

British Society for Digestive Endoscopy

The following are abstracts of free papers given at the second annual general meeting held in London on 20 September 1973. The account of the meeting was published in the October issue of the journal (page 832).

The Endoscopic, Radiological, and Surgical Findings in Chronic Duodenal Ulceration

P. BROWN, P. R. SALMON, R. J. BURWOOD, A. J. KNOX, G. CLENDINEN, AND A. E. READ Comparisons of endoscopic and radiological findings are less meaningful than when assessed against an independent parameter. A prospective study of endoscopic, radiological, and surgical features of chronic duodenal ulceration has been performed. A barium meal with tubeless hypotonic duodenography by one radiologist and upper gastrointestinal endoscopy by one of two endoscopists were each performed within five days of surgery. The pylorus and duodenal bulb were examined at surgery by one of two surgeons. Particular attention was paid to the presence of inflammation, oedema, ulceration, or scarring, to the number of ulcers present, and to the position of an ulcer or scar. Results were collected independently and compared postoperatively. Forty-three patients were admitted to the trial and there was complete agreement on the presence of ulceration in 31 cases (72%), radiology being at variance with the other two parameters in seven cases, endoscopy in four cases, and surgery in only one case. There were no false positive endoscopic diagnoses, but four false positive radiological diagnoses. Radiology and endoscopy were equally accurate in assessing the numbers of ulcers, but endoscopy was more accurate in assessing the position of an ulcer within the duodenal bulb. In those 31 cases in which there was agreement on the presence of ulceration, endoscopy and surgery agreed in 70% but radiology and surgery agreed in only 45%. It is recognized, however, that there are difficulties both radiologically and at endoscopy in defining the exact position of lesions.

Emergency Fibreendoscopy following Acute Gastrointestinal Haemorrhage in Patients with Portal Hypertension

R. WALDRAM, M. DAVIS, HEATHER NUNNERLY, AND ROGER WILLIAMS We report here our initial experience of emergency fibreendoscopy in 22 patients with portal hypertension within 24 hours of gastrointestinal bleeding. Twenty patients had cirrhosis and there were two with extrahepatic portal vein obstruction. Although oesophageal varices were found in every case, they were seen to be bleeding in only six patients. Five others were bleeding from gastric varices, one from a duodenal ulcer, one from gastric ulcers, one from oesophagitis, and two from erosions. The bleeding site was not identified in six cases, including two of the five patients in whom the examination was incomplete because of the volume of retained blood. Thus, 70% of those in whom the site was identified were bleeding from oesophageal or gastric varices, in contrast to findings in American series (Dagradi *et al.*, 1969; Bonnano *et al.*, 1972) showing that variceal bleeding accounts for only half the bleeding episodes in cirrhotic patients, the great majority of whom were alcoholics. In the present series, alcoholic cirrhosis was present in only 32% but the sites of bleeding did not appear to be related to the type of cirrhosis. Barium studies were done within seven days of endoscopy in 15 of the 22 patients and always showed oesophageal varices, but only once indicated another lesion—a duodenal ulcer. Although there were no complications from endoscopy in this series, the examinations were difficult and the sedation necessary may precipitate hepatic encephalopathy in those with decompensated cirrhosis.

References

- Bonnano, C., James, G., Robilotti, J., and Martel, A. J. (1972) The value of emergency endoscopy in active bleeders. *Gastroenterology*, **62**, 882.
- Dagradi, A. E., Mehler, R., Tan, D. T., and Sempien, S. J. (1970) Sources of upper gastro-intestinal haemorrhage in patients with liver cirrhosis and large oesophageal varices. *Amer. J. Gastroent.*, **54**, 458.

Hazards in Electrosurgery via the Fibre-optic Endoscope

A. E. HANWELL The development of the flexible fibreoptic endoscope as a diagnostic tool has been rapid. Many endoscopists are now carrying out electro-surgical procedures with electrodes passed through the instrument biopsy channel. The first results are extremely encouraging and one may anticipate an 'explosion' in the use of such techniques, since they offer considerable saving of time and often avoid the need for major surgery with its attendant risks. However, the combination of a fibrescope designed for diagnostic purposes and electro-surgical equipment designed for use directly or in conjunction with conventional rigid instruments poses significant hazards to both endoscopist and patient. The primary hazard arises from the high frequency of the currents used which enables them to pass from the active electrode through apparently satisfactory insulation into the metallic undersheath of the fibrescope. Depending on the precise electrical arrangements used, there is then a hazard of high frequency burns to the endoscopist's hand and eye and also a risk of unintended burn to the patient at an internal site which is outside the field of view. Suitable circuit arrangements are shown which enable the endoscopist largely to eliminate these risks. The relevance of electrical precautions taken to avoid the risk of low frequency (50Hz) mains shock is outlined. The nature of electro-surgical currents and the fundamental distinction between cutting and coagulating phenomena are not well understood by endoscopists. A brief outline of the basic principles is given.

Extraction of Foreign Bodies Utilizing Fibreendoscopy

K. F. R. SCHILLER AND P. R. SALMON The diagnostic yield of modern gastro-intestinal fibreendoscopy has been great. By comparison, operative fibreendoscopy is in its infancy. It is now possible, for example, to perform endoscopic polypectomy and attempts have been made

to coagulate, and even to clip off, bleeding points and to inject varices. There is little published material on the extraction of foreign bodies utilizing fibreendoscopic techniques. We have succeeded in removing a hairpin from a normal oesophagus, and a piece of vegetable matter causing acute oesophageal obstruction in a patient with a benign stricture. We have also removed a dental reamer (a device similar in size to a hypodermic needle but with a corkscrew-like shaft) which had been swallowed and which had become embedded in the antral mucosa. Retained sutures following gastric operations have been removed on six occasions. We have failed to remove a florin retained in the stomach of a child, and have also failed to remove a swallowed toothbrush despite two attempts using 'cannulation' of the hole in the proximal (handle) end by biopsy forceps, snaring of the handle with a nylon loop, and traction on the distal (bristle) end. Experimental forceps designed for the endoscopic removal of foreign bodies are described. Removal of foreign bodies from the oesophagus may be safer when flexible rather than rigid instruments are employed whenever the size and nature of a foreign body makes this possible. Removal of suitable foreign bodies from the stomach utilizing fibreendoscopy is quicker, simpler, and probably safer than surgical removal.

Notes and activities

New Liver Failure Unit at King's College Hospital, London

An intensive care unit expressly for patients with acute liver failure was formally opened at King's College Hospital by Sir Douglas Black on 9 October. The new Unit, to be directed by Dr Roger Williams, complements the other clinical and research facilities of the Liver Unit, and was provided by the Department of Health at a cost of £80 000.

The new Unit is designed to care for two patients at any one time. It is equipped with the latest monitoring devices, including facilities for continuous electroencephalographic and cardiac recording. It also contains a small operating theatre for placing arteriovenous shunts and other procedures likely to be needed with the development of artificial liver support systems. Care has been taken, by special air-filtering systems, to reduce the risks of cross infection and to protect staff and patients alike from virus B hepatitis. X-ray equipment within the Unit can be operated by remote control and the self-contained suite has, in addition, changing rooms for nursing and medical staff.

Provisional International Nomenclature of Diseases of the Gastrointestinal Tract

The Council for the International Organization of Medical Sciences has published a booklet, 'Provisional international nomenclature of diseases of the gastrointestinal tract'. It can be obtained from Dr S. Btsh, Executive Secretary, c/o World Health Organization, 1211 Geneva 27, Switzerland, at a special price for members of the British Society of Gastroenterology of Sw. frs. 7.50.

Future Meetings of the British Society of Gastroenterology

In an attempt to prevent future meetings clashing with those of other societies the following arrangements have been made: 29-30 March, 1974, Nottingham (closing date for abstracts 19.1.74); 19-21 September, 1974, Birmingham (closing date for abstracts 22.6.74); 11-12 April, 1975, Southampton; 25-27 September, 1975, Oxford; Spring 1976, ? London; 28 September-2 October, 1976, ? Aviemore.

Symposium on Prostaglandins in Medicine

A symposium on prostaglandins in medicine organized by the Medical Research Council Gastroenterology Unit will be held at the Avery Jones Postgraduate Medical Centre in the Central Middlesex Hospital on Friday 1 March 1974.

The programme will include:

Biochemistry and distribution

Dr Harvey Main

Measurement in biological fluids

Dr Keith Hillier

Role in inflammation and fever

Dr Sergio Ferreira

Mechanism of action of anti-inflammatory drugs

Dr Roderick Flower

Prostaglandins and inflammation of the skin

Dr Malcolm Greaves

Pharmacology of actions of prostaglandins on human smooth muscle

Dr Alan Bennett

Prostaglandins and asthma

Dr Maurice Cuthbert

Prostaglandins and heartburn

Dr George Misiewicz

Prostaglandins and peptic ulcer

Dr Alvin Newman

Prostaglandins and diarrhoea

Dr John Cummings

Panel discussion

Future therapeutic implications

The registration fee of £3.00 will cover meals and refreshments.

Application forms can be obtained from Dr J. J. Misiewicz, MRC Gastroenterology Unit, Central Middlesex Hospital, London, NW10 7NS. Tel: 01-965-5733, ext. 289.