study, necroses were performed on 604 adult blacks from southern Africa and one of five grades of hepatic and splenic iron was assigned based on the Prussian blue reaction obtained when a piece of tissue was dipped in a mixture of potassium ferrocyanide and hydrochloric acid.1 Using logistic regression models, we found that iron overload was strongly associated with the findings of cirrhosis (p<0.001), HCC (p<0.001), and tuberculosis (p<0.001).2 Secondly, we reviewed all 320 diagnostic liver biopsy specimens processed at the University of Zimbabwe from 1992 to 1994. HCC was present in 19% of the evaluable specimens, cirrhosis in 21%, and high grades of iron in 19%. We found significant associations between the presence of iron overload and the histological diagnoses of cirrhosis and HCC.

We do not completely share the pessimism of Drs Walker and Segal with regard to changing the method of preparation of traditional beer and to instituting a phlebotomy programme. The iron drums that are now used to prepare beer have replaced clay pots around the turn of the century, but these clay utensils are still used in most rural communities to prepare food and other forms of beverages. It seems feasible to us to encourage the use of the clay pots for the preparation of traditional beer in place of the newer and more convenient, but probably more dangerous, iron drums. For the past two years our research team has been working with a rural based traditional dietary iron overload. We have been struck by the overwhelming level of cooperation that we have been able to obtain through close and regular contact with the rural communities. Despite the need for venenation and heightened awareness of the problem of HIV, it has been unusual for subjects to refuse to take part.

In summary, we believe the available data point to both HCC and dietary iron overload as major health problems in rural Africa. There is a strong body of evidence to suggest an association between the two conditions. Major initiatives are needed to combat these diseases beginning in the communities where the problem is most widespread.

Analysis of biological variables in Crohn’s disease

EDITOR,—We wish to comment on the paper by Sahmoud et al (Gut 1995; 37: 811–8) where the authors suggested the following features: duration of disease, interval since previous relapse, and colonic involvement as powerful prognostic factors to predict relapse in quiescent Crohn’s disease. We also followed up for 18 months 107 patients with quiescent Crohn’s disease in a single institution1 and we used laboratory tests enhanced by clinical characteristics for predicting relapse.

Interestingly, our results about clinical characteristics were, for some aspects, similar to those of Sahmoud et al. A dose obtained by the Cox regression analysis indicated interval since previous relapse, previous surgery, location (ileum versus non-ileum), and occurrence of post-surgical clinical recurrences as predictors of relapse; however an intercorrelation was found among these characteristics and particularly between previous surgery and location (but simultaneous Cox regression indicated that the risk would be more pronounced when location was ileum). Thus two groups of risk of relapse according to clinical characteristics were defined: (a) favourable group consisted of patients in clinical remission after last relapse for at least 12 months or patients with less than 24 months but who had undergone surgery without subsequent post surgical clinical recurrence; (b) unfavourable group consisted of patients in clinical remission for less than 24 months or not included in the previous group.

In the French study surgery was not identified as a prognostic factor; this could be explained because in that study quiescent disease induced by surgery seems to be excluded and ileal location (our reason as the other previous resection) is present in a small number of patients in comparison with colonic location. In our experience duration of illness was not a useful predictor of relapse; we did not study age of duration.

In the study by Sahmoud et al biological indicators such as albumin and erythrocyte sedimentation rate did not result in predicting the course of the disease; in contrast, in our experience, laboratory tests seem to be extremely useful for this aim. In a previous study2 a prognostic index based on laboratory tests was proposed. In our last study3 the ability of this index to predict relapse was validated and a simplified application was proposed; patients with at least one of the laboratory tests changed (α1 acid glycoprotein >130 mg/dl, or α2 globulin >9.0 g/nl or erythrocyte sedimentation rate >40 mm/h, or all three) presented within 18 months a relapse rate of 75% whereas in patients with normal tests it was 13%. In our study nine among 18 false-negative (normal laboratory tests with subsequent relapse) were presented by patients with previous remission <3 months who had recently stopped corticosteroid treatment. Usually, however, values of laboratory tests are rapidly normalised by a period of corticosteroid treatment and it is shown4 that these tests, performed during or immediately after corticosteroids have poor ability in discriminating the clinical outcome. In our opinion, laboratory tests could be used to show a prognostic ability of sedation rate and albumin because at least 64 patients among 167 included were treated with corticosteroids at the entry of the study (placebo group of the trial about subcutaneous dexamethasone). For us, it is necessary to show a prognostic ability of sedation rate and albumin in patients with previous remission treatment in clinical remission after prednisolone treatment for an acute attack.

We agree, however, with Sahmoud’s conclusion about the necessity of identifying patients with different risks of relapse in quiescent Crohn’s disease. In our study, at the end of 18 months of follow up, the predicted proportion of patients with relapse was 13% and 31% in the subgroup with normal laboratory tests and favourable and unfavourable clinical characteristics respectively, and 87% in patients with abnormal tests and unfavourable clinical characteristics. Thus risk of relapse varies substantially among different subgroups of patients with clinical remission; prediction of this risk is helpful not only for a correct design of clinical trials, but also, in clinical practice, for timing subsequent clinical visits and for selecting groups of patients where preventive treatment could be justified.


Reply

EDITOR,—Thank you for referring the interesting comments of Brignola et al to us concerning our article. The Italian group has considerable experience in investigating the value of biological parameters in Crohn’s disease and has published several research results in that field. One of their most recent publications1 suggests a prognostic index for predicting relapse in quiescent Crohn’s disease patients using the baseline blood values of α1, γ globulin, α2 globulin, and erythrocyte sedimentation rate. This index was based on data from 41 patients who had been in remission for at least six months. The same study suggested that the blood values of C-reactive protein and α1 antitrypsin were of no predictive value. The predictive value of some of other biological variables were much less important, namely the haemoglobin concentration, the white blood cell count, serum iron, albumin, and γ globulin blood values.
Analysis of biological variables in Crohn's disease.

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