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Response:

We agree with Ragunath and Krasner that our study showed lower specificity and sensitivity for methylene blue staining in detecting intestinal metaplasia than the studies by Canto et al. and Kiesslich et al.[1-3] We clearly admit the limitations of our study in the article: a small number of patients, evaluation of patient discomfort in the absence of a validated patient questionnaire, and possible retrograde amnesia caused by midazolam use.[1]

The key message of our study was that there is a potential risk of spraying a large volume of liquid in the esophagus. We agree that with increased experience in the staining technique, the sensitivity and specificity of staining in detection of intestinal metaplasia and the time for staining may possibly improve. We are concerned regarding the complete safety of spraying a large volume of liquid during a prolonged endoscopy with the patient under sedation or with the use of topical pharyngeal anesthesia induced by spraying local anesthetic.

Recently the value of surveillance in Barrett's esophagus is being questioned.[4] We strongly feel that any surveillance procedure that is associated with a potentially serious adverse effect should be very carefully evaluated before it is adopted in clinical practice.

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The continuing search for a good working relationship between endoscopic and surgical teams in the treatment of cholecysto-choledocholithiasis

To the Editor:

There is still no consensus regarding the management of patients with choledocholithiasis who are to undergo laparoscopic cholecystectomy (LC) for cholelithiasis. This is a practical and common problem for clinicians. Therefore, articles such as that by Iodice et al.[1] that recently appeared in *Gastrointestinal Endoscopy* are of interest. These investigators reported a large series of patients who were managed by single-step endoscopic-laparoscopic treatment. This report is welcomed, but there are a few points that require further discussion.

As Iodice et al.[1] stated, there are a variety of therapeutic options available for patients with stones in the bile duct as well as the gallbladder. However, because LC has rapidly become the treatment of choice for cholelithiasis, there is an increasing focus on the treatment of associated choledocholithiasis by LC. But because of the great skill and experience required for the management of both problems by LC alone, there is also a growing interest in the concept of ERCP-LC as a single-stage treatment.[2-6]

Iodice et al.[1] performed LC in 812 patients over a 3.5-year period regardless of whether stones were unsuspected, suspected, or known. Intraoperative cholangiography was obtained in all patients at LC. If stones were demonstrated, ERCP was performed during the LC procedure. The mean time required for the combined procedure was nearly twice that of LC alone. A mean of 22 minutes was required for alerting the endoscopic team and for the installation of the ERCP equipment and team in the surgical theater. Although the time required is relatively short, the majority of hospitals are unlikely to be able to match this time.

When choledocholithiasis is unsuspected before LC, it is very difficult to quickly organize an unscheduled ERCP during LC. Moreover, it is extremely expensive if an ERCP team has to be on stand-by for every LC. The number of hospitals and surgeons performing LC will certainly increase in number in the future, more so than the number of skilled biliopancreatic endoscopists. There are many hospitals in which more than one surgeon and surgical team perform LC, whereas such hospitals have only a single, or perhaps no, expert biliopancreatic endoscopist. Furthermore, improvements in the pre-LC diagnosis of choledocholithiasis can be expected, mostly because of the diffusion of MRCP. This should reduce the number of cases in which LC is performed in patients with bile duct stones that were unrecognized before the procedure. In this era of managed care and high costs associated with the hospitalization of a patient, it is essential that patients with bile duct stones be managed by the most economical strategy.