Papilloma of the esophagus

To the Editor:

Papilloma of the esophagus is considered to be a rare tumor. Formerly, it was detected as an incidental finding at surgery or autopsy. Now, with the endoscope in wide use, it is being diagnosed more frequently. We wish to report our experience to your readers.

In our clinic 8900 esophagogastroduodenoscopies were performed between 1969 and 1980. GIF-D2 or GIF-D3 Olympus forward viewing endoscopes were used. Esophageal papilloma was found in nine patients. Only one patient had dysphagia, but this was not due to the papilloma because it occurred after its removal. Barium esophagogram was negative in all cases. Single papillomas of 2 to 12 mm in diameter were found localized 4 to 12 cm proximal to the cardia of the stomach. Papillomas were entirely removed in every case using biopsy forceps in eight patients and a transendoscopic wire snare in one patient. The final diagnosis was established by histological examination (Fig. 1).

Papilloma occurs as a single, rarely multiple, lobulated sessile or pedunculated lesion. Histologically it is an epithelial proliferation with interspersed connective tissue. Although regarded as rare tumors in the esophagus, papillomas are common in the larynx, trachea, urinary bladder, and uterine cervix.

Viruses have been noted as causative agents in animals and in some human papillomas. Adler et al. and Parnell et al. presumed a correlation between the papilloma and chronic irritation because they had found gastroesophageal reflux or hiatal hernia in their patients.

Papilloma usually does not cause any complaint because of its small size, but sometimes dysphagia or bleeding may occur with larger tumors. Because they are small they usually escape detection by barium esophagogram but can be detected and removed endoscopically with biopsy forceps or the endoscopic wire snare.

It has been reported that papillomas in the larynx and uterine cervix undergo malignant change, but there is no clinical or pathological evidence that this is true for those arising in the esophagus. Although it is doubtful that the papilloma of the esophagus is a premalignant lesion, its removal is nevertheless recommended.

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Figure 1. Characteristic low power picture of esophageal papilloma (H & E, ×40).

Hurricane warning

To the Editor:

Recently Hurricane® spray (Beutlich, Inc., Chicago, Ill.) for topical analgesia of the throat and pharynx was intro-
duced in our endoscopy department. The active principle in this spray is 20% benzocaine. The manufacturer markets it as a good-tasting, fast-acting topical anesthetic spray that has a duration of action in the order of 15 to 20 min.

Since the introduction of this agent, we noticed that the esophagus was covered with a white mucous material which at times suggested the possibility of an underlying esophagitis, except for the fact that at the end of the procedure this precipitate had dispersed and the esophagus then appeared normal. During the period that we used the spray we also noted plugging of the endoscope channel and, particularly during endoscopic retrograde cholangiopancreatography, increasing difficulty with passing cannulas down the channel of the GIF-B3 side-viewing duodenoscope. When we stopped using the Hurricaine® spray and reinstated the routine use of Xylocaine® spray, we no longer had problems with the precipitate or the plugging.

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Lactate dehydrogenase isoenzyme pattern in gastric juice

To the Editor:

In the report by Moreno-Otero et al., our previous data of lactate dehydrogenase (LDH) isoenzyme pattern evaluated in gastric juice of patients suffering from gastric neoplasm were confirmed. In our study LDH isoenzymes were investigated by collecting gastric juice by fiberendoscopy before and after stimulation of gastric secretion (6 μg of pentagastrin/kg) in two groups of patients. The grouping of patients was done by x-ray and endoscopic and histological examination. Only juice macroscopically free of blood and bile was chosen for separation of LDH isoenzymes by an agarose gel electrophoresis according to the method of Rapp et al. in a slightly modified manner. After staining and fixation of the agarose gel the isoenzyme pattern was estimated by a photodensitometer (Vitatron, U.S.). The results are seen in Table 1. In contrast to patients without gastric diseases and other groups such as chronic atrophic gastritis or gastric and duodenal ulcers, only patients with gastric malignancies revealed highly significant differences (p < 0.0005) of LDH-1 and LDH-5 isoenzymes in the stimulated gastric juice. This effect was much more pronounced, forming a ratio between LDH-5 and LDH-1 that might be more helpful in the diagnosis of gastric neoplasm, whereas the determination of total LDH activity despite its occasional elevation does not seem a useful parameter.

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REFERENCES


Vessel clip as a nidus for formation of common bile duct stone

To the Editor:

Silk sutures retained in the common bile duct leading to calculus formation have been previously noted. We think endoscopists should be aware of a case in which a vessel clip used during cholecystectomy acted as a nidus for the formation of a common duct calculus.

An 84-year-old white woman was admitted for evaluation of repeated attacks of epigastric pain over a period of 6 weeks. Laboratory studies showed elevated bilirubin, alkaline phosphatase, and serum glutamic oxaloacetic transaminase. An intravenous cholangiogram performed 2 weeks prior to admission was inconclusive.

On two previous hospital admissions she was treated for pancreatitis. Three years before this present admission a cholecystectomy was performed for cholelithiasis. At that time an intraoperative cholangiogram was normal. The common bile duct was not explored. Vessel clips were used only to obtain hemostasis of several small bleeders in the gallbladder bed. The cystic duct was ligated with silk suture material.

During the present admission an endoscopic retrograde cholangiopancreatography and papillotomy were per-

Table 1.
Lactate dehydrogenase (LDH) isoenzyme pattern in gastric juice investigated during basal secretion and after pentagastrin stimulation in patients without any gastric diseases and in gastric malignancies. a

<table>
<thead>
<tr>
<th></th>
<th>LDH-1</th>
<th>LDH-2</th>
<th>LDH-3</th>
<th>LDH-4</th>
<th>LDH-5</th>
<th>LDH-5:LDH-1 ratio</th>
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<tr>
<td><strong>During basal secretion</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>No gastric diseases (N = 7)</td>
<td>19.6 ± 5.9</td>
<td>22.3 ± 9.9</td>
<td>19.0 ± 5.8</td>
<td>13.4 ± 8.3</td>
<td>25.7 ± 9.9</td>
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<td>Gastric malignancies (N = 8)</td>
<td>20.4 ± 11.1</td>
<td>24.4 ± 7.6</td>
<td>19.3 ± 6.5</td>
<td>19.7 ± 6.6</td>
<td>16.2 ± 7.2</td>
<td>0.79</td>
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<tr>
<td>After pentagastrin stimulation</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>No gastric diseases (N = 7)</td>
<td>17.6 ± 6.9</td>
<td>21.7 ± 11.5</td>
<td>23.2 ± 6.5</td>
<td>18.4 ± 7.3</td>
<td>19.3 ± 7.8</td>
<td>1.10</td>
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<tr>
<td>Gastric malignancies (N = 8)</td>
<td>11.9 ± 4.1</td>
<td>19.5 ± 6.3</td>
<td>19.6 ± 8.5</td>
<td>20.2 ± 4.9</td>
<td>28.8 ± 8.8</td>
<td>2.42</td>
</tr>
</tbody>
</table>

a Values are given in mean percentages ± SD.