

IBS followed cessation of vigorous exercise, but it is also possible that symptoms of IBS would deter some people from athletic pursuits. Did the authors consider the possibility that what they call 'symptomatic diverticular disease' might prevent exercise?

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Reply

EDITOR,—Most of the points of Drs Thompson and Heaton were already considered and discussed in our article. The Health Professionals Follow up Study (HPFS) is indeed a prospective study that began in 1986 when cohort members completed a baseline questionnaire about dietary intake, history of medical conditions, and about other risk factors. Follow up questionnaires were sent in 1988, 1990, and 1992. The 1990 and 1992 follow up questionnaires contained specific questions pertaining to whether diverticular disease had been diagnosed during the previous two years. For this reason, our follow up for diverticular disease was from 1988 to 1992. To maintain the prospective design of our study, we used the 1986 baseline questionnaire for the assessment of several variables such as self reported physical activity, as this provides the only strictly prospective data for all cases. It is worth mentioning that the HPFS assessed many medical conditions in addition to heart disease and cancer (please refer to the study population in the method section). In prospective studies, the relevant exposures may or may not have occurred at the beginning of the study but the outcomes have not yet occurred,¹ which was the case in our study. While in the retrospective cohort study, however, both the exposures and the outcomes of interest have already occurred when the study began.¹ Although this difference in design is very basic, it is unfortunate that such a distinction is not always appreciated.

Biased recall of physical activity was unlikely because the physical activity data were collected before the diagnosis of symptomatic diverticular disease, and we controlled for several potential risk factors such as age, dietary fibre, and other dietary and non-dietary factors. Most of these aspects were not considered in previous case control studies of diverticular disease, which therefore limited

their interpretation. We have doubts that a 'better' and practical design to study diverticular disease is as Dr Heaton once suggested 'provided the ethical problem of radiographing normal people can be overcome, we need a large survey of the general population for diverticulosis and colon spastic symptoms so that diet histories can be obtained from groups of people with neither disorder, with each disorder on its own and with both disorders. It would be a formidable undertaking, but without it doubts will remain.'² As this would not be a prospective study, the recall of past diet would be subject to reporting bias.

Drs Thompson and Heaton are again suggesting that diverticular disease may be an asymptomatic condition, and that the symptomatic presentation is due to existing irritable bowel syndrome (IBS). Strong evidence exists that the two conditions are separate entities sharing a common presentation, which is abdominal pain. We have discussed some of the evidence and emphasised in our article that as both conditions are common, some overlap between them might exist (please see the discussion section). The prevailing understanding, however, is that diverticula can cause symptoms, which vary from a mild left quadrant pain to severe abdominal pain, and in extreme cases perforation or bleeding. Painter has suggested that because of the abnormal motility of the colonic muscle and the pain it is associated with, diverticular disease may cause symptoms whether or not diverticula are inflamed.³ Moreover, it was shown that intraluminal pressure was significantly higher in diverticular disease patients than controls, unlike patients with IBS, who had lower pressure than controls.⁴ High intracolonic pressure is necessary for the formation of the diverticula, and with the excessive segmentation leads to intermittent colonic obstruction, which may produce pain.³ Finally, it is worth mentioning that even among the limited number of diverticular disease cases in our study who presented only with bleeding, physical activity was inversely associated with the risk of diverticular disease (RR=0.46 (95% CI 0.14, 1.49)). We would like to think of this article as a 'Diverticular Contribution' and not a 'Distraction'.

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BOOK REVIEWS

Diagnosis and Management of Liver Disease. Edited by R Kirsch, S Robson, C Trey. (Pp 327; illustrated; £29.95). London: Chapman & Hill, 1995. ISBN 0-412-57570-1.

There are quite a few books on liver disease, but this medium size (327 pages) one takes an interesting approach in that each chapter is written by a member of a research unit in South Africa and then international experts were invited to complete each chapter. The result is a readable, authoritative, and clear book with a good mixture of pathophysiology and disease plus two useful chapters on immunology and molecular biology for the practising doctor. There is some transatlantic spelling.

I think the main weakness of the book, apart from too many scattered typing errors, is that some conditions that can be important to the gastroenterologist are only mentioned, including Wilson's disease, diabetes mellitus, methotrexate induced liver disease, post-operative jaundice, extracorporeal shockwave lithotripsy and endoscopic lithotripsy, Gilbert's syndrome and benign recurrent cholestasis. There is also no description of the lobule and acinus, which are important in an understanding of the function and anatomy of the liver, while there were rather obscure words such as scissura and incisura, when describing the surgical anatomy of the liver and photoferic, referring to a red cell scan. There was also confusion between aminotransferase and transaminase, even on the same page. I suspect these are errors of editing and no doubt the gaps can be filled in in the next edition.

I would have welcomed more diagrams and tables, while some of the scans reproduce poorly. Two radiographs of biliary ascariis are no doubt prize exhibits in a slide collection but seem excessive!

In general, I therefore recommend it as a useful textbook of liver disease, although clearly a larger textbook would be required for deeper reading and reference lists.

The authors have apparently donated their royalties to charity but, despite that, it seems rather expensive at close on £30 for a soft back.

Perhaps this illustrates how little the financial rewards given by publishers to their authors contribute to the overall cost of books.

R P H THOMPSON

Paediatric Gastroenterology. Edited by B S Kirschner, J A Walker-Smith. (Pp 228; illustrated; £27.50). London: Bailliere Tindall, 1994. ISBN 0-7020-1866-X.

The number of publications catering for the postgraduate medical education (that is, training after qualification) and continuing medical education (that is, keeping yourself up to date after being fully trained) market continues to increase. These publications divide into those that present brief highlights of the recent literature, and those that present an in depth review of key topics in the field. Ideally those for the postgraduate medical education market need to consider topics that will probably appear in examinations and those for the continuing medical education market need to consider topics of interest to the generalist in the specialty. It would be interesting to know if the current interest in documenting (in the form of credits) the uptake of continuing medical education has led to an increase in the number of people reading these publications, to no change, or indeed to a decrease (how much you read is not counted in the credit tally).

The first volume of this series appeared two years ago. It fits into the 'in depth review of



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