Increased intestinal permeability in ankylosing spondylitis

SIR,—We read with great interest the excellent paper by Morris et al (Gut 1991; 32: 1470–2) on intestinal permeability in ankylosing spondylitis but do not agree, however, with their conclusions.

Using the "Cr-EDTA resorption test" we recently studied gut permeability in inflammatory rheumatic disorders. Intake of non-steroidal anti-inflammatory drugs (NSAIDs) significantly increases gut permeability irrespective of the underlying disease. Patients with ankylosing spondylitis and with other spondylarthropathies not taking NSAIDs also presented a significant increase of gut permeability compared with controls. This indicates that gut permeability is disease-related. Gut permeability was not significantly increased in patients with histological gut lesions on ileocolonoscopy, or in patients with a normal ileum, although patients with ankylosing spondylitis and chronic gut lesions (resembling Crohn's disease) showed a significant increase in gut permeability compared with patients with ankylosing spondylitis and acute gut lesions. There are several explanations for the absence of a relationship between increased gut permeability and ileocolonoscopic evidence of gut inflammation. On ileocolonoscopy only the terminal aspect of the ileum is examined, which is very small part of the small bowel, can be examined. Moreover, the distribution of the observed lesions was patchy. Intake of NSAIDs causes such major gastrointestinal symptoms that patients may not feel local inflammation of the ileum would not influence the results of the "Cr-EDTA resorption test.

Inflammatory gut lesions were not found in patients with ankylosing spondylitis or ankylosing arthritis taking high doses of NSAIDs for prolonged periods, while such lesions were present in more than 50 patients with spondylarthropathies who had not taken anti-inflammatory drugs. This suggests that a lesion in the ileocaecal region is associated with the spondylarthropathies, while intake of NSAIDs probably induces more extensive and diffuse functional disturbances of the entire small bowel.

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Crohn's disease after ileocecal resection

SIR,—Olaison, Smedh and Sjödahl (Gut 1992; 33: 331–5) have provided endoscopic evidence that in many cases of Crohn's disease the ileal ulceration may occur soon after surgical resection of the terminal ileum. In 20 of 30 examined cases the ileal ulceration was present or proportionately more at 12 months. The authors consider that their data support views held by many that the bowel is permanently affected in Crohn's disease and is not liable to frequent clinical relapse even after apparent radical resection. Yet some follow up studies have also shown that as many as 25% of patients remain free of clinical symptoms for many years or even indefinitely, with a relapse or recurrence rate as high as it is, it is clearly the responsibility of every physician and surgeon to do all that is possible to stave off renewed activity of the disease. Olaison et al's report suggests that this needs to be done if possible before the onset of clinical symptoms when the disease process will have progressed to extensive ulceration and/or strictures.

Relapse clinicians at present have few means of assessing these patients by regular checks for symptoms and signs of recurrence and test for anaemia, a rise in sedimentation rate and muramidases. Others, influenced by reports such as this one, may be inclined to prescribe maintenance doses of drugs such as amino-salicylates, immunosuppressors or corticosteroids. There is however, evidence that such measures alone are not always enough. How evidence concerning the adverse affects of definitive emotional stress in this disorder which has either been forgotten or overlooked, or disbelieved and therefore ignored. The case history presented and against it has been repeated on Crohn's disease in a recent book.1 Appropriate psychological management of such cases is well within the competence of a non-psychiatrically trained physician once he or she has become aware of what is needed to help these sensitive and vulnerable people to change their previously damaging coping mechanisms in dealing with abrasive interpersonal strife in their immediate environment. How can this be done? It is perhaps one of the case histories and transcripts. What so often happens now, however, is that patients, many of them very young, are returned without psychological help to the same abrasive domestic or social environment which immediately preceded the onset or relapse of their disease. Case histories and the few outcome studies available illustrate the value of such intervention in cutting short relapse when done in specific case histories and patients find themselves caught in the middle.

Before treatment they lack the ability to cope or escape. Many such patients managed in this way remain free of disease for many years or suffer only minor relapses. The authors of that article from a Department of Surgery may be unaware that the first reports on psychosomatic disease after ileocecal resection are Crohn's disease.
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