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 pregnancy in extrahepatic portal hypertension as exemplified by cases 1 and 2 while residual varices predisposed to massive bleeding in case 3.

Although pregnancy may be a potential hazard causing increased portal pressure and further bleeding from varices, total obliteration of esophageal varices by sclerotherapy may overcome this hazard in extrahepatic portal hypertension as exemplified by cases 1 and 2 while residual varices predisposed to massive bleeding in case 3.

REFERENCES

Hazards of contact tip use of Nd:YAG laser in treatment of colonic lesions

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 angiodyplastic 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.

REFERENCES

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 the button 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.

Michael W. L. Gauderer, MD
Thomas A. Stellato, MD
Case Western Reserve University School of Medicine
Cleveland, Ohio

REFERENCES