endoscopies until the appearance of early carcinoma. Moreover, various papers report that mild, or low grade, dysplasia progresses to moderate dysplasia in only 9% of cases, is associated with or progresses to cancer in a small but significant percentage of cases, is not distinguished from high grade dysplasia in terms of evaluation of results, and is not even included among cancer precursor lesions. This is probably confusing for those who are not directly concerned in the problem and discouraging for those who would like to find in published papers a rational approach to pre-malignant gastric lesions. We think that the reasons for these contrasting results are as follows:

1. Gastric epithelial dysplasia is a rare diagnosis and in all the reports quoted (all of which appeared in authoritative journals) there were no more than 250 cases; only multicentre studies, such as those carried out by the British Society of Gastroenterology in which we also collaborated, are therefore likely to provide us with sufficient information.

2. As Lansdown and coworkers correctly emphasised, it is surprising that such a condition, particularly in its mild form, from atypical hyperplasia is not done easily or always reliably; we think that the concept of mild dysplasia is changing and that only five years ago we were confident that mild dysplasia was not an indication for follow up, we now consider follow up of these lesions, when correctly classified, to be mandatory.7

3. The stomach is a relatively large organ and in the absence of a persistent focal lesion it is difficult to target biopsies and ensure that samples are obtained from the same site (which is why regression of severe dysplastic lesions is reported so often).

4. Few papers have been published with results from a truly prospective study, and retrospective investigations, particularly in this field, are burdened by the risk of bias.

Nevertheless, we think that a few clinical aspects are fairly well established. Firstly, severe, or high grade, dysplasia, whether associated with gastric ulcer, polyposis, erosions, or any endoscopic change, is the most reliable indicator that cancer is present or will develop in a short time and patients must therefore undergo surgery when feasible. We think that such a policy will save the patient and the doctor medical and legal problems.

Secondly, new prospective and multicentre studies focusing on the role played by moderate or low grade dysplasias are needed because we still do not know the relative risk of cancer for each type of lesion (though we have made an attempt in this direction), whether it is justified to consider moderate dysplasia as a separate entity, or how to follow up such patients.

Finally, we agree that when expert advice is not available locally specimens suspected of dysplastic changes should be examined by expert pathologists, who should be trusted with educating, with suitable tools, their colleagues in the field.

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Correspondence to: Dr Fabio Farinati, Cattedra Malattie Apparato Digerente, Istituto di Medicina Interna, Policlinico Universitario, Via Giustini 2, 35124 Padova, Italy.