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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.

When the diagnosis of cholecysto-choledocholithiasis is known before ERCP, it is perhaps better to perform ERCP during the LC session. This is a feasible option, but one that requires coordination of schedules for the surgical and endoscopic teams. Thus, there are a number of potential advantages if both problems can be managed during a single therapeutic session instead of two.

Iodice et al.[1] indicate that they changed their selection criteria for the combined procedure over the course of time, but unfortunately information regarding the reasons for these changes is not presented in their report.

The combined LC-ERCP procedure should be compared with ERCP after LC, possibly after the insertion of a biliary endoprosthesis through the papilla during LC, with respect to feasibility, outcome and costs.[7] I agree with Iodice et al.[1] that when choledocholithiasis is recognized before LC, it can be better managed by the combined endoscopic-laparoscopic approach, at least until surgical expertise for bile duct exploration is widely available. One exception would be the difficult case in which the endoscopic approach would require significantly more time and equipment. This type of procedure is best performed in the endoscopy room with the patient under conscious sedation.

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Response:

We thank Dr. Mosca for his interest in our recent article on the single-step treatment of gallbladder and bile duct stones with a combined endoscopic-laparoscopic technique. We agree that our approach might prove difficult to reproduce in a large, overcrowded hospital. At our small institution a collaborative feeling between all specialists involved in the care of patients with biliary stone disease allows the combined treatment to be quickly arranged in the operating room. Undoubtedly, these are the advantages of being "small."

As to our changing selection criteria over time, it should be stressed that at the beginning of our experience the single-step technique was often not planned before surgery because bile duct stones were found incidentally at intraoperative cholangiography. These patients account for the smallest group of subjects included in the study (group IV). Afterward, we tried to optimize selection criteria by placing greater emphasis on ultrasonographic, clinical, and laboratory findings. Presently, all patients who are candidates for laparoscopic surgery for cholecystolithiasis undergo 3D ct cholangiography and wideband second harmonic tissue US of the bile duct to improve preoperative diagnosis of choledocolithiasis (MRCP is not yet available).

As clearly stated in the discussion section of our paper, our current policy is to perform preoperative ERCP in patients with stones requiring urgent bile duct decompression and those in whom a neoplasm is suspected, whereas postoperative ERCP is performed in the few cases in which the combined technique is unsuccessful.

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Has the endoscopic treatment of sclerosing cholangitis been rediscovered? Not likely, just old news recycled

To the Editor:

The article by Baluyut et al.[1] is a report of experience in treating patients with primary sclerosing cholangitis (PSC) by using endoscopic techniques. Although the authors referred to a number of previous reports on the subject, they failed to refer to a seminal report we published in 1993.[2] This was a review of the literature and a report of a large, ongoing series of patients with PSC that we treated with endoscopic techniques. Although our study was not randomized but evidenced-based, we