Duodenal bulb biopsies and celiac disease

To the Editor:

We read with great interest the study by Gonzalez et al,1 in which the role and the diagnostic value of duodenal bulb biopsies in the management and diagnosis of celiac disease were investigated. The authors conclude that the diagnostic yield, because of the patchy damage of the celiac disease enteropathy, is increased by performing duodenal bulb biopsies. The study investigates an interesting topic, but we think that some methodological points need to be clarified. First, it is unusual that in a tertiary referral hospital, only 319 of 1079 biopsy samples (30%) were well oriented, and consequently there was an unacceptable loss of approximately 37% of the patients. Orientation of the duodenal specimens is a determinant for a correct diagnosis, and well-known techniques to obtain adequate samples are available in the literature.2,3 Second, from their Tables 4 and 5, it appears that 50% of the samples from duodenal bulb were inadequate and only 1 patient had 4 adequate biopsy samples from the distal duodenum, as required by international standards4; thus, it is very difficult to derive conclusions about the concordance of bulb and D2 lesions and, moreover, to define true negative subjects.

In conclusion, these results should be interpreted with caution and, by our own experience, the main message is that in a center devoted to celiac disease diagnosis and management, strict collaboration among gastroenterologists, endoscopists, and pathologists is essential.

Luca Elli, MD, PhD
Maria Teresa Bardella, MD
Center for Prevention and Diagnosis of Celiac Disease
Fondazione IRCCS Cà-Granda Ospedale Maggiore Policlinico
Milan, Italy

REFERENCES


doi:10.1016/j.gie.2010.11.001

A questionnaire study assessing overuse injuries in United Kingdom endoscopists and any effect from the introduction of the National Bowel Cancer Screening Program on these injuries

To the Editor:

We read with considerable interest the review “Minimizing occupational hazards in endoscopy: personal protective equipment, radiation safety, and ergonomics” by Pedrosa et al1 from the American Society for Gastrointestinal Endoscopy Technology Committee and wished to share our own experience of endoscopy overuse injuries from a United Kingdom perspective. From a questionnaire survey sent to 143 gastroenterologists in the northwest of England, we had a response rate of 41% (58) and found that 57% reported pain in at least one anatomical region more than once a week during endoscopy. Pain was felt most commonly in the back, neck, and left thumb. Seventeen percent of respondents thought the pain would lead them to reduce their endoscopy commitments in the near future; this increased to 36% in bowel cancer screeners (P = .07), who typically perform more high-intensity endoscopy sessions.

Specifically, both carpal tunnel syndrome and de Quervain tenosynovitis were reported in 7% of endoscopists, and 5% had required some form of surgery for overuse injuries. An average of 3 work days per endoscopist had been lost, but there were no cases of responders stopping endoscopy. Those undertaking more than 10 colonoscopies a week had a much greater chance of pain at work and time off from work. Our results are in line with those previously reported in the United States and Korea.

We believe that the specialization of endoscopy and the increased burden on endoscopists will lead to more overuse injuries, but simple interventions, particularly advice on posture and endoscope handling techniques to reduce the stress placed on the body, can mitigate many of these problems. We invited an occupational therapist into our department to critically appraise the techniques of all our endoscopists and found significant improvements in “niggling pains” after implementation of the tailored advice, especially on maintaining a neutral posture. Highly trained endoscopists are a great resource and need to be looked after.

Joe Geraghty
Gastroenterology
Royal Liverpool University Hospital
Liverpool, United Kingdom

R. George
Gastroenterology
Rochdale Infirmary
Rochdale, United Kingdom
To the Editor:

We read with interest the article by Coté et al\textsuperscript{1} regarding the risk of post-ERCP pancreatitis (PEP) after placement of biliary self-expandable metal stents (SEMSs). This has been a topic of considerable interest to us for several years, given the increasing frequency with which biliary SEMSs are used for palliation of biliary obstruction, most commonly because of cancer. The article, and its accompanying editorial, might lead readers to consider withholding the placement of a biliary SEMS out of fear of causing PEP.\textsuperscript{2} We disagree with this sentiment.

As the authors describe, the literature does not definitively suggest that SEMSs are associated with an increased risk of complications after ERCP, with some studies showing an extremely low rate of PEP after biliary SEMS placement and others showing up to a 9% rate of PEP.\textsuperscript{3,4} In their retrospective study, Cote et al\textsuperscript{1} reported that SEMS placement was associated with the development of post-ERCP pancreatitis in 18 of 248 patients (7.3%) receiving a SEMS, compared with 3 of 296 patients (1.3%) receiving a plastic biliary stent. The authors hypothesize that the higher rate of PEP as defined by consensus criteria and elevated serum pancreatic enzyme levels associated with pain in patients receiving a SEMS may be due to radial expansion forces of the SEMS itself.

Earlier this year we published a retrospective study specifically designed to assess whether or not an endoscopic biliary sphincterotomy (EBS) is required when a transampullary biliary SEMS placement (regardless of length, diameter, or presence or absence of a stent covering) was not associated with the development of PEP. Our study was retrospective and was smaller than the Cote et al\textsuperscript{1} study, but these results were concordant with our personal observations during placement of a large number of biliary SEMSs over many years.

Overall, although the study by Cote et al\textsuperscript{1} is important and intriguing, we believe that it is premature to globally conclude that the placement of biliary SEMSs is associated with a higher risk of PEP, as compared with placement of traditional plastic stents. Multiple other factors are likely playing a role in the development of PEP besides the potential role of the SEMSs. Large, prospective trials are warranted to more definitively address this question before such a conclusion can be drawn.

DISCLOSURE

D. Adler is a consultant for Boston Scientific, Merit, and Bee Corp. T. Baron is a consultant for Cook Endoscopy, Conmed, and Olympus. No other financial relationships relevant to this publication were disclosed.

REFERENCES


doi:10.1016/j.gie.2010.11.013

C. Babbs
Gastroenterology
Salford Royal Hospital
Salford, United Kingdom