LETTERS TO THE EDITOR

ACUTE HEMORRHAGIC PANCREATITIS

To the Editor:

I would like to comment on some points raised in the discussion of the paper by Schapiro et al, “Acute hemorrhagic pancreatitis in the dog. II: effect of vasopressin on survival times (Am J Dig Dis 18:1075, 1973). The portal system stasis, as well as the increase in the portal pressure, was noted during the experimental hemorrhagic pancreatitis. Details were not given because we had not obtained enough data. Similar increase in the portal system pressure was noted by Anderson and his associates (Anderson MC et al: A study of circulatory changes in acute pancreatitis. Surg Clin North Am 47:127, 1967). Although the action of the vasopressin on the portal system pressure is known, it is not yet known in cases of pancreatitis. Based on this analogy we gave vasopressin during our experimental study on acute pancreatitis.

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PERCUTANEOUS TRANSHEPATIC CHOLANGIOGRAPHY

To the Editor

Okuda et al (Am J Dig Dis 19:21, 1974) made a plea for the all-round use of percutaneous transhepatic cholangiography in the differential diagnosis of hepatobiliary disorders. We should like to comment on several points.

1. The described technique (thin needle, lateral approach, injection instead of suction) was introduced by one of us and has been used since 1955 (1, 2) and indeed provides a higher success rate than the original method (3).

2. The author’s conclusion that repeated failure to enter a bile duct would be an argument for intrahepatic cholestasis seems too simplistic, as is illustrated by the following case report.

A 49-year-old woman showed the symptoms of obstructive jaundice for the first-time in 1970. In 1966 a prosthetic Teflon tube had been inserted into the main bile duct for a localized stenosis (pathological diagnosis: fibrosis). After the intervention she continued to experience further attacks of cholangitis, which resulted in persistent jaundice with severe itching. Despite repeated failure of two attempts for transhepatic cholangiography, the diagnosis of obstruction of the Teflon tube was retained and an operation was performed in 1971. However, the surgeon was unable to identify a suitable bile duct for anastomosis after wedge resection on the left lobe. Microscopical examination of the resected specimen disclosed obliteration of the lumen of some canaliculi, whereas on other sites proliferation of the canaliculi was obvious.

Recently, an ERCP was performed (Figure 1), which showed obstruction at the level of the prosthesis with dilatation of the choledocus above the level. The intrahepatic branches were mostly dilated, whereas others were narrowed. In this case the failures of the percutaneous cholangiography must obviously be attributed to “sampling error.”

3. As the diagnostic value of the technique is undeniably demonstrated by Okuda et al, the question remains whether this technique can still be defended on ethical grounds, when less harmful procedures such as peritoneoscopy — mortality rate 0.08%, morbidity rate 1.09% on 4459 examinations (4)— and ERCP can obtain the same information. Misuse of the technique must be avoided (5), and in our opinion its proper indication is restricted to cases with postoperative ligation of the main bile duct, in order to define the operative repair tactics (3).

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REFERENCES

1. Daniels J, Schmidt W: Percutaneous transhepatic cholangiography Arch Chir Neerl 12:71, 1960

Response by the Author

Drs. Demeulenaere and Van Waes seem to maintain the superiority of peritoneoscopy over percutaneous transhepatic cholangiography, or at least they are comparing their credibilities. Although it seems unnecessary, I would like to answer their letter point by point.

1. We never recommend "all-round use," as Drs. Demeulenaere and Van Waes state, of transhepatic cholangiography. In fact, we have been careful to stress indications and contraindications with statistical data on the complication. We emphasize, however, that valuable information otherwise never revealed is often obtained by this procedure. We do not insist that the percutaneous procedure is the best. We have already done endoscopic cholangiography in more than 250 patients. In a certain proportion of the patients this approach never succeeds. We use whatever method is successful. Percutaneous transhepatic cholangiography has

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