Letters. Book reviews

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target biopsy specimens can be obtained from an abnormal area.

It is true that a small proportion of patients develop carcinoma in colitis without dysplasia elsewhere in the colon and that dysplasia, when present, is usually patchy. The paper by Rasonhoff et al., however, is quoted as evidence that dysplasia at a distance from the cancerous lesion occurs in only 50% of colectomy specimens. This paper was based on histological blocks of only 22 specimens with cancer in colitis, complete resections were performed in only 11 of the 1 patients, and more than five blocks were available from only 13 of the specimens. Some dysplasia at a distance from the tumour was found in 73% of specimens with high grade dysplasia in 50%. The authors suggest that one reason why the incidence of dysplasia was less than in other reports may have been due to limited sampling. Careful examination of 62 colectomy specimens with cancer in colitis at St Mark's Hospital has shown dysplasia at a distance from the tumour in 87%.

Dr Sheleld selected three clinical studies for comment and we appreciate her remarks about the importance of high levels of follow up and of clinical care in regard to our surveillance programme. It is a pity that she made no reference to two excellent Swedish series,1,2 one recent study from which there has been no cancer death and in which the three tumours treated surgically were at an early stage (Dukes A).

Like Dr Gyde, we would welcome the development of a new marker of neoplastic potential in colit is. Apart possibly from analysis of aneuploidy, which is complex and expensive, no such marker has been identified. Despite its limitations, dysplasia still the only thoroughly tested marker we have and it should not be rejected.

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Reply

Lennard-Jones makes several important points in his letter concerning screening for colorectal cancer. Firstly, while the term 'surveillance' or 'screening' is the appropriate term, given that the population screened are not 'healthy' members of the population. Ulcerative colitis patients benefit from regular follow up or 'surveillance' despite the presence of the disease process itself. Gastroenterologists add this general 'surveillance' a screening test for colorectal cancer (for which these patients are at high risk) in the form of colonoscopy and multiple biopsies to

detect 'dysplasia.' As far as colorectal cancer is concerned these patients are 'healthy' and the screening test is introduced (as with any other screening test for colorectal cancer elsewhere in the body) to detect either precancerous changes or cancer at an early stage. To call this screening procedure 'surveillance' confuses the issue, since it is no different from other 'screening' procedures for cancer.

The other major issue is whether a randomised controlled trial would be a practical proposition. Professor Lennard-Jones suggests that patients might not agree to participate in such a trial, and that a survey among patients at St Mark's Hospital showed that few would accept random allocation. This might or might not prove to be the case but would come apparent in any event in the pilot study. A trial might be a daunting prospect but given European collaboration, it necessary numbers could be recruited quickly. In my view there would be little value in following self selected groups since, whatever differences in survival between the two groups were found, it would not be possible to decide whether the differences were due to selection biases between the two groups or whether the differences were due to 'screened' versus 'non-screened.' Random allocation is an essential prerequisite for meaningful results.

It could be argued that screening for cancer in ulcerative colitis patients is screening a small group relative to, for example, population screening for colorectal cancer. The costs and workload generated are therefore relatively small and a coloscopy may be little more trouble than a flexible sigmoidoscopy. Also very few patients come to any harm from the procedure itself. The situation, however, is still unsatisfactory while screening remains of no proved benefit.

There must be many district general hospitals in the United Kingdom with limited facilities and many patients who would willingly forego the procedure if they knew it was not of proved benefit.

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Long-term maintenance therapy with sucralfate

Stnr,—Professor Blum et al report the superiority of sucralfate over placebo in the prevention of gastric ulcer recurrence.1 They speculate that continued treatment with sucralfate may have theoretical advantages over longterm maintenance therapy with antisecretory drugs, but fail to discuss the potential risk of aluminium accumulation. Administration of sucralfate (1 g twice a day) will result in a daily intake of 414 mg aluminium. The aluminium moity of sucralfate can dissociate at a low pH,1 and short-term administration of 4 g daily can lead to appreciable increases in serum and urine aluminium concentrations.2,3 Long-term administration of sucralfate (1 g twice a day) will not result in statistically significant increases in plasma aluminium in either of two small maintenance studies2 but animal experiments indicate that bony accumulation of aluminium may occur in the absence of raised serum concentrations.2,4 Sucralfate may prove to be effective and safe for the prevention of gastric ulcer recurrence. However, further studies of aluminium accumulation from longterm use are likely to be needed before this drug can be widely recommended as an alternative to antisecretory agents.

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Reply

Stnr,—MC Allison mentions in his letter experiments in rats which showed an increase of bone aluminium concentrations. This finding, however, could not be confirmed in patients receiving 4 g sucralfate daily for 8-10 weeks before total hip replacement. There was no increase of bone aluminium concentration compared with a control group.1

Aluminium toxicity is mainly discussed in connection with uremic patients and the application of high dose aluminium hydroxide as a phosphate binding agent. There is no evidence that longterm maintenance treatment with sucralfate in the recommended dosage in patients with normal kidney function will lead to unwanted side effects.

It should finally be mentioned that sucralfate is approved for the maintenance treatment of duodenal ulcer in several countries; recently it was approved for this indication also by the Federal Drug Administration in the USA.

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BOOK REVIEWS


This monograph written by Starzl and Demetris is an up to date summary of liver transplantation.