Treatment of Schatzki's ring

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To the Editor:

I enjoyed the article by Wills et al[1] comparing electrosurgical incision and bougie dilation for the treatment of Schatzki's ring, and the authors are to be congratulated on their effort to add to the limited literature on this common problem. I have the following comments/concerns.

1. The authors state that, ''However, there are no trials comparing the efficacy of electrosurgical incision or any other treatment with standard dilation of SR.'' The comparison of treatment using bougies to alternative modalities in a randomized controlled fashion was first addressed by us,[2] and there has been at least 1 other subsequent study.[3]
2. Contrary to the authors' assertion, that ''the efficacy of acid suppression in decreasing the recurrence rate after treatment has not been studied,'' this issue also has been addressed in the past in a prospective, randomized, placebo-controlled study.[4]
3. The authors conclude that ''Electrosurgical incision of Schatzki's rings is safe.'' This strong vote of confidence about the safety of the electrosurgical incision, even in the hands of experts, may reflect a big leap of faith considering that the number of patients (n = 25) studied was so few.
4. The authors also conclude that electrosurgical incision of Schatzki's rings ''offers longer symptom-free survival compared with bougie dilation.'' This conclusion is questionable for the following reasons.
   a. The patients in the bougie group had a much higher severity of dysphagia at baseline (median dysphagia score 7 vs 5; $P = .01$) compared to the electrosurgical incision group. On the basis of their Figure 2, this is more than the median difference between the 2 groups at 6, 9, and 12 months.
   b. The investigators did not measure the diet score in their study. Patients with dysphagia frequently modify their diet, and only a diet score may help detect subtle differences in severity of dysphagia.[5]
   c. The high dropout rate of 36% in their study, even though similar in both groups, further clouds the picture and precludes drawing any definitive conclusions.

No study is perfect, and the above comments do not diminish the excellent contribution by Wills et al[1]; rather, they merely reflect a need for more randomized, controlled trials before any definitive conclusions can be drawn.

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Caustic ingestion in children: is endoscopy always indicated? A perspective from a Sierra Leone experience

To the Editor:

We read with great interest the article by Betalli et al[1] regarding the indication for urgent endoscopy in children after accidental ingestion of corrosive substances. We are currently running a program of management of such injuries in children in Sierra Leone, one of the poorest developing countries.[2] From December 2005 to July 2008, we admitted 148 children (1-15 years of age) after accidental caustic soda ingestion. The features and management of these injuries in Sierra Leone differ deeply from those of Western countries. The most frequently ingested substance in developing countries is caustic soda, with a most powerful solvent action that results in very serious injuries, as confirmed by 126 (85%) children requiring dilation for severe strictures (62% of them needing gastrostomy). This is in sharp contrast with the 11% of severe injuries reported by the Italian study.

Is endoscopy always required to establish a proper treatment, even in these settings? Only 29 (19.5%) children arrived to our hospital within 72 hours of ingestion. Endoscopy was negative or showed mild lesions in those without symptoms. Those with major symptoms (dyspnea, dysphagia, drooling, or hematemesis) showed third degree

lesions at endoscopy and underwent surgical gastrostomy to ensure adequate nutrition. When oropharyngeal lesions due to ingestion of crystals of caustic soda were observed in 8 patients, most esophageal lesions were trivial. In 7 of these children who showed mild esophageal damage at early endoscopy, a gastrostomy was needed after a few weeks due to severe dysphagia and esophageal stricture. Thus, endoscopy was not so reliable in our hands, and it never changed our management approach. We agree that these patients should not unnecessarily undergo endoscopy, although our time interval between injury and endoscopy (36 hours) is obviously greatly different from the mean 3.3 hours of the Italian study. Unfortunately, in developing countries, most patients arrive late after ingestion, and this delay makes dilations more difficult.[3] We consider even 72 hours a safe time interval in which to perform endoscopy. In these settings, we believe that the life-saving therapeutic procedure is a surgical gastrostomy, either for feeding purposes or for retrograde dilatation, which is considered safer and somewhat easier. Yet, the decision to perform a gastrostomy has always been based on clinical signs, not endoscopy. In conclusion, although the clinical features of children who have ingested corrosive substances in Western and developing countries may be different—and likely more severe in the latter—we agree that an early endoscopy (within 72 hours of ingestion) is not particularly helpful for further management.

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Response:

We read with interest the letter of Dr Contini et al regarding a large experience of caustic ingestion in children carried out in Sierra Leone that reported important and unique information on the outcome of caustic soda ingestion in one of the poorest developing countries and confirming our finding that asymptomatic patients do not develop severe esophageal sequelae. Such observation probably differs from ours in some points that might justify the different outcome: the group from Sierra Leone included definitely more severe cases. In our cohort, 43% of patients were asymptomatic, whereas, in the cohort of Sierra Leone, only a few patients had no symptoms at presentation. As a matter of fact, we often wondered whether the ingestion truly occurred in our patients, whereas, we believe that, in the setting of a developing country, such patients go to the clinic either with a strong history of ingestion or because of emergence of symptoms. In fact, 85% of their patients eventually required esophageal dilation. Besides, in our cohort, all endoscopies were carried out within 12 to 24 hours from ingestion, which gives the chance to start treatment with steroids when required, and, although the efficacy of such treatment has not been confirmed, this might have improved the outcome of children with severe lesions. In their cohort, timely treatment with steroids was not possible because of the delay of the endoscopic staging. Their surgical approach appears aggressive, with nearly 80 patients undergoing surgical gastrostomy, but it is probably justified by the severity of their cases and seems appropriate.

Our study cannot comment on the impact of any treatment but demonstrates that the absence of symptoms corresponds to normal mucosa or mild esophageal injury. We, therefore, believe that endoscopy is not indicated in asymptomatic patients, both in developed and developing countries. Early endoscopy could be useful in symptomatic children in the view of an effective treatment. However, the efficacy of currently proposed management is still unproven. From this perspective, the aggressive approach adopted in the Sierra Leone cohort is justified, because timing of the assessment and severity of the lesions make gastrostomy the only way to reestablish feeding and save lives.

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