LETTERS TO THE EDITOR

Endoscopic sphincteroplasty for the management of duct stones

EDITOR,—I was very interested to read the paper by MacMathuna *et al* (*Gut* 1994; **35:** 127–9) in which the authors describe a new technique of dilatation of the ampulla using a balloon tipped biliary catheter to facilitate endoscopic retrieval of bile duct stones. I am sure this technique deserves further assessment as it has been shown to be safe and effective at least for stones up to 20 mm in size. I do question their use, however, of the term sphincteroplasty in naming the technique.

Before the development of endoscopic instruments capable of accessing the bile duct choledocholithiasis usually required surgical intervention either by choledocholithotomy or transduodenal sphincteroplasty. The second operation constitutes opening the second part of the duodenum and then incising the ampulla of Vater usually over a probe to a depth of about 2 cm. The cut edges of the ampulla are then sutured so as to maintain the ampulla open thus changing the shape of the ampulla permanently. Ductal stones can then be retrieved easily and furthermore if any stones are inadvertently left in the duct system at operation they can pass easily into the duodenum thereafter through the widened sphincter. During my time as a registrar in surgery at St James' Hospital, Balham in 1984 I reviewed a consecutive series of 86 such procedures as part of an in house audit with no mortality and a zero retained stone rate with no upper limit in stone size.

The use of the term 'plasty' infers the actual change in shape of an organ or part thereof by instrumentation and is derived from the Greek (plassein – to mould)[1-2] and whereas ductal stones can now be dealt with safely and efficiently endoscopically in a manner far preferable to open surgery I feel that the term sphincteroplasty should be reserved for operative surgical intervention. I suspect that the authors may have coined the use of the suffix from the currently popular procedure of angioplasty (dilatation of diseased arteries), which in itself may also be a misnomer. Their methodology and results are excellent in comparison with those of open surgery but I suggest that they name the procedure endoscopic ampullary balloon dilatation to avoid any further confusion with a technique that is long established in the surgical literature.[3]

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1 *Churchill's illustrated medical dictionary.* Edinburgh: Churchill Livingstone, 1989: 1758.
2 *Dorland's illustrated medical dictionary.* Philadelphia: W B Saunders, 1989: 1232.
3 Jones SA, Smith LL. Transduodenal sphincteroplasty for recurrent pancreatitis – a preliminary report. *Ann Surg* 1952; **136:** 937–47.

Reply

EDITOR,—We thank Mr Parker for his comments in supporting the more widespread application of our sphincteroplasty (papillary dilatation) technique for bile duct stones as a less traumatic alternative to endoscopic papillotomy or surgery. Our initial encouraging results have been borne out in over 100 patients to date, with a bile duct clearance rate of over 75% using sphincteroplasty for stones up to 2 cm in size without any associated haemorrhage. These results are particularly important in the context of the concern expressed regarding the longterm sequelae of papillotomy for bile duct clearance in young patients undergoing laparoscopic cholecystectomy.[1 2]

Although not questioning our results, Parker takes issue with our use of the word 'sphincteroplasty'. The word 'plasty' is indeed derived from the Greek 'plassein' – to mould, but it does not imply an irreversible change to the structure concerned. True, the term to date is well established in the surgical literature but our deliberate use of the term 'endoscopic sphincteroplasty' should help avoid any potential confusion. In vascular intervention, it is clearly understood that angioplasty is equivalent to balloon dilatation without any implication as regards permanent structural change. In essence therefore, we have no problem with the use of the term endoscopic papillary (ampullary) balloon dilatation as an alternative to sphincteroplasty, as long as the technique becomes more widely validated. In short, we recommend endoscopists to start stretching more and cutting less.

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1 Cotton PB, Ballie J, Pappas TN, Meyers WS. Laparoscopic cholecystectomy and the biliary endoscopist [editorial]. *Gastrointest Endosc* 1991; **37:** 94–7.
2 Sherman S, Ruffolo TA, Hawes RH, Lehman GA. Complications of endoscopic sphincterotomy: a prospective series with emphasis on increased risk associated with sphincter of Oddi dysfunction and nondilated bile ducts. *Gastroenterology* 1991; **101:** 1068–75.

BOOK REVIEW

Manual of Clinical Problems in Gastroenterology. 2nd ed. Edited by M M Van Ness, S M Chobanian. (Pp 380; illustrated; £21.95.) New York: Little, Brown Medical, 1993.

I suspect that if gastroenterologists were subject to rapid fire word association during Freudian psychoanalysis, in response to the word 'manual' many of us might come up with the word 'evacuation'. For the less anally retentive, the term 'manual' may conjure up images of one of a series of over 50 spirally bound, pocket sized texts produced by the publishing firm of Little, Brown. It is a source of some curiosity as to why publishers in this country have not really gone in for spiral texts of this nature. There are various pocket sized books for doctors in training, but their success in the market rather depends on the amount of vacant space in white coat pockets up and down the land.

This volume is intended for students, interns, and trainee fellows, and its 380 pages are certainly impressive in their scope and depth. Sadly, the price for this level of coverage has been at the considerable cost of readability. Rarely can so much information have been conveyed in such a dull manner.

Potential purchasers may be attracted to this book by the considerable success of this volume's stable mate, the 'Manual of Medical Therapeutics', which has now achieved a 27th edition – which, by any yardstick is a success. I would not bank on this companion volume in gastroenterology getting anywhere like as far. I worry a little about the therapeutics in this book. Medical treatment seems to generate more controversy than any other area of gastroenterology. Differences of opinion are fine, but erroneous statements are quite unacceptable. In this book, you can read that 'the backbone of medical therapy of ulcerative colitis is aspirin-containing agents . . .' Well, one knows what the author means, but acetyl- and amino-salislyic acid are not quite the same thing. Total parenteral nutrition is suggested for patients with severe ulcerative colitis who do not respond to intravenous corticosteroids after 'five to seven days.' There will be many on this side of the Atlantic who might have other ideas.

Many book reviewers like to stumble across the occasional error and cite it in the review as evidence that they have actually read their review copy. Unfortunately, in this volume, finding statements with which you might want to disagree does not take very long. Surely, the editors of a book, given its distinguished pedigree, would have searched long and hard for errors in dosage. Those of us who like to wind down at the end of a stressful day with a can of low alcohol lager will be distressed to learn (page 89) that 'alcohol consumption exceeding 80 mg/day . . . indicates a non-surgical case of jaundice'.

Maybe just looking at the contents page should be sufficient warning. Any book for doctors in training that devotes more space to chronic intestinal pseudo-obstruction than it does to irritable bowel syndrome has got a really big problem.

IAN FORGACS

NOTE

Sir Francis Avery Jones BSG Research Award 1995

Applications are invited by the Education Committee of the British Society of Gastroenterology who will recommend to Council the recipient of the 1995 Award. Applications (**fifteen copies**) should include:

(1) A manuscript (2 A4 pages *only*) describing the work conducted.

(2) A bibliography of relevant personal publications.

(3) An outline of the proposed content of the lecture, including title.

(4) A written statement confirming that all or a substantial part of the work has been personally conducted in the United Kingdom or Eire.

Entrants must be 40 years or less on 31 December 1995 but need not be a member of the BSG. The recipient will be required to deliver a 40 minute lecture at the Spring meeting of the Society in 1995. Applications (**fifteen copies**) should be made to: The Honorary Secretary, BSG, 3 St Andrews Place, London NW1 4LB by 1 December 1994.