and compound heterozygotes) was undertaken (with no extra funding) by one of the authors (MB) as part of the routine Clinical Haematology service.

Since then, the Health Authority has awarded us continuing revenue for this targeted screening, and included in these monies are the clinical, clerical, and nursing costs incurred in providing this service as a routine for patients in our District.

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NOTES

American College of Gastroenterology
2001 International GI Training Grants Programme

The ACG International GI Training (IGT) Grant Programme provides funding for clinical or clinical research training in gastroenterology and hepatology so that an individual can acquire or develop new cognitive knowledge or a technical skill. This newly acquired knowledge or skill would then be used to improve patient care in the applicant’s geographic area. Physicians outside of the United States and Canada are eligible to apply. At least one fellowship with a maximum of $10 000 per IGT fellowship will be awarded during 2001, for a training period of not less than six months. Awards will be made by a special committee of the ACG and will be based upon the applicant’s credentials, the merit of the proposed training by the selected host training centre and the potential for enhancing the field of gastroenterology in the applicant’s home country. Application forms can be obtained from the ACG administrative office: 4900B South 31st Street, Arlington, Virginia 22206-1656. Tel: +1 703 820 7400; fax: +1 703 931 4520; website: www.acg.org. Deadline for submission of application is 1 April 2001.

Redefining Priorities in Gastroenterology

This congress will be held on 11–14 April 2001 in Monte Carlo, Italy. It will be chaired by Professor Massimo Crespi (Rome, Italy) and Professor Emmon Quigley (Cork, Ireland). Further information: Maddalena Massaro, Project Leader, AISC-AIM Group, Via A Ristori 38, 00187 Rome, Italy. Tel: +39 06 809681; fax: +39 06 80968229; email: gastro2001@aisc.it.

3rd European Federation of Autonomic Societies (EFAS)

The third European Federation of Autonomic Societies (EFAS) meeting in conjunction with the annual meeting of the sections “Autonomic nervous system” of the German Neurological Society, “Diabetes and Nervous System” of the German Neurological Society, and “Autonomic Nervous System” at the University of Erlangen-Nuremberg, Germany, will be held in Erlangen, Germany on 26–28 April 2001. Further information: Professor Dr M J Hilk, Department of Neurology, University or Erlangen-Nuremberg, Schwabachanlage 6, D-91054 Erlangen, Germany. Tel: +49 0131 8534444; fax: +49 9131 8534328; website: www.neurologie.med.uni-erlangen.de/oeffentliche Veranstaltungen.htm

Falk Workshop

The workshop entitled Update in Inflammatory Bowel Diseases will be held in Ljubljana, Slovenia, on 5 May 2001. Further information: Prof Dr S Marković, University Medical Center Ljubljana, Division of Internal Medicine, Jaljeva 2, 1525 Ljubljana, Slovenia. Tel: +386 (1) 231 6925; fax: +386 (1) 433 4190; email: sasa.markovic@ckl.si

33rd European Pancreatic Club

The meeting will take place on 13–16 June 2001 in Toulouse, France. A training course will be organised on 13 June on “Genomics and post genomics: developments in biomedical sciences”. Further information: Dr Nicole Vaysse, Inserm U531, CHU Rangueil, 31403 Toulouse, France. Tel: +33 (0) 5 61 32 24 02; fax: +33 (0) 5 61 32 24 03; email: nicole.vaysse@ranguel.inserm.fr; website: www.epgs.nl.

Gastroenterology and Endoscopy:
XIXth European Workshop

This course, to introduce the experienced gastroenterologist to the growing field of therapeutic endoscopy, will be held on 16–20 June 2001 in Brussels, Belgium. Further information: Mrs Nancy Beauprez, Gastroenterology Department, Erasme Hospital, Route de Lennik 808, B-1070 Brussels. Tel: +32 02 555 49 00; fax: +32 02 555 49 01; email: beauprez@ulb.ac.be

CORRECTION

Abstract A277 in Gut 2000:57(suppl III) contained errors. The title should read “Disposable versus reusable endoscopic biopsy forceps: comparison of costs and histological quality”, and the complete author list is C Lejeune, P Prost, C Michiels, J-M Phelip, L Martin, J Favier. Gut would like to apologise for this error.