References


Bowel rest and nutritional support in the management of Crohn’s disease

sir,—We read with interest the paper by Dr Greenberg and colleagues (Gut 1988; 29: 1300–15) who report a trial of bowel rest and nutritional support in the management of Crohn’s disease. Remission rates were similar in groups of patients treated by bowel rest and total parenteral nutrition (TPN), oral diet (OD) with supplemental parenteral nutrition and enteral diet. Consequently it was concluded that any benefit was derived from nutritional support and not bowel rest. Unfortunately both the TPN and OD groups received part of their non-protein energy as intralipid. Intralipid has an immunomodulatory effect, impairing monocyte and phagocyte function.1 The possibility that such an influence may mask any impact of oral feeding on disease activity does not appear to have been considered either in this paper or in the accompanying editorial (Gut 1988; 29: 1304–8). Contrary to the views expressed in this editorial we believe the case against bowel rest remains unproven. Furthermore our own group has found very high levels of antibody to Saccharomyces cerevisiae (baker’s yeast) in patients with Crohn’s disease, but not in patients suffering from ulcerative colitis.2 The presence of mannans in cell wall structures in both yeast and atypical mycobacteria raises the possibility that Crohn’s disease develops when predisposed individuals become sensitised to such dietary components after infection with atypical mycobacteria. In the light of our findings, it would seem important that the effect of oral intake is not obscured by other manipulations. Further work is required to determine the effect, if any, of dietary components on disease activity.

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References


Reply

sir.—We thank Dr Pennington and colleagues for their interest in our study. Remission rates were comparable in groups of patients treated by a defined formula diet (polymeric feeding without Intralipid) and by TPN (nil per os with Intralipid). Thus, it is unlikely that Intralipid masked an effect by feeding on disease activity. Although specific and direct immunomodulatory reactions by intravenous fat preparation on the activity of Crohn’s disease were not examined in our study, proof of such a phenomenon would only add to the contention that provision of nutritional support, rather than bowel rest was the major factor contributing to remission in our patients. It is also noteworthy that effects reported by Fischer et al (quoted in your letter) are achieved at lipid concentrations that are three-fold greater than occurs in our patients receiving TPN and 15 fold greater than in patients receiving PPN. Moreover, subsequent studies by others3,4 have shown no immunosuppressive effect after lipid. The yeast hypothesis is intriguing: we look forward to any findings that provide insight into the pathogenesis of Crohn’s disease.

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