and/or IgM anti-HBc antibody in 18 patients (25%) with AVH, 22 (52.3%) with FHF, 6 with SAHF, 9 with CAH, 20 (51.2%) with cirrhosis and 4 with HCC. Sera samples which tested negative for the above markers were tested for HCV by a second-generation ELISA test (Pinnisome Biosystem, USA) and HCV RNA by PCR (Table). PCR was more frequently positive than ELISA.

Newer antibody tests, including third-generation ELISA and RIBA tests,${}^{2,3}$ particle agglutination tests,${}^{3}$ and IgM anti-HCV test${}^{4}$ are quite sensitive and specific and can diagnose HCV infection early. The RIBA-2 test can detect anti-HCV antibody at 11 weeks and always within 20 weeks from the onset of infection. But this is too long a period for a patient with FHF.

HCV is a more important etiologic agent in chronic liver diseases, and in these patients anti-HCV detection by ELISA may be used as a routine diagnostic modality.

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Improvisation of indigenous pneumatic dilator

We had reported earlier the use of an indigenous pneumatic dilator developed by us. 1 We have now incorporated several modifications:

1. A single condom is as effective as three condoms used earlier as balloon, this avoids the possibility of puncture of the two inner condoms and entrapment of air in the outer condom, thereby preventing deflation of the dilator after the procedure.

2. The tied ends of the silk cloth are covered with pieces of latex tubing, this protects the thread from getting wet during the procedure and later while washing the dilator, and rules out the possibility of loosening of the thread.

3. The lumen of the Levin's tube is blocked with a metal ball and cyanoacrylate glue, which is more effective than other adhesives.

4. The center of the dilator is marked with a black cloth ring, this helps in positioning the dilator at the gastroesophageal junction during dilatation under endoscopic guidance.

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References

Partington's pancreaticojejunostomy does not need modification

Bapat et al have described a modification of the Partington-Lachelle modification of the Puestow-Gillesby procedure, where they have anastomosed the jejunal side-to-back to the pancreas, rather than the conventional side-to-side method. They claim that this “avoids closure of the jejunal end, a potential site of leak if there is distal obstruction,” and that the fish-mouthing effect created better drainage.

I am not, however, aware that leakage from the terminal stump of the jejunum is indeed a frequent complication. In our series of over 160 pancreaticojejunostomy operations, we have never encountered this problem. The authors failed to show in their literature review that this is a serious problem which needs correction. Should distal obstruction occur, the pancreatic anastomosis would disrupt long before the jejunal suture line. If, on the other hand, the stump were to give way first, it would be a blessing as it might be easier to correct.

The authors have also concluded that the modification provides a “dependent, wide, funnel-shaped, Roux-en-Y anastomosis” and therefore it is superior. It is rather presumptive that an end-to-back anastomosis would allow...
better drainage than an end-to-side procedure. Anastomotic patency may depend more on whether or not a duct-to-mucosa anastomosis could be performed.

I thus cannot agree with the authors that the modification has advantages over the original procedure. In fact, there are potential disadvantages: i) the vascularity of the Roux loop is poorest at the end, and most surgeons would prefer not to anastomose the end to the pancreas; ii) in cases where an anastomosis of greater than 10 cm is required (and many require such a long anastomosis to deal with disease of the pancreatic head), it may be difficult to achieve a good tie of the opened-out jejunum over the pancreas especially at the fish-mouthed end.

Incidentally, the authors describe parenchymal calcification in 15 of 53 patients. Did these cases have hyperparathyroidism as well? Most patients with calculous pancreatitis (alcoholic or tropical) have stones confined to the ducts and the "parenchymal calcifications" have now been clearly shown to represent stones lying in the minute side-branches.

Finally, the authors describe that the "side-to-side longitudinal pancreaticojunostomy relieved pain in 80%...". Partington and Rochelle described the longitudinal pancreaticojunostomy, as opposed to the longitudinal type where the spleen and distal pancreas were removed and the flected pancreas was dunked into the jejunum.

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References

Reply from the authors

The genesis of this modification was the type of obstructive pancreatitis that we see, where there is an easily identifiable duct lying antero-inferior; hence, spleenectomy and filling of the end of the pancreas can be avoided. The procedure described originally involves closing the end of the jejunum, followed by jejunopancreaticocholedochal anastomosis. Our modification avoids closure of the jejunal end and eliminates a potential site of leak. The procedure is quicker and easier. The vascularity of the fish-mouthed loop is good, and fish-mouthing gives adequate anastomotic length.

Because the diagram accompanying the article was printed reverse, the technical details were confusing. Our modification is not side-to-side, but the side of the opened pancreatic duct in its entire length is anastomosed to the end of the fish-mouthed jejunum.

We did not mention details of the etiology of the condition in our patients because this was not our primary aim; none of our patients had hyperparathyroidism.

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(Editors note: The correct diagram is printed on page 122)

Screwing a carrot out of the rectum

A 40-year-old man presented with a carrot impacted in his rectum, pushed into place by some persons while he was in the open fields answering the call of nature. He did not give a history of homosexuality. Nothing was visible outside on anal examination, but the sphincter was lax. On rectal examination, the carrot was felt high up in the rectum.

We attempted to remove the carrot with the help of Allis forceps and Kocher's forceps with abdominal pressure applied, but only pieces could be extracted. We then screwed in a myotomy screw per rectally under proctoscopy, and the carrot was gradually pulled out — a carrot-and-screw approach!

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Endoscopic retrieval of impacted spigot from gastrostomy tube

A variety of complications have been described with percutaneous endoscopic gastrostomy (PEG). We report the endoscopic removal of a spigot that was accidentally passed into the stomach with a PEG tube.

A 35-year-old man with encephalitis was referred to us for PEG. The PEG tube used was made from a nasogastric tube. Unfortunately, prior to the procedure, which was performed by the pull-through technique, we failed to remove the spigot and it passed with the tube into the stomach. We noticed this after we reinserted the gastroscopy to check the final tube position in the stomach. Attempts to dislodge the spigot with biliary forceps passed through the external end of the tube failed. A grasping forceps (Endo technik, Wolfgang, Germany) was introduced through the endoscopy and the spigot was removed from the PEG tube with a forceful jerk and withdrawn. The procedure was uneventful.

To the best of our knowledge, spigot retrieval using grasping forceps has not been reported before.

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