Dear Sir:

Cystic dilation of the intrahepatic biliary tree is a rare disorder associated with cystic renal abnormalities thought to be congenital or familial in origin. Stones in the biliary tree are common, and are frequently the presenting clinical manifestation. Cholelithiasis and its sequelae determine the prognosis, and the disorder would probably remain asymptomatic in its absence. Intrahepatic cholelithiasis occurs with subsequent cholangitis resulting in a high morbidity and mortality.

It has recently been shown that bile lithogenicity undergoes a diurnal variation dependent on the fasting-feeding cycle. During fasting, many normal control subjects have "hepatic" bile which is lithogenic (cholesterol and mixed micelles), while gallbladder bile contains only mixed micelles. Thus, it is conceivable that hepatic cystic areas filling with bile act as reservoirs for an abnormal solution. Subsequent stasis and cholesterol precipitation would occur, and the "physical" stage of cholelithiasis is initiated. Obstruction and inflammation compound the process with further destruction of hepatic architecture.

Recent studies have shown that feeding bile salts not only decreases bile lithogenic potential, but slowly dissolves gallstones. Side effects are few, and therapy presently appears safe. It would seem reasonable to treat these patients with an acceptable bile salt regimen, both to prevent further cholelithiasis and perhaps resorb stones present. Antibiotics, the present mode of therapy, should be continued.

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REFERENCES

Dear Sir:

For the study of the esophagogastric junction in addition to the three tests used by Venkatachalam and associates (radiographic examination for hiatus hernia, intraluminal pH electrode detection of acid reflux, and manometric assessment of the lower esophageal sphincter), we think it important to include the endoscopic examination of that region. As regards the reflux of gastric contents into the esophagus, the esophagus is better examined by esophagoscopy; thus we can appreciate the duration and quantity of reflux as well as the condition of the esophageal mucosa.

It is known that some reflux of short duration can be observed in individuals with normal esophagus and stomach. In patients with stomach diseases and, especially, in gastrectomized patients, we have observed, by esophagoscopy, the greatest reflux into the esophagus. This is probably due to the reduction of the circulating gastrin which results to decreased lower esophageal sphincter pressure. On the other hand, we did not find any correlation between reflux and relaxation of the valve-like mucosal folds at the cardia and the esophageal peristalsis.

In individuals with esophageal reflux, esophagitis is frequently present, as judged by esophagoscopy.