

20 lesions (4 flat type and 16 superficial depressed type). Furthermore, the diagnostic performance was less than 50%, even by chromoendoscopy with indigo carmine dye or acetic acid alone. Thus, there should be a relatively high possibility of overlooking a superficial gastric cancer without a combination of these 2 methods, "bi-chromoendoscopy." In our previous article, we obtained the clear demarcation around the tumor by using a mixed solution with indigo carmine dye and acetic acid in chromoendoscopy.² Among 27 patients in our series, 39 lesions were identified with spraying the mixed solution of indigo carmine dye and acetic acid, 6 of which were overlooked by conventional endoscopy and chromoendoscopy with indigo carmine dye alone. In addition, when this technique was applied for the preoperative evaluation of gastric cancer in the lower stomach, additional cancerous lesions were detected at the upper area in 2 patients. The information is very important for the suitable treatment for these patients. Therefore, we totally agree with the conclusion by Sakai et al that "bi-chromoendoscopy" is clinically useful to detect small-sized early gastric cancer.

The 2 substances should be sprayed sequentially, as in their method, or simultaneously, as in ours, because clear demarcation is probably because of a dynamic chemical response of gastric epithelium to acetic acid.³ In our experience, the best demarcation line of the neoplastic lesions is obtained at 3 to 4 minutes but gradually disappears thereafter, but we would like to know the exact time course of the visualization of target lesions in their method. In general, these 2 techniques might be separately applied based on the aim of endoscopy: routine observation, preoperative close examination, or marking, before endoscopic resection.

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Biliary plastic stents: does the color of the stents influence their deployment?

To the Editor:

Biliary endotherapy is evolving, with day-to-day improvement in techniques and technologies. Innovative newer accessories are being added to the armamentarium of therapeutic endoscopy, leading to simplification of procedures and decrease in procedure-related morbidity and mortality. Various biliary stents are available in plastic or metal and can be selected according to the clinical situation.

Commercial plastic biliary stents are made up of Teflon (DuPont, Wilmington, Del) and polyurethane coating and are available through various companies in different colors. We have observed that the color of these plastic biliary stents plays an important role during the deployment. We have noted that when the white-colored stents are pushed out of the working channel for deployment, a sudden darkening of the background vision of the duodenal mucosa occurs. This may be due to the optical autofocus properties of the camera lens, which senses the white stent as a bright object and focuses on it, automatically leading to darkening of the background. This darkening will persist for a few minutes, thereby affecting the deployment.

This has been seen only with white-colored stents. Both endoscope- and stent-manufacturing companies should look into this issue and try to rectify it.

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Diabetes mellitus is a risk factor for incomplete small-bowel capsule endoscopy

To the Editor:

We read with interest the article by Westerhof et al¹ that identified risk factors for incomplete small-bowel capsule endoscopy (CE) examination. Their study did not confirm our results,² which detected significant prolongation of CE gastric transit time (GTT) and resulted in incomplete CE studies in patients with diabetes. The investigators pointed out that this discrepancy could be attributed, at least in part, to the potential confounding effect of different bowel preparations administered in our study on GTT.