
To the Editor:

I read with great interest the article by Aljawad et al (1) regarding current practice patterns and barriers toward percutaneous liver biopsy (PLB) among hepatologists in Canada in the November issue of the Journal. They suggest that PLB is turning into “a lost art in hepatology practice” and is increasingly becoming an activity of radiologists, due to the lack of resources, perception of improved safety when performed by radiologists and unsatisfactory reimbursement fees. Additionally, the emergence of novel noninvasive techniques for assessment of liver fibrosis (FibroTest and FibroScan) has reduced the need for PLB.

However, having extensive experience with performing interventional ultrasound (US) and US-guided PLB in the management of liver diseases (2-6), I would like to address the study statements about which I have a few reservations.

The statement that “the main reasons for this trend can be attributed to lack of resources…” is questionable. US-guided PLB is the standard procedure for obtaining histological samples essential for the management of various liver diseases. US is a relatively inexpensive method, and many doctors are of the view that it should be routinely performed in clinical practice and deservedly so be considered “the stethoscope of 21st century”. In the discussion section, the authors stated “…interestingly, although multiple studies have shown that ultrasound-guided PLB is associated with lower rates of complications and postprocedure hospitalizations, 54% of respondents who perform PLBs still use a percussion-guided technique…” Given the widespread availability of ultrasound and its acceptance as standard-of-care practice for performance of PLB, using a percussion technique alone may well have medicolegal consequences in cases of complications from PLB, especially because multiple professional societies recommend the routine use of ultrasound. I believe that this explanation contains most of the answer to the question posed in the title. Our main concern is based around the question whether blind biopsy would be ethical nowadays considering the extensive use of US. It is very surprising that clinicians in some countries perform blind biopsy (without visual inspection of the needle pathway) on a routine basis at a time when US is available to almost every clinician, allowing full control of the needle pathway during biopsy. From a clinical point of view, it is unquestionable that it is better to be able to visualize the needle pathway during biopsy (7-11).

The statement that “the lack of available ultrasound machines for use by the hepatologist may have been contributory” is also doubtful because it was never a question whether endoscopic US should be performed by gastroenterologists/hepatologists, although it is more expensive, and both endoscopic and US skills are required.

The assertion “the perception of improved safety (by either the hepatologist or the patient or both) when liver biopsy is performed by radiologists” is realistic only in the last part (both). The patient may have a perception of improved safety when liver biopsy is performed by a new doctor (radiologist), only if his doctor (hepatologist) shows a lack of confidence in his own biopsy performance skills.

I partly agree with authors statement that the emergence of novel noninvasive techniques (FibroTest and FibroScan) is reducing the need for PLB. However, these techniques are based on imaging and laboratory parameters and, in many cases, as such, cannot replace the need for histopathological analysis of liver tissue.

I am certain that one of the main reasons behind hepatologists’ avoidance of US-guided liver biopsy and referral of patients to radiologist is not “…unsatisfactory reimbursement for PLB to the hepatologist” but the lack of US and interventional US education provided to hepatologists.

My main concern is aimed at the health authorities of the countries in which only radiologists are allowed to perform US examinations. I believe that the usefulness of education in ultrasonography for hepatologists is invaluable and would like to encourage discussion among experts regarding this topic. I strongly believe that preventing gastroenterologists/hepatologists from performing ultrasonography so far has not been based on scientific or clinical reasoning and has had no use for clinical practice (12,13). Unfortunately, preventing clinicians from performing US can be encountered in countries that have high impact on guidelines in clinical practice worldwide, such as the United States and Great Britain.

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REFERENCES

The Author’s response:

We thank Dr Zerem for his letter regarding our study, and we welcome the opportunity to respond to his critiques systematically. We concur that ultrasound guidance in the performance of percutaneous liver biopsy (PLB) is the appropriate standard of care for the procedure and that ultrasound itself is relatively inexpensive. We respectively remind Dr Zerem that our study is a reflection of current practice patterns in Canada only, and we do not generalize our findings to other health care systems or jurisdictions, where ultrasound may be more readily available, and/or hepatologists may perform the majority of their PLBs reflective of country-specific practice patterns and differences in clinical training. Furthermore, while we did not specifically address endoscopic ultrasound in our survey, we assert that it is rightfully not the conventional means to obtain a random core liver biopsy. Our findings that many hepatologists in Canada perceive that patients believe liver biopsy is safer when performed under image guidance by a radiologist requires further study before conclusions can be drawn. However, we contend that this perception likely relates more to the setting where PLB is performed and the ultrasound-guided technique, rather than “a lack of confidence” in PLB, because hepatologists without confidence in their ability would not, presumably, perform biopsies. We again assert, as we did in our article, that histopathology remains essential to the diagnosis and management of many liver diseases, but it is also indisputable that noninvasive techniques for fibrosis assessment (specifically FibroScan and FibroTest) are appropriately reducing the need for a substantial number of liver biopsies in patients with an established diagnosis of liver disease, and are often preferred owing to their superior safety profile and relative accuracy to rule in or rule out advanced fibrosis. Finally, we remind the author that guidelines and practice patterns are typically country specific, and while there may be some benefit to hepatologists performing diagnostic liver sonography, we maintain that such a practice would be unrealistic in light of the infrastructure and regulations of the Canadian health care system and, moreover, do not reflect current Canadian standards in fellowship training in gastroenterology and hepatology.

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