

CORRESPONDENCE

Correspondents are asked to be brief

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Massive Upper Gastrointestinal Bleeding

SIR,—Your leading article on massive upper gastrointestinal bleeding (9 March, p. 403) cannot be allowed to pass without comment. It states: "One of the great difficulties often encountered in the past in treating large haemorrhages from the upper gastrointestinal tract was to determine with reasonable accuracy the lesion responsible . . . an emergency barium meal would only occasionally be helpful. It is in the latter type of case that endoscopic examination of the oesophagus, stomach, and duodenum with the modern fiberoptic panendoscope has proved such an advance in recent years." There then follows an impressive list of five references to papers in support of this statement—impressive, that is, until one reads them.

The first paper¹ describes 90 cases of upper gastrointestinal haemorrhage in which the site of the bleeding was determined by endoscopy in 81 cases, but there is no reference to or comparison with radiology. The second paper² is a panel discussion on the diagnosis and management of massive gastrointestinal haemorrhage. One of the members of the panel expresses the view that "endoscopy is now becoming the most useful single diagnostic step for the localization of the site of bleeding," but no facts are given to support this opinion. The third paper³ is on the surgical management of superficial gastric erosions, but there is no mention of either endoscopy or radiology in this paper.

The fourth paper⁴ is a 23-year prospective study of 1,400 cases of upper gastrointestinal haemorrhage starting in 1946 and using the older, rigid endoscopes. In this series, so far as it is relevant, endoscopy was performed first followed by radiology. Endoscopy detected the bleeding site in only 60% of cases and radiology determined the bleeding site in a further 33% of cases which had

escaped detection at endoscopy. The fifth paper⁵ is a review article on gastrointestinal endoscopy with only a brief mention of endoscopy in upper gastrointestinal bleeding, and quotes the results obtained by Palmer.⁴ It concludes with the hope that "Endoscopic results should be significantly better with the new instruments because they permit routine duodenal examinations."

In these five papers no evidence has been put forward to support the statement that "an emergency barium meal would only occasionally be helpful."

We are reviewing the relative accuracy of radiology and endoscopy in the detection of the site of upper gastrointestinal bleeding, and so far we have found no evidence to support the view that radiology is less accurate than endoscopy in detecting the lesion responsible for upper gastrointestinal haemorrhage. Until further controlled trials have been carried out no conclusions can be reached as regards the relative merits of radiology and endoscopy. In the meantime, your leading article making dogmatic statements such as "pride of place is now accorded to fibroscopy in the investigation of massive upper gastrointestinal haemorrhage" without any valid evidence to support it is, in our opinion, both misleading and dangerous.—We are, etc.,

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¹ Lightdale, C. J., *et al.*, *Journal of the American Medical Association*, 1973, **226**, 139.

² Dunphy, J. E., *et al.*, *Archives of Surgery*, 1973, **107**, 367.

³ Wilson, W. S., *et al.*, *American Journal of Surgery*, 1973, **26**, 133.

⁴ Palmer, E. D., *Journal of the American Medical Association*, 1969, **207**, 1477.

⁵ Morrissey, J. F., *Gastroenterology*, 1972, **62**, 1241.

** It is not disputed that emergency barium meal examination has often been quite successful in demonstrating the grosser conditions like peptic ulcers of the stomach and duodenum. But it would be generally agreed, we think, that it is a notably unreliable method of detecting more superficial lesions such as gastric erosions or oesophagitis, which are not infrequently the cause of upper gastrointestinal haemorrhage even when an associated peptic ulcer is present. The main attraction of emergency endoscopy in these cases is that with modern equipment in expert hands the lesion that is actually responsible for the bleeding can be identified with certainty in the great majority of cases, as the reports of Cotton *et al.*¹ and Sugawa *et al.*² make abundantly clear. In saying that "pride of place is now accorded to fibroscopy in the investigation of massive upper gastrointestinal haemorrhage" we believe that we were only recording what is the accepted practice of most progressive gastroenterologists at the present time.

—ED., B.M.J.

¹ Cotton, P. B., *et al.*, *British Medical Journal*, 1973, **2**, 505.

² Sugawa, C., *et al.*, *Archives of Surgery*, 1973, **107**, 133.

SIR,—On reading your leading article on this subject (9 March, p. 403) we were surprised to note that arteriography was not mentioned as a procedure in either diagnosis or treatment of upper gastrointestinal haemorrhage. Percutaneous arteriography was described as a method for locating haemorrhage almost 10 years ago¹ and the more recent reports of the use of arterial infusions of vasoconstricting drugs to control haemorrhage^{2,5} have enhanced its usefulness.

We feel that endoscopy should be per-