in an inversely proportional manner according to the severity of the disease. In fact, the decrease in polyunsaturated fatty acids as the disease activity increases occurred for both sexes, although it was more noticeable for polyunsaturated fatty acids. As a consequence our hypothesis was that in inflammatory bowel disease an increased polyunsaturated fatty acid biosynthesis coexists with an increased polyunsaturated fatty acid consumption, the second being associated with the disease activity. The increased polyunsaturated fatty acid biosynthesis would be more noticeable in the n3 series as these fatty acids have the highest affinity for inflammatory macrophages. Hyperconsumption, although occurring in both polyunsaturated fatty acids series, is more evident in n6 products probably because of an increased arachidonate derived eicosanoid production. This hypothesis seems to be further supported by data from recent studies in patients with non-active inflammatory bowel disease.

Of course, it will be interesting to confirm these findings in different plasma lipid fractions in inflammatory colonic mucosa. As we are analysing these data, which hopefully will be reported soon. Nevertheless, as far as plasma long chain polyunsaturated fatty acids (mainly n3) are concerned, their concentration in total lipids remains relatively high in phospholipids, as most of them are bound to this fraction.

The dietary habits of the patients in our study were similar to that of healthy controls (standard Western diet). This type of diet contains negligible amounts of n3 polyunsaturated fatty acids (less than 1% of the total fat). In addition, most of the patients included were in hospital because of moderate to severe attacks of inflammatory bowel disease. Most of them were anorectic and tended to decrease their food intake rather than change to different types of food. No patient had been on nutritional support before plasma sampling was performed.

Although a 14 hour overnight fast might theoretically be a source of error, it is generally assumed that this condition provides an easily repeatable analysis of metabolic equilibration. In fact, approximately 15 hours after the last meal there is a progressive decrease in carbohydrate oxidation and a rise in fat oxidation. Increased lipolysis in adipose tissue and fatty acid mobilization is the result, whereas, in the liver, long chain fatty acid synthesis is progressively replaced by fatty acid oxidation and ketone body production. Therefore, longer fasting would lead to misleading results.

We looked forward to seeing the findings reported by Belluzzi et al published in full as it is difficult to draw real conclusions from an abstract. Data on the location and extent of the disease, bowel resections, nutritional state, and other factors that lead to fat malabsorption would be of utmost interest as in the patients described there is a decrease in essential precursors – that is, linoleic acid, which may account for the fatty acid deficiency seen in long chain polyunsaturated fatty acids. In fact, similar data were also reported by Farkkila et al in plasma lipids from a series including many Crohn’s disease patients with bowel resection. So, it would be interesting to see how Belluzzi et al, by comparing their data with ours, closely resemble the pattern of essential fatty acid deficiency.

Certainly, our results may be interpreted in different ways. On the one hand, as n3 polyunsaturated acids are increased, it would not be necessary to supply them in increased dietary amounts. Conversely, a plasma long chain n3 polyunsaturated fatty acid increase might be seen as an unsuccessful attempt to prevent an excessive production of arachidonate derived eicosanoids. In such cases the slight clinical response seen when fish oil is given, despite modifying eicosanoid production, could suggest that the amount of n3 polyunsaturated fatty acids given should be increased. All these data, however, provide an attractive insight into the pathogenesis of inflammatory bowel disease, in which the true role of fatty acid treatment also has to be investigated further.

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Open access gastroscopy

Editor — Dr Bramble and colleagues describe a most efficient and well run open access gastroscopy endoscopy service (Gut 1993; 34: 422–7). Even they, however, only achieve a mean waiting time of 17 days for open access endoscopy. Most of us would far rather see and therefore is not impressed with the report only if it is felt that a diagnosis is important before treatment is given or if this has happened and there has been a failure to respond after a reasonable time. The general practitioners in our district have a range of options for patients with dyspepsia and almost one in these of dyspepsia referrals are still by standard letter to a targeted consultant. The type of service described by Drs Trewha and Saunders is still available in Middlesex. We should not made the impression that general practitioners from treating patients with dyspepsia on clinical grounds. Our guidelines point out that it is appropriate to refer patients for investigation. It is felt that a diagnosis is important before treatment is given or if this has happened and there has been a failure to respond after a reasonable time. The general practitioners in our district have a range of options for patients with dyspepsia and almost one in these of dyspepsia referrals are still by standard letter to a targeted consultant. The type of service described by Drs Trewha and Saunders is still available in Middlesex. We should not made the impression that general practitioners from treating patients with dyspepsia on clinical grounds. Our guidelines point out that it is appropriate to refer patients for investigation. It is felt that a diagnosis is important before treatment is given or if this has happened and there has been a failure to respond after a reasonable time. The general practitioners in our district have a range of options for patients with dyspepsia and almost one in these of dyspepsia referrals are still by standard letter to a targeted consultant. The type of service described by Drs Trewha and Saunders is still available in Middlesex. We should not made the impression that general practitioners from treating patients with dyspepsia on clinical grounds. Our guidelines point out that it is appropriate to refer patients for investigation. It is felt that a diagnosis is important before treatment is given or if this has happened and there has been a failure to respond after a reasonable time. The general practitioners in our district have a range of options for patients with dyspepsia and almost one in these of dyspepsia referrals are still by standard letter to a targeted consultant.

We found 68% of patients that had an endoscopy preferred this system to open access endoscopy despite the need for two hospital visits and if those spared endoscopy are taken endoscopy patients 81% preferred the clinic appointment first. Pressure from general practitioners to set up open access endoscopy is considerable. We feel a clinic appointment first, however, is a more logical solution and the one favoured by the patient. The endoscopies saved may also it more cost effective.

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1 Saunders BP, Trewha PN. Is an out patient visit of value in patients suitable for open access endoscopy? Gut 1992; 33 (suppl 1): S50.

Reply

Editor — We are grateful for the opportunity to respond to the comments of Drs Trewha and Saunders. There is a basic misunderstanding in their letter. Our provision of an efficient open access gastroscopy service does not in any way deprive patients of effective treatment. We have not made the impression that general practitioners from treating patients with dyspepsia on clinical grounds. Our guidelines point out that it is appropriate to refer patients for investigation. It is felt that a diagnosis is important before treatment is given or if this has happened and there has been a failure to respond after a reasonable time. The general practitioners in our district have a range of options for patients with dyspepsia and almost one in these of dyspepsia referrals are still by standard letter to a targeted consultant.

In the case of open access endoscopy, the general practitioner has a further choice of asking for ‘report only’ or giving the endoscopy. We have tried to be clear that this is not a question of ‘report only’ and it is felt that a diagnosis is important before treatment is given or if this has happened and there has been a failure to respond after a reasonable time. The general practitioners in our district have a range of options for patients with dyspepsia and almost one in these of dyspepsia referrals are still by standard letter to a targeted consultant.
Open access gastroscopy.

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