Flumazenil in routine upper gastrointestinal endoscopy

To the Editor:

The double-blind controlled trial of flumazenil performed by Birkenfeld et al. confirms the efficacy of this agent in reversing the sedative effect of benzodiazepines. Undoubtedly, rare occasions of iatrogenic respiratory depression and/or arrest can occur but fatal incidences related to benzodiazepine administration alone in routine upper gastrointestinal endoscopy are vanishingly rare. However, can the use of a relatively expensive drug be justified for the purpose of slightly earlier patient discharge? Each ampule of flumazenil contains 0.5 mg and costs £16.52. Assuming that 0.2 mg were required for each patient to reverse the benzodiazepine effect, it would increase our annual budget by £16,520 (approximately 2500 procedures are carried out annually in our unit) if we were to use it routinely on every patient. If this were extrapolated to every endoscopy unit in the United Kingdom, the extra cost would be phenomenal. Under the current "cost-effective"-conscious health service climate in the United Kingdom, such an unnecessary additional cost would be unwelcome.

We would suggest either performing endoscopy in high-risk patients without sedation, which is safe and acceptable, as demonstrated previously or using sedation sparingly, and only using flumazenil in life-threatening situations. The high proportion (11 of 31) of the placebo-treated group who still had a low score after 120 min, as reported by Birkenfeld et al. could reflect an overall excessive benzodiazepine dosage given to the patients. We would like to emphasize that flumazenil should be kept in the drug cupboard to reassure experienced endoscopists who may encounter, perhaps once a lifetime, an iatrogenic respiratory emergency related to benzodiazepines during routine endoscopy!

C. K. Ching
G. K. T. Holmes
Derbyshire Royal Infirmary
Derby, United Kingdom

REFERENCES

Response

Drs. Ching and Holmes suggest that, after endoscopy, flumazenil should not be administered routinely and that it should be used only in life-threatening situations to reverse the effect of benzodiazepines. A routine use of flumazenil will add unnecessary cost to endoscopy. We definitely agree with their approach.

In our study, we evaluated the efficacy and safety of flumazenil in reversing the effect of either diazepam or midazolam in patients who underwent upper gastrointestinal endoscopy. We found it to be both safe and efficient. On the basis of our study, we recommended its availability in the endoscopy suite. Its use should be restricted only to life-threatening situations.

Simon Bar-Meir, MD
Shlomo Birkenfeld, MD
Department of Gastroenterology
Edith Wolfson Medical Center
Holon, Israel

Nasobiliary remote high-dose rate radiation

To the Editor:

In the report by Urban et al., the authors state: "we describe the new endoscopic technique..." We would like to mention that we have published the same technique as early as 1987. Since then, we have had a lot of experience with the technique. We have also designed a special nasobiliary catheter suitable for introduction of the iridium seeds, which is available through Wilson-Cook Medical, Inc. (Winston-Salem, N.C.) (catalog #INBS-10-Venu-C). A similar technique has already been described by Levitt et al. from Australia and Ede et al. from England.

Rama P. Venu, MD
Joseph E. Geenen, MD
Racine, Wisconsin

REFERENCES

Response

We feel that Drs. Venu and Geenen have misconstrued the statement "we describe the new endoscopic technique..." and misunderstood this technique. Our paper differs from previous reports of endoscopic insertion of radioactive substances, as radioactive substances are not being inserted. Therefore, this is a "new" technique. Our technique differs considerably from that described by Venu et al., Levitt et al., and Ede et al. In their afterloading technique, a 5 F or 7 F nasobiliary catheter is placed through a stricture in the bile duct and a radioactive, iridium-192 wire is afterloaded into the catheter and left in place for several days to deliver a tumor dose of radiation. Incidentally, our new technique also differs from one we previously...
described as a "new technique" in which we "preloaded" a double lumen prosthesis with iridium and inserted it through an obstructing tumor. In both the afterloading and preloading techniques, radioactive material is handled by experienced personnel, either a physician or technician, and left in position in a stricture for several days, exposing the patient and other health care personnel to radiation. This is not the case in the procedure described in our most recent presentation.

There are many differences between our new technique and the previously described techniques, including our new double lumen stent. First, a 10 F, straight, nasobiliary catheter (Wilson-Cook Medical, Inc., Winston-Salem, N.C.) is placed through the tumor into the liver and a 6 F catheter is placed through the nasobiliary tube to the distal end. Second, under fluoroscopic control, a "dummy" wire is advanced into position in this 6 F catheter while the patient remains in the endoscopic suite. The patient is subsequently taken to the Radiation Oncology Department where other studies are conducted. This evaluation includes biplane fluoroscopy to determine the size and shape of the tumor and calculations of tumor dosage. Thirdly, the major difference between our new technique and the other afterloading techniques is that radiation is delivered through a high-dose remote system, exposing no one but the patient to radiation for only a few minutes rather than a few days. This major difference of high-dose delivery of radiation qualifies this procedure as a new technique as it has not been previously performed endoscopically or described in the endoscopic literature. Therefore, we conclude that this procedure is new and totally different from previous endoscopic procedures described by us (preload) or others (afterload).

We recognize the outstanding accomplishments previously reported by other workers in this field, and we apologize for not listing the three references quoted by Venu and Geenen. The report by Venu et al., which described their afterloading technique, was previously cited in our earlier paper, in which we reported a series of 14 patients using the new iridium preloading stent technique. However, since our latest report describes a new and different application of a high-dose remote generator and not iridium afterloading, only references to the new technology were included. Our latest report is the only one describing endoscopic delivery of this new system, the others being percutaneous. For this reason, endoscopic papers which were not relevant to the new technology were not included.

The significance of small colonic polyps found at flexible sigmoidoscopy

To the Editor:

During the last 18 months, we performed flexible sigmoidoscopy on 900 patients. Sixty-three patients (7%) had one or more polyps in the rectosigmoid. Exclusion criteria were polyps of >1 cm in size, history of bleeding, inflammatory bowel disease, or past polypectomy. After excluding 18 patients, 45 of the 900 (5%) patients with small polyps remained in the study. All of these patients were submitted to total colonoscopy and biopsy of all polyps found. Histopathology showed that 27 of 45 (60%) patients had hyperplastic polyps and 18 of 45 (40%) had at least one adenomatous polyp. Among the 27 patients with hyperplastic polyps at flexible sigmoidoscopy, 5 (18.5%) had a more proximal hyperplastic polyp and 9 (33.3%) had a more proximal adenomatous polyp. Of the 18 patients who had at least one adenomatous polyp in the rectosigmoid, three (16.6%) were found to have them more proximally.

We conclude that size alone is not an accurate predictor of the histology of the polyp. Because small polyps, either hyperplastic or adenomatous, in the rectosigmoid indicate a risk for adenomatous polyps proximally, all patients with small polyps found during flexible sigmoidoscopy should be submitted for total colonoscopy. Our findings are in agreement with those of others.1,2

Theodore Rokkas, MD
Andrew Karameris, MD
Departments of Gastroenterology and Histopathology
Army General Hospital
Athens, Greece

REFERENCES

Differential diagnosis of tumor-like appearance of the papilla of Vater

To the Editor:

Currently, duodenoscopy is the most important method for diagnosing periampullary tumors, but both malignant and benign lesions can produce a tumor-like appearance of the papilla of Vater.1 Because a tumor-like appearance of the papilla of Vater can assume many forms, we conducted a study to assess the possible association between the nature of the tumor-like lesions and their different endoscopic appearances.

From March 1985 to December 1989, we reviewed reports on over 1500 consecutive ERCP examinations performed on patients at the Veterans General Hospital and associated endoscopic photos of the papilla of Vater. In 63 patients, tumor-like appearances of the papilla of Vater were found by endoscopy. All cases in which all of the clinical features and imaging studies favored periampullary malignancies,