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## Twenty more ERCP lawsuits: why? Poor indications and communications

To the Editor:

In 2006, I published an analysis of 59 lawsuits concerning ERCP in which my advice as a medical expert had been requested.<sup>1</sup> The main conclusions were rather clear. Many procedures had been done without a good indication, and communications were often poor.

The sad pattern continues. Since that publication, and perhaps because of it, I have received calls and reviewed papers on another 20 lawsuits involving ERCP. All had resulted in severe complications (mainly pancreatitis). The main issue in no fewer than 12 of these cases was whether there was a recognized indication for the ERCP (or the associated sphincterotomy). Nine of the patients had "pain only" (5 postcholecystectomy) with no recent laboratory abnormalities and with normal US and/or CT scans. None had been offered or had undergone MRCP, and none had sphincter manometry.

It is really difficult to defend such cases. The American Society for Gastrointestinal Endoscopy guidelines from 2000 and 2005,<sup>2,3</sup> the National Institutes of Health (NIH) State of the Science conference on ERCP in 2002,<sup>4</sup> and other authorities<sup>5</sup> state clearly that ERCP should be avoided if at all possible in such cases, with emphasis on noninvasive imaging, specifically MRCP and EUS. The NIH consensus panel also strongly recommended referral of "sphincter of Oddi dysfunction III" cases to tertiary specialists (who may not know exactly how to manage them, but at least have ways to reduce the risk of complications).

A few years ago, it was plausible to claim that EUS was not widely available, and that the quality of local MRCP was not optimal, but that is not sustainable now, at least for MRCP.

Although, of course, all plaintiffs signed informed consent documents, it is obvious that they would not have agreed had they really understood that the potential risks actually exceeded the potential benefits, and that there were several alternative approaches. Most patients also complained about inadequate communication before and indeed after the event.

The final problem is that most of the practitioners involved seemed to be unaware of the American Society of Gastrointestinal Endoscopy guidelines, or the NIH consensus statement.

We need to reduce this burden on our patients, which is a stain on our profession. So, can anyone suggest how

to get the message out to those who do not keep up with the relevant literature?

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## EUS aspiration needle size: smaller is better?

To the Editor:

We read with interest the study by Siddiqui et al<sup>1</sup> comparing EUS-FNA of solid pancreatic masses using 22-gauge (22G) with 25-gauge (25G) needles. Like most other centers performing EUS-FNA, we routinely used 22G needles initially until 25G needles became commercially available.

Several retrospective and prospective studies comparing needle size have been recently published.<sup>2-7</sup> Most of these studies conclude that there is no significant difference between the needles, but suggest a trend favoring the use of the 25G needle for improving diagnostic yield at EUS-FNA when compared with the conventional 22G needle. Other studies have obtained significantly superior results by using the 25G needle.<sup>2,6</sup>

We performed a retrospective audit of EUS-FNA cases performed at our institution over the past 4 years.<sup>3</sup> In our study, we analyzed all solid lesions that were targeted for EUS-FNA and the diagnostic yield. Adequate yield was defined by the diagnosis of cancer, other neoplasms, or benign conditions.

A total of 326 consecutive EUS-FNAs were evaluated. Of these, 182 samples were from solid lesions. The target lesions were situated in the pancreas (92), mediastinum (46), stomach (31), esophagus (6), and other areas (7). There were 96 male and 86 female patients, with a median age of 64 years (range, 24-88 years).

The yield of "suspicious or confirmed" cytology for the 22G and 25G needles was 60% (90/150) and 75% (24/32), respectively ( $P = .111$ ). The yield of "confirmed" cytology