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References

IgA protease-producing bacteria in patients with ulcerative colitis

Sir,—We have studied the relationship between IgA protease producing bacteria and the pathogenesis of inflammatory bowel disease for several years. We read with great interest the study by Barr et al (Gut 1987; 28: 186–9) concerning IgA1 protease activity of the colonic bacterial flora obtained from five patients with ulcerative colitis. They concluded that colonic bacterial IgA1 protease production was unlikely to contribute to the pathogenesis of ulcerative colitis, on the basis that any isolate from patients with ulcerative colitis was unable to provide IgA1 protease activity.

In our studies, four bacterial strains (three strains of Bifidobacterium spp and one strain of Clostridium sp) capable of releasing IgA proteases were isolated from faecal material of three of 17 patients with inflammatory bowel disease.1 Interestingly, the extracellular enzyme produced by Clostridium ramosum from an ulcerative colitis patient was specific to not only IgA1, but also to IgA2 (A2m1) allotype.2 The isolate frequency of Cl ramosum producing IgA protease was no more than 3%, although IgA protease negative Cl ramosum was indigenous (approximately 80% detected) in the human intestinal tract.3 So far, we have no evidence supporting that IgA protease played a role in the pathogenesis of inflammatory bowel disease.

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References

Colorectal carcinoma in ulcerative colitis

Sir,—The Swedish study1 and the accompanying editorial2 in a recent issue of your journal have reiterated the need for cancer surveillance in patients with long standing ulcerative colitis. The Swedish study does not clarify the referral pattern of their centre. Two other recent editorials3 4 have pointed out that most of the cases of carcinoma complicating ulcerative colitis have been reported from tertiary referral centres. Another interesting comment in some of the recent articles is that this complication may have some geographical basis as well.5 6 Studies from Czechoslovakia,7 Denmark8 and Israel9 have failed to show the higher risk of cancer reported from other countries.10 11 The Czechoslovakian study was from a centre which was getting referrals of all patients with ulcerative colitis over a period of 40 years.12 Thus the bias of a referral centre reporting an exaggerated incidence of cancer in such patients was excluded. The authors pointed out that colorectal cancer is not uncommon in the general population. The study from Denmark accounted for more than 99% of the patients with ulcerative colitis in the region.10

Although ulcerative colitis is not uncommon in India, the complication of cancer has been rarely reported among Indians.13 This observation has led some of the gastroenterologists to proclaim that surveillance in Indian patients may not be warranted.14 We do not agree with this but feel that there is a strong geographical basis for the development of colitis carcinoma. At our centre, which is a referral hospital for five of the north Indian states, we have encountered four cases of carcinoma complicating ulcerative colitis in the last 10 years. In the same period about 400 cases of ulcerative colitis have been managed by us.

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References
1 Brostrom O, Lofberg R, Ost A, Reichard H. Cancer surveillance of patients with longstanding ulcerative...
encouraging as a sign of emerging talent, but it also gives a certain freshness to the text. Although shorter, it is an obvious competitor to the 1984 Textbook of gastroenterology edited by Ian Bouchier and his colleagues; indeed, about a dozen of the authors (including one of the editors) have hedged their bets by contributing to both books. Both books differ from the majority of gastroenterology textbooks by the welcome inclusion of a surgeon in the editorial team. Gastroenterology is the prime example of a specialty requiring close collaboration between surgeon and physician, as the mistakes of one require the intervention of the other. In the new book, the balance between surgery and medicine is more even, and does not convey the feeling that surgeons were only recruited for the parts that physicians could not reach; surgeons should feel comfortable with this text.

There is a significant difference between the two editorial approaches. Bouchier et al decided that their book ‘... should reflect to a large extent the practice of British gastroenterology, which has such a strong tradition of sound clinical practice.’ In contrast, Misiewicz et al have emphasised pathophysiology; American readers will recognise this as the difference between Bockus on the one hand, and Fordtran and Sleisinger on the other. This is an important consideration when you come to decide where to put your money. My preference is for a book that contains, as does this one, a positive bias towards pathophysiology, because I would regard this as the basis of both rational diagnostic and rational therapeutic strategies. To put it simply, if you don’t understand how normal function is deranged by a disease process, you won’t understand the problems faced by your patient or how they can be solved.

Whereas the earlier book was written in the first instance for ‘specialist gastroenterologists’, here the editors hope that the volume will be ‘of particular value to general physicians and surgeons’. While both groups are presumably not averse to reaching a wider public, the difference in the primary sales target is reflected not only in the shorter length of the new work, but also in an emphasis on common problems in clinical gastroenterology rather than on encyclopaedic coverage. I consider that the editorial team have achieved their stated aim; this is a book for the specialist rather than the subspecialist. The chapters are relatively short. Line drawings and half-tone illustrations abound to relieve the monotony of the printed page. Easy reading appears to have been a priority, with extensive referencing for those seeking ‘in depth’ information on a particular point; while this simplifies the text, it also places a premium on access to a good library.

Books


The review, in these columns, of a major new textbook edited by a distinguished trio headed alphabetically if not otherwise, by the editor of this journal is a high risk undertaking. A decision that the buck (and the book) would not be passed to someone else prompted visions of the dread summons to the editorial sanctum to face the dreaded wrath of Himself, shirt sleeved, green eye-shaded, and jabbing the air with an unlit cigar in an ungovernable tantrum of rage. . . . Clearly the freedom of this corner of the journal must be defended, but, in reality, can the tail wag independently of the dog? Happily, such fantasies do justice neither to our editor nor to the book.

The editors of this book have assembled an impressive team of 85 contributors, all but 11 from the UK, to write a textbook of ‘hollow tube’ gastroenterology. Although there are many names that are expected as acknowledged experts, there are also many that are less well known. This is not only
Colorectal carcinoma in ulcerative colitis.

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*Gut* 1987 28: 917-918
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