
Response

The results reported by Atmakuri et al. are similar to ours and confirm that a high rate of major complications, mainly due to esophageal ulcers, follows the use of absolute alcohol for sclerotherapy of esophageal varices. Another study cited seems to suggest that even diluted alcohol is exceedingly ulcerogenic despite a reduced efficacy compared with 5% ethanolamine oleate.1 By contrast, Sarin et al.2,3 in two different studies, reported only minor complications with the use of absolute alcohol. In the first study, this result was obtained in spite of a high rate (69%) of esophageal ulcers. Since most sclerotherapy/associated esophageal ulcers cause no significant side effects, it is possible that the lack of major complications was due merely to chance.

The very low rate (16%) of esophageal ulcers reported in the other study is more difficult to explain. A different study design may well have contributed to this result. In fact the amount of alcohol injected was lower (2 to 4 ml vs. 3 to 18 ml) and the interval between sclerotherapy sessions longer (3 weeks vs. 1 week). Furthermore, a specially designed sclerotherapy needle was used, designed to reduce paravascular injections associated with ulcers. A further important factor may be patient selection. We have in fact recently reported that patients with alcoholic cirrhosis are more prone to develop sclerotherapy associated esophageal ulcers than patients with nonalcoholic cirrhosis.4,5 Only a small fraction of patients studied by Sarin et al.2,3 had alcoholic cirrhosis. On the basis of current evidence, we feel that widespread use of absolute alcohol as a sclerosing agent cannot be recommended. Further studies may define a beneficial application of this agent in selected subgroups of patients; for example, those with nonalcoholic cirrhosis.

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REFERENCES
1. Ref. 6, above.
2. Ref. 7, above.
3. Ref. 5, above.

Sclerotherapy for esophageal varices and pregnancy

To the Editor:

We read with interest the letter by Salena and Sivak1 reporting a case of successful gestation and pregnancy occurring after endoscopic sclerotherapy of esophageal varices in a woman with extrahepatic portal vein obstruction. We would like to add our experience with three cases of successful pregnancy in women with extrahepatic portal vein obstruction who had undergone endoscopic sclerotherapy of esophageal varices. In the southern Indian state of Kerala, a large number of cases of portal hypertension occur as a result of idiopathic portal vein thrombosis in childhood. Sixty-nine (30%) of our 230 cases of portal hypertension in which endoscopic sclerotherapy was completed over the past 5 years had extrahepatic portal vein obstruction. The three cases reported below belong to this group.

A 30-year-old woman (case 1) had splenomegaly and recurrent upper gastrointestinal hemorrhage from the age of 10. At age 16, she underwent surgery for a possible portosystemic shunt, but due to extensive cavernous malformation of the portosplenic axis no anastomosis was feasible. A splenectomy was performed. She remained symptom free for 6 years. From age 22 she again had recurrent bleeding from varices. At age 29, her first child was delivered by cesarean section without complication. After another hemorrhage, endoscopy showed large esophageal varices and sclerotherapy was done using 1% polidocanol by a combined para- and intravariceal technique. During the course of treatment, she conceived and her second child was delivered by cesarean section when she was 32 years old. She has remained symptom free with no residual varices 2 years after the second childbirth.

A 22-year-old woman (case 2) had splenomegaly and a massive upper gastrointestinal bleed. She was found to have large esophageal varices at endoscopy and extensive splenoportal thrombosis on ultrasonography and percutaneous splenoportovenography. She underwent sclerotherapy using 1% polidocanol para- and intravariceally. At the 36th week of pregnancy, she was referred back to our hospital for confinement. Surveillance endoscopy revealed recurrence of major grade varices and although she had no further bleeding, it was decided to repeat sclerotherapy. She was delivered by cesarean section without complication at full term. She has remained symptom free following delivery for 28 months.

A 22-year-old woman (case 3) underwent emergency surgery for massive upper gastrointestinal bleeding in another hospital at age 20, when transgastric ligation of esophageal varices and gastric devascularization were performed. She was reexplored 1 year later for possible portosystemic shunt surgery but no anastomosis could be done due to extensive splenoportal thrombosis. She was seen in our center before our sclerotherapy program was available, and was put on propranolol. She continued to have recurrent melena, needing blood transfusions, and sclerotherapy was performed using 1% polidocanol para- and intravariceally.

A surveillance endoscopy 3 months later showed residual varices confined to the gastroesophageal junction. No sclerotherapy was done. She conceived 1 year later and at the
To the Editor:

The study by Hunter et al. comparing the effects of monopolar electrocautery, argon laser, and Nd:YAG laser on flat mucosal lesions and small sessile polyps in the canine model highlights the potential for full-thickness injury using these modalities, especially in thin-walled structures such as the ascending colon. They used the Nd:YAG laser with open fiber at 60 watts for 0.5 sec at a 1-cm distance from the lesion. We have also been aware of the potential hazard of this method in clinical situations. Recently, we have been treating flat angiodysplastic lesions in the colon with Nd:YAG laser by direct application using a fulgurating contact tip at 10 watts for 0.5 to 1.0 sec. We have now treated 12 patients, including lesions in the colon and duodenum, successfully with this method without complication. We believe the contact tip method provides good ablation of the lesion while producing less depth of penetration than the open fiber method. An extension of the work of Hunter et al. using the contact tip method in the canine model would certainly be helpful in better defining the use of the Nd:YAG laser in the treatment of colonic lesions.

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Gastrostomy button: why complicate an office procedure?

To the Editor:

We would like to congratulate Foutch et al. on their prospective review of gastrostomy button placement in 31 adults. Their study does demonstrate many of the advantages of thebutton over gastrostomy tubes. However, our 6-year experience, which presently includes 108 children and 8 adults, clearly shows that the technique and recommendations for insertion by these authors are costly and unnecessary. The button was first developed as a simplified alternative to the gastrostomy tube. Since its inception, insertion was meant to be an office procedure, performed without sedation in the patient with a well-established gastrostomy tract. Following the initial report, we detailed our experience with gastrostomy buttons placed in 50 children and 6 adults during a 20-month span. In all but three instances, gastrostomy button placement was performed in the office without sedation. The other three patients had button insertions in the operating room while under general anesthesia because of a concomitant, unrelated procedure. Endoscopic verification of button placement was never used and never needed. A single physician inserted the button in each case, and any additional personnel present were for educational reasons only. Assistants, as recommended by Foutch et al. are not needed. Thus, these authors have complicated a simple office procedure by recommending the use of endoscopy, sedation, and assistance for gastrostomy button placement. This can only add to the cost and complexity of the procedure, and rather than ensure safety, they actually make gastrostomy button placement a riskier procedure.

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