

Correspondence

Splenic function in adult coeliac disease

Sir,

Corazza and colleagues¹ suggest that splenic function, as measured by the pitted red cell test, may improve in the short term after treatment with a gluten-free diet. As they point out this was not our experience in the longer term using different tests of splenic function and splenic area.² Nor, in fact, was it the experience of Corazza *et al* in an earlier study using the same pitted red cell test.³ They showed that 44% of patients with the same mean age as patients described in their present study had evidence of splenic hypofunction, a mean of 3.8 years after starting on a gluten-free diet.

Whatever changes may occur immediately after starting a gluten-free diet, their previous data support our conclusion that splenic hypofunction and splenic atrophy persist in patients after many years on a strict gluten-free diet. The practical implication stands: Howell-Jolly bodies in the peripheral blood film of patients with adult coeliac disease cannot be used as evidence of poor dietary compliance.

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References

- 1 Corazza GR, Frisoni M, Vaira D, Gasbarrini G. Effect of gluten free diet on splenic hypofunction of adult coeliac disease. *Gut* 1983; **24**: 228–30.
- 2 Trewby PN, Chipping PM, Palmer SJ, Roberts PD, Lewis SM, Stewart JS. Splenic atrophy in adult coeliac disease: is it irreversible? *Gut* 1981; **22**: 628–32.
- 3 Corazza GR, Bullen AW, Hall R, Robinson PJ, Losowsky MS. Simple method of assessing splenic function in coeliac disease. *Clin Sci* 1981; **60**: 109–13.

Reply

Sir,

We are grateful to Trewby and Stewart for their comment on our paper concerning the improvement of splenic hypofunction, as measured by pitted red cell test in early treated adult coeliacs.¹ Our results differ from those of a previous study of theirs in which, on the basis of paired routine blood film examinations, Trewby *et al* did not observe a regression of the hyposplenic changes in coeliacs after longer periods of gluten-free diet.² From their letter, however, it seems to us that some of our conclusions may have been misinterpreted.

In three out of six hyposplenic coeliacs the percentage of pitted red cells did not fall in the normal range after gluten withdrawal, and the lack of correlation between the percentage of recovery of hyposplenism and the duration of gluten-free diet led us to believe that in these three patients splenic hypofunction, probably due to splenic atrophy, was not reversible. After our paper had been accepted, we have had the opportunity to confirm the persistence of similarly raised pitted red cell counts in two of these three patients. In support of these results, we quoted a previous work³ in which one of us, studying a different patient series, had detected a raised incidence of hyposplenism in treated coeliacs. The discrepancy, therefore, between our previous and present results, suggested by Trewby and Stewart, actually does not exist. In fact in the two series the percentage of treated coeliacs with splenic hypofunction is not remarkably different – that is, 20% in the Italian series (age range 24–61 years), and 32% in the English series (age range 7–72 years).

In consequence, we do admit that hyposplenism is present in a number of treated coeliac patients and thought that this belief was made clear in our paper. Accordingly, we do agree that the presence of Howell-Jolly bodies (or pitted red cells) in the peripheral blood of adult coeliacs cannot be used as evidence of poor dietary compliance. If the main question is, as the title of Trewby *et al*'s paper suggests,² whether splenic atrophy of adult coeliac disease is reversible, then our answer is 'no', but as far as functional hyposplenism is concerned, we believe that it may be improved or reverted by gluten withdrawal. This improvement may be transient, but it is noteworthy that another two serial studies, one based on heat-damaged red cell clearance,⁴ and the other on pitted red cell count⁵ have provided confirmation of our results on remission of splenic hypofunction after gluten withdrawal.

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References

- 1 Corazza GR, Frisoni M, Vaira D, Gasbarrini G. Effect of gluten-free diet on splenic hypofunction of adult coeliac disease. *Gut* 1983; **24**: 228–30.
- 2 Trewby PN, Chipping PM, Palmer SJ, Roberts PD, Lewis SM, Stewart JS. Splenic atrophy in adult coeliac disease: is it reversible? *Gut* 1981; **22**: 628–32.
- 3 Corazza GR, Bullen AW, Hall R, Robinson PJ, Losowsky MS. Simple method of assessing splenic function in coeliac disease. *Clin Sci* 1981; **60**: 109–13.

- 4 Palmer KR, Sherriff SB, Holdsworth CD. Changing pattern of splenic function in coeliac disease. [Abstract.] *Gut* 1980; **20**: A920.
- 5 O'Grady JG, Stevens FM, O'Gorman TA, McCarthy CF. Hyposplenism of coeliac disease is largely reversible. [Abstract.] *Gut* 1983; **24**: A494-5.

Varicocoele caused by a pancreatic pseudocyst

Sir,

We were interested to read the case report by Drs Dixon, Armstrong, and Fremin of a varicocoele caused by a pancreatic pseudocyst (*Gut* 1983; **24**: 438-40), but we believe the pancreatogram reproduced in Fig. 1 may have been misinterpreted. While accepting the difficulty of interpreting reproduced radiographs, we believe the appearances shown, and the description in the text of a blind ending to the main pancreatic duct are more suggestive of main pancreatic duct obstruction, a radiological feature which may be seen in the presence of a pseudocyst, rather than the fine terminal arborisation of the duct system more typical of an unfused ventral pancreas.² Although this in no way detracts from the interest of the report we would hesitate to ascribe this patient's recurrent acute pancreatitis to congenital duct malfusion, particularly in the presence of gall stones.

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References

- 1 Hamilton I, Bradley P, Lintott DJ, McMahon MJ, Axon ATR. Endoscopic retrograde cholangiopancreatography in the investigation and management of patients after acute pancreatitis. *Br J Surg* 1982; **69**: 504-6.
- 2 Ansel HJ. Normal pancreatic duct. In: Stewart ET, Vennes JA, Grenen JE, eds. *Atlas of endoscopic retrograde cholangiopancreatography*. St Louis: C V Mosby, 1977: 46 and 70-2.

Reply

Sir,

Thank you for allowing us to comment on the letter of Drs Hamilton and Soutar.

We recognise that the radiological features of the pancreatogram in our case reports may be caused by a pseudocyst. The latter, however, appears unlikely as an ultrasound performed the day after the pancreatogram showed no evidence of a pseudocyst.

We agree with the authors that radiology of the ventral pancreas usually reveals fine terminal arborisation of ducts. Pathological change in the ventral pancreas (as may have occurred in the case

described), on the other hand, can lead to dilatation of the main duct and absence of the branching pattern.¹

J M DIXON,
C P ARMSTRONG, AND
O EREMIN

Reference

- 1 Belba JP, Bell K. Fusion anomalies of the pancreatic ductal system: differentiation from pathologic states. *Radiology* 1977; **122**: 637-42.

Books

A colour atlas of upper gastrointestinal surgery By Charles Grant Clark. (Pp. 168; illustrated; £50.) London: Wolfe Medical Publications. 1983.

The best way to learn operative surgery is undoubtedly to assist a master surgeon and then be assisted by him. The place of books has always been controversial because, on one hand, drawings, which highlight key steps, appear unreal; whereas, on the other hand, photographs of actual operations are often difficult to orientate and interpret. This latest addition to the literature is lavishly illustrated with 544 colour photographs at a cost of £50 but also displays the severe limitations of this format, particularly in the section on truncal vagotomy, where the pictures add little to the text. It might have been better if there had been more annotations of the photographs or accompanying line drawings to clarify the anatomy. The attempt to avoid the glare of a white background has resulted in considerable areas of yellow patches in many photographs. Perhaps dark green or blue would have been better.

By contrast, the text is good, clear, and concise, and is of most value when it highlights mistakes that can occur. An introduction to each section discusses the indications for the different operations which is particularly important in peptic ulcer surgery. All surgeons have their own personal preferences and any book on operative surgery is a personal view. For example, many surgeons do not like twin clamps for a gastroenteromy but the techniques shown in this book are standard and safe and appropriate for surgeons in training.

In summary, unfortunately the use of colour photographs has not been a great success, but this is not belittle the skill of the photographer nor the skill of the surgeon - it is inherent in the method.

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Reply

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Updated information and services can be found at:
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