Letters

Our recent paper1 focused primarily on describing the histological features of micro- 
cancer syndromes in our first six well-defined cases. We have previously, however, 
studied different aetiological aspects in both lymphocytic and collagenous colitis.2 The 
importance of factor(s) in the faecal stream is considered by some authors.3

1 Lindström CG. 'Colaginous colitis' with watery diarrhoea. A new entity? Pathol Eur 1976; 11: 


5 Einarsson K, Eusufzai S, Johansson U, Löfberg R, Theodorsson E, Veress B. Villous atrophy of 

6 Eusufzai S, Löfberg R, Veress B, Einarsson K, Ansell BM. Increased bile acid malabsorption 

7 Ridsel BH, Tanaka M, Mazzoleni G. Non-steroidal anti-inflammatory drugs as a possible 

Helicobacter pylori reinfection

EDITOR.—We read with interest the article by Schütze et al (Gut 1995; 36: 831–3). It is 
difficult to understand that transmission of reinfection has been shown to occur 
for the first time with near certainty.3,4 Besides transmission from the spouse, there are at least three possibilities of reinfection of the patient in the home.5 Moreover, H pylori has been demon-
strated in the dental plaque of patients from developed1 and developing6 countries. 
Furthermore, H pylori in the dental plaque persists despite its clearance from the gastric mucosa after treatment.7 Hence, dental plaque is considered a potential source of reinfection by the same strain of H pylori.8 (2) It is possible that both the patient and the spouse had acquired infection of the same strain of H pylori from a common source. Contaminated water supply has been previously shown to act as common reservoir of infection.9 The fact that the prevalence of serum antibodies to H pylori and hepatitis A virus is familial spread from another member of the family has been reported.10 The study does not provide any data of other family members or the exact mode of transmission (kissing?) from the spouse.

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Reply

.Editor.—In our publication an autoreinfection was discussed as a possibility but simultaneously considered as highly unlikely as the reintroduction occurred as late as after 14 and 43 months, respectively. The possibility of a common exogenous source cannot be ruled out but it seems rather unlikely and has also been discussed in our publication. In our study the possibility of a contaminated water supply is extremely unlikely as water supplies in Vienna originate from Alpine sources and are renowned for their excellent quality. The patients studied in our project were married couples without any other family members.

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2 Ewing DJ, Winny R. Autonomic function in patients with renal failure on intermittent 


4 Bolondi L, Bortolotti M, Santi V, Calletti T, Giuani S, Labo G. Measurement of 


5 Wedemann B, Schaeffer J, Wegener M, Schmidt G, Coenen C, Rücker D. Sonographic 


Reply

.Editor.—The study performed by Dr D L Dumitrascu et al is indeed relevant to our 
article, which describes highly variable gastric emptying in patients with diabetes mellitus, and we appreciate his comments. Our study showed that some diabetic patients have rapid gastric emptying, some have a normal rate of gastric emptying, whereas others have delayed gastric emptying which is appreciated to be delayed gastric emptying — that is, ‘diabetic gastroparesis.’ The precise mechanism responsible for the variability in gastric emptying in diabetic patients is unknown although autonomic neuropathy has been incriminated. In our study nearly all of the patients showed evidence of parasympathetic autonomic neuropathy evidenced by an abnormal respiratory variation in heart rate (as a percentage of the duration of diabetes was significantly cor-

rected, implying that a longer duration of diabetes is associated with a slower rate of gastric emptying. Our findings lead us to speculate that short-term diabetes mellitus is

437: 23–9) reports on the highly variable gastric emptying rates in patients with dia-
betes mellitus. The finding of accelerated (apart from the classic delayed) gastric emptying in humans with insulin dependent dia-
betes mellitus is consistent with previous findings.1 The authors investigated the possible correlation between gastric emptying and chronic renal failure caused by diabetes. As the values obtained in this study have a very wide distribution, it was concluded that the influence of chronic renal failure on gastric emptying cannot be estimated from their own results. However, chronic renal failure is associated with autonomic neuropathy, which was the main reason that had autonomic neuropathy and diabetes mellitus, evidenced by orthostatic hypotension, showed a signifi-
cantly longer half time of gastric emptying than non-diabetic control subjects. Likewise, those patients who did not have evidence of sympathetic autonomic neuropathy showed a significantly faster gastric emptying half time (accelerated gastric emptying) than non-diabetic controls. Finally, our study showed that the duration of diabetes was significantly corre-
lated with the gastric emptying shape coefficient, implying that a longer duration of diabetes is associated with a slower rate of gastric emptying. Our findings lead us to speculate that short-term diabetes mellitus is
Gastric emptying in patients with insulin dependent diabetes mellitus.

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