tion for both radiologist and gastroenterologist, as well as providing a prompt service with appropriate quality.

In my heart I know that the comments by Dr West and Dr Vallance are well-argued. However, it must be acknowledged that the potential difficulties and drawbacks that may result from ultrasound examinations being undertaken by practitioners other than skilled trained radiologists. In my head, however, I do not accept that there are other arguments that must be resolved. Some gastroenterologists and indeed clinicians in other specialities, do genuinely wish to provide an ultrasound service and this wish has been given validity by the declaration of the European Board of Gastroenterology that ultrasound should be part of the training programme for gastroenterologists. Neither radiologists individually nor collectively through their Royal College, are in a position to prevent non-radiologists from using ultrasound for diagnosis and therefore we find ourselves in a position in which we can adopt one of three responses.

Radiologists can ignore the needs of non-radiologists to train in ultrasound and decline to be involved in such training. In doing this we will deny to non-radiologists an understanding of our own skills, which contribute to the quality of diagnosis, and we may thus contribute to the poor quality non-radiological service which we fear.

Radiologists may believe that because non-radiological ultrasound training is in vogue, that we should simply keep our heads down for a while in the hope that the fashion will pass, but again we risk the development of a second rate service without our contribution.

Thirdly, we could permit our non-radiologist colleagues access to our skills. Of course we do this already by providing a service for them and their patients, but we should extend this to the provision of training, so that the service which non-radiologists provide is of sufficient standard to fulfil radiologists' definition of quality. Additionally the links forged between radiologist and non-radiologist during training should contribute to more open communication, which must be to the ultimate benefit of our patients.

I believe that the responsible and logical reaction of radiologists to the wishes of some non-radiologists to train in ultrasound, is to provide them with sensible achievable guidelines for training so that radiologist and non-radiologist can work together to provide what the patient needs, a rapid ultrasound service of appropriate quality.

significant reduction in water and electrolyte secretion and slows small intestinal transit.1

The high output of jejunal fluid post-prandially is therefore likely to be due to a combination of increased gastric emptying, decreased small intestinal fluid absorption, and increased small bowel motility. The development of orally active peptide YY agonists and antagonists will provide further insight into the physiological role of this peptide and could provide a novel approach to the water and electrolyte disturbances associated with high ileostomy outputs. Physiological concentrations of peptide YY do, however, cause significant increase in sodium excretion by the kidney and the relative benefits of electrolyte conservation by the intestine might be counterbalanced by the increased electrolyte lost by the kidney.2

Peptide YY and electrolyte homeostasis

EDITOR,—We wish to comment on the article by Nighsheard and coworkers on the possible importance of peptide YY as the mediator of the colonic brake to gastric emptying (Gut 1996; 39: 267–72). Their studies suggest that the lower concentrations of peptide YY seen in patients without a colon are associated with an increased rate of gastric emptying. This may well contribute to the increased jejuno-stomy output seen in these patients. We have previously shown in humans that peptide YY in volunteers with jejuno-stomies (infused at physiological postprandial values) causes

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