LETTERS TO THE EDITOR

Soluble TNF receptors as prognostic factors for mortality

EDITOR,—We read with interest the paper by Bennetts et al (Gut 1996; 38: 226–30) describing their investigations of systemic tumour necrosis factor (TNF) and soluble TNF receptor (sTNFr) concentrations in mice with biliary obstruction. Endotoxaemia has been demonstrated frequently in both clinical and experimental biliary obstruction. It is probably responsible for much of the morbidity and mortality seen in jaundiced patients1 and exerts these effects by stimulating for TNF for antibody, TNF. We have previously reported increased TNF secretion by Kupffer cells2 and peritoneal macrophages3 in jaundiced rats, and Pun-
tis and Jiang have described increased TNF secretion from stimulated peripheral TNF monocytes in jaundiced patients.4 Soluble TNF receptors are released during Gram neg- ative sepsis and in response to endotoxin and TNF.5 6 The findings of Bennetts and col-
leagues of systemic TNF and sTNF concentrations of both TNF and sTNF in mice with biliary obstruction, support the hypothesis suggesting that TNF is an important mediator in the systemic inflammatory response to endotoxin in the jaundiced animal.

Bemelmans et al found that systemic TNF and sTNF concentrations were increased further following surgical trauma and that only sTNF concentrations correlated with subsequent mortality. These results suggest that the sTNF concentration may be a better indicator of ongoing inflammation and a more accurate predictor of outcome than TNF. In patients with inflammatory bowel disease1 and acute pancreatitis,8 plasma sTNF con-
centrations correlate better with disease activ-
ity than measurements of TNF. Soluble TNF receptor concentrations were increased in patients with inflammatory bowel disease and sepsis patients.9 10 Beaux et al, Goldberg, Ross, Fearon, Kuch, Fanger,9 11 Saran soluble tumour necrosis factor receptor concentrations are associated with disease severity in acute pancreatitis. Br J Surg 1996; 83: 687.

Kihara IC, Roux-Lombard P, Dayer JM, Pan-
ayi GS. Tumor necrosis factor soluble recep-


Reply

EDITOR,—We thank Dr Parks and colleagues for their interesting comments on our article on TNF and sTNFr in obstruction. We agree that sTNF concentrations are better indicators of the inflammatory response than TNF in several diseases such as pancreatitis and Crohn's disease. Nevertheless, more information on TNF and its release and function could also offer new insights and possibly more strategies for treating patients.

Concerning their question on sTNFr concen-
trations 24 hours after induction of renal ischaemia, we can report that there was a tendency towards lower sTNF concentrations in all surviving mice after 24 hours, although these concentrations were still relatively high. The kinetics of the sTNF concentrations differed significantly from the endotoxin induced sTNF increase, where peak levels of sTNF–P55 were found at 30 min and peak levels of sTNF–P75 four to eight hours after LPS injection.7 There was a further significant decline in sTNF concentrations in the TN3 group as suggested by Dr Parks, although one has to state that the number of mice in all groups was too small to draw definite conclusions. Additional experiments with more mice which will be followed over a longer time interval after induction of renal ischaemia will be necessary to answer their questions completely.

Finally, we agree with their concluding remark on the importance of further research in obstructive jaundice and the cytokine cascade in this disease.

Helicobacter pylori and ulcer healing

EDITOR,—Bianchi Porro et al (Gut 1996; 39: 22–6) conclude that eradication of Helico-
bacter pylori does not confer any significant advantage on the healing of gastric and duodenal ulcers associated with long term use of non-steroidal anti-inflammatory drugs (NSAIDs). It is questionable, however, whether they have truly shown this in their study.

In the study, H pylori positive patients with NSAID related peptic ulcers were ran-
donized to treatment with either omeprazole plus amoxicillin or omeprazole alone. Although it is not stated, it might be assumed that characteristics such as sex, age, smoking status, and dose and nature of the NSAID ingested were similar in both treatment groups. Of the 36 subjects who received ome-
prazole and amoxicillin, only 20 (56%) were cleared of H pylori infection. Comparing the healing rates in only these 20 subjects with the rates in those where H pylori persisted defeats the purpose of the original randomisation and raises the possibility that confounding factors explain the failure to observe a difference in healing rates.

Analysing the results on an intention to treat basis would allow a conclusion to be made as to whether H pylori positive subjects with omeprazole and amoxicillin is associated with a difference in ulcer healing rate. An intention to treat analy-
sis would not, however, permit a conclusion to be made regarding the effect of H pylori eradication given that eradication was only successful in 56% of patients. Similarly, the analyses of ulcer recurrence rates need to be interpreted with caution given that it is unclear whether the groups involved were matched for confounding factors, such as those listed above, which have been re-
ported to be risk factors for NSAID related peptic ulcer disease.1 2


B W GROVE
M BEEMELMANS
B A BUIRMAN
Department of Surgery,
Academic Hospital Maastricht,
Maastricht, The Netherlands

D J GOMUA
Department of Surgery,
Academic Medical Centre,
Amsterdam, The Netherlands

1 M BEEMELMANS
Department of Surgery,
De Weer Ziekenhuis, Haren,
PO Box 84400, 4401 CX Heeren,
The Netherlands
DAMIAN DOWLING
Department of Gastroenterology,
The Royal Melbourne Hospital,
Parkville 3050,
Victoria, Australia


EDITORS,—We are grateful for Dr McCutcheon's comments and while it is possible that endoscopic papillotomy may increase the risk of developing pancreatitis the fact remains that none of our 10 patients have suffered pancreatitis or ascending cholangitis after papillotomy (25 months follow up to date). In reply, we feel two points should be made. Firstly, the closed duodenal loop method described is not comparable with our patients' situation as there was no distal obstruction and hence no cause for reflux of duodenal contents through the damaged papilla of Vater. Secondly, while the common or external sphincter are excised at papillotomy both internal sphincters (biliary and pancreatic) are preserved hence serving as a natural barrier to reflux of duodenal contents. Finally, we would only recommend endoscopic papillotomy as a means of aiding cannulation in limited circumstances such as a large obstructive ampullary tumour, or an ectopic ampulla with an ectopic orifice or low bile duct stones.

ENDOSCOPIC PAPILLOTOMY

EDITORS,—I read the recent article on endoscopic papillotomy by Dr Farrell et al (Gut 1996; 39; 36-8) with considerable interest because of a simple experiment done in 1964, which indicates that papillotomy might be hazardous.1 The closed duodenal loop model of haemorrhagic necrotic pancreatitis closely resembles severe human pancreatitis and is caused by the reflux of duodenal contents through the papilla of Vater;2 it was suggested that pancreatitis could be produced by much smaller intraduodenal pressures provided that the papilla of Vater was damaged of incompetence.

The duodenal papilla in humans and in dogs is lined by mucosal folds or 'valvules', which serve to prevent regurgitation of duodenal contents.3 The isolated dog duodenum was filled with coloured saline maintained at a pressure of 30 mm Hg without any fluid escaping from the cut ends of the pancreatic ducts or common bile duct. A simple mucosal papillotomy was performed at the main pancreatic duct. A duodenotomy incision was closed, and the intraduodenal pressure raised again to 30 mm Hg. Within two minutes coloured saline oozed from the main pancreatic duct but not from the separate lesser pancreatic duct or the common bile duct. When the common bile duct papilla was also excised saline escaped from the common bile duct.1 The histological picture of the papilla, before and after excision (photographed), plus the findings above suggest that: (1) the mucosal portion of the papilla of Vater serves a useful purpose in preventing duodenal reflux; (2) papillotomy may increase the risk of developing pancreatitis, depending on the nature of the underlying pathology for which papillotomy was performed.

R J Farrell
P W N Keeling
Department of Gastroenterology,
St James's Hospital, Dublin 8, Ireland

BOOK REVIEWS


A review of the second edition of this book published in 1995 was only requested in late 1996 (accompanied by an invoice marked ‘rush’!) which explains the interval between publication and this review.

I was brought up on Gray's Anatomy to achieve adulthood around the dining table. A wide selection of two volume books on gastroenterology could now do this job admirably.

This remarkable book has more than 200 contributors, mostly North American with a smattering of other contributors from seven different countries. Its approach is so different that comparison with other textbooks of gastroenterology is inappropriate. No other book could find the reviewer at the end of volume one, some 67 chapters and 1500 pages later, still not yet through the pylorus. This is not an obsession with the oesophagus and stomach, but extensive consideration of basic mechanisms relevant to clinical problems (26 chapters) and, more importantly, an extended section of similar length concerned with approaches to the symptomatic patient. This section is particularly relevant for the younger postgraduate whose patients in real life present with a constellation of symptoms rather than a specific diagnosis. This focused approach is both a strength and a weakness as...
Helicobacter pylori and ulcer healing.

D Dowling

Gut 1997 40: 560-561
doi: 10.1136/gut.40.4.560-b

Updated information and services can be found at:
http://gut.bmj.com/content/40/4/560.3.citation

These include:
Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/