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Re: "Islet Hyperplasia in Adults: Challenge to Preoperatively Diagnose Non-insulinoma Pancreatogenic Hypoglycemia Syndrome"

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We read with interest the article titled "Islet Hyperplasia in Adults: Challenge to Preoperatively Diagnose Non-insulinoma Pancreatogenic Hypoglycemia Syndrome" by Achim Starke *et al.*[1] (World J Surg 2006;30:670-679). The differentiation of patients with non-insulinoma pancreatogenic hypoglycemia syndrome (NIPHS) from patients who have occult radiologically nondetectable insulinomas is a challenge to all endocrine surgeons. The attempt to differentiate between these groups preoperatively is commendable, as it is of great help in planning a surgical strategy and has prognostic importance as well. However, we have some questions.

First, the original case studies by Service *et al.* and Thompson *et al.*[2,3] laid down the criteria for NIPHS as referring to those patients who have postprandial neuroglycopenia, a negative 72-h fasting test, negative perioperative imaging studies, and a positive calcium stimulation test. Starke *et al.* state that the diagnosis of NIPHS was made in 11 of their patients, yet only 2 of those patients had a negative 72-h fasting test. This leads us to wonder what the indication was for performing the oral glucose tolerance test (OGTT) in the remaining 9 patients, because it is not routine to perform OGTT in suspected fasting hypoglycemia. Based on the authors' experience, do they believe that OGTT should be recommended in all cases of pancreatogenic hypoglycemia, even if the patient has a positive 72-h fasting test?

Second, the authors have done pancreatic resections of varying degrees in their group of 11 patients, but a regionalization study with intra-arterial calcium stimulation test was done only in 2 patients. On what basis was the decision of extent of pancreatic resection made, particularly in patient number 6, where pancreatic head resection was carried out without any regionalization study. In addition, 6 patients had a false-positive radiological study, but it is unclear what caused the result: i.e., lymph node, spleniculi, or artifact?

Third, the histological features of diffuse nesidioblastosis, have been clearly laid down,[4] and microadenomas are not a feature of NIPHS. In the Starke *et al.* study patients 6, 7, and 10 had microadenomas, and patient 6 also had an insulin/glucose ratio of more than 0.3. Is it possible that these patients have multifocal insulinomas rather than NIPHS?

Finally, the authors conclude that preoperative selective arterial calcium infusion improved their cure rate, yet only two of their 11 patients underwent this procedure and one of those (patient 11) developed mild diabetes later on, although the exact duration of postoperative follow-up was not mentioned. Further, in the author's opinion, what should be the broad guidelines for recommending regionalizing studies in similar situations?

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