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# Letters and comments

## The diagnostic value of fine needle aspiration in parotid lumps

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### **COMMENT ON**

Mallon DH, Kostalas M, MacPherson FJ *et al.* The diagnostic value of fine needle aspiration in parotid lumps. *Ann R Coll Surg Engl* 2013; **95**: 258–262

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We read with interest the article by Mallon *et al* and would like to make further comment. Their paper documents what is becoming increasingly clear about fine needle aspiration (FNA) in the salivary glands. In experienced hands, it is capable of a high degree of accuracy, and is quick and safe to perform. FNA performance is optimised by the use of ultrasonography guidance, presence of cytologist/cytology technician to allow repeat aspiration and use of ancillary cytology techniques. Outside specialised units, however, the performance of FNA varies widely, as demonstrated in the recent meta-analysis by Schmidt *et al.*<sup>1</sup>

Even in optimised circumstances, FNA remains associated with both a high rate of non-diagnostic sampling and also false negative results.<sup>1</sup> These perceived failings have led to investigation into alternative biopsy techniques, which may more reliably provide an accurate preoperative diagnosis, allowing informed patient consent and appropriate operative selection.

Ultrasonography guided core biopsy (USCB) has been described recently in the parotid glands, and has been shown to be both highly accurate and well tolerated.<sup>2</sup> USCB obtains a core of tissue, using a small bore needle (18G or 20G) deployed via an automated biopsy device, which can be sent for immunohistochemical analysis. This enables typing and grading of tumours. Furthermore, it allows improved diagnosis of nodal hyperplasia and the differentiation of reactive node from low grade lymphoma. USCB does not appear to be associated with either the high non-diagnostic and false negative rates or the variability in performance associated with  $\mathrm{FNA.}^3$  We would recommend that USCB should be considered the biopsy technique of choice for parotid lump diagnosis, particularly in units where FNA is undertaken in nonoptimised circumstances.

### References

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# Minimally invasive endoscopic therapy for the management of Boerhaave's syndrome

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Newcastle upon Tyne Hospitals NHS Foundation Trust, UK doi 10.1308/003588414X13814021678754

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### COMMENT ON

### Darrien JH, Kasem H

Minimally invasive endoscopic therapy for the management of Boerhaave's syndrome. *Ann R Coll Surg Engl* 2013; **95**: 552–556 doi 10.1308/003588413X13629960049315

In this paper, the authors describe minimally invasive endoscopic therapy in a highly selected group of five patients with Boerhaave's syndrome. There are two issues we wish to raise.

First, the authors state that the primary goal of minimally invasive endoscopic therapy is to seal the oesophageal perforation. The results demonstrate that stenting is actually very poor at achieving this goal. Four patients required stents to be replaced owing to ongoing oesophageal leaks. In three of these cases, an oesophagocutaneous fistula was still identified at the time of stent removal. Given these results, the favourable outcomes reported in this paper cannot be attributed to the use of stenting.

Second, the management of the late oesophagocutaneous fistulas was performed using a combined percutaneous-endoscopic rendezvous technique. It is surprising that the authors do not reference that this technique was in fact first reported in 2001 in relation to T-tube insertion.<sup>1</sup>

Care must be taken when interpreting the results of endoscopic therapy in such a highly selected patient group. The mainstay of treatment remains surgery or active aggressive but non-operative management in appropriate cases.<sup>2</sup> The contribution played by stenting in the process of patient recovery remains at best controversial and potentially dangerous.<sup>5</sup>