Liver biopsy under ultrasound control

Editor,—I read the recent occasional viewpoint by Shah et al (Gut 1999;45:628–629) with much interest. The authors describe their regional practice of mandatory real-time ultrasound guidance for percutaneous liver biopsy in all cases of suspected diffuse liver disease. However, the published literature does not convincingly support the universal adoption of such a policy.

The only recent prospective study cited in support of their protocol, by Lindor and colleagues, is open to a number of methodological criticisms. In particular, in an unspecified proportion of the patients randomised to ultrasound guidance, the procedure was not actually performed under direct guidance and was instead immediately preceded by a “biopsy room” ultrasound scan. The net result of this may have been to selectively raise the pre-biopsy scanning rates in the “ultrasound” cohort who were already more likely to have been previously scanned than the “blind” patients (76–78% vs 67–68% in the respective groups).

In terms of the reduction in post-biopsy complications claimed by Lindor et al, the major impact was a reduction in hospitalisation due to pain. There was no statistically significant difference in the rates of bleeding or hypotension. The reduction in pain, in a non-blinded study, could have been due to several factors such as the patients’ perceptions of a “safer” guided scan or the potential for the physicians to more readily hospitalise patients with abdominal pain in the “blind” group.

This is considerable published data available regarding the safety of percutaneous liver biopsy without real-time ultrasound guidance. Indeed, the British Society of Gastroenterology’s recent guidelines do not advocate changing from the practice of liver biopsy under imaging control which will be part of the routine investigation of most patients with suspected hepatic disorders anyway) to biopsies performed exclusively by radiologists under imaging control and is difficult to see how adopting such a policy nationally could be justified.

Finally, I would urge that too much gravity is placed on the cited abstract regarding a survey in which 75% of British gastroenterology trainees requested formal training in ultrasound. The performance of sufficient procedures to be certified competent in this radiological procedure and to remain so throughout a lifetime of clinical practice would have enormous ramifications for the workload of gastroenterology units in this country. I personally suspect that most specialist registrars would ask for training in how to ride a unicycle if they thought it might make them more marketable to potential employers.

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Informed consent

Editor,—The phrase “informed consent” falls so readily from the pen that it is easy to forget that two distinct processes are involved: firstly, providing appropriate information and then obtaining consent from the patient. In attempting to combine these two steps, Shepherd and colleagues (Gut 2000;46:37–39) remove some of the patients’ essential safeguards. As Neale (Gut 2000;46:5–6) points out in his gentle and thoughtful comment, “written information . . . is undoubtedly useful but it does not replace the over-riding need for doctors to speak with their patients . . .”

Neither the paper nor the commentary cite the GMC advice although they are quoted extensively in the British Society of Gastroenterology guideline on informed consent for endoscopy procedures. Particularly relevant is this: “obtaining informed consent cannot be an isolated event. It involves a continuing dialogue between you and your patients . . . you should give . . . the patient time to ask questions”.

However carefully prepared, a booklet cannot be appropriate for every patient and every circumstance. Pressing patients to “sign consent” in advance of meeting any endoscopy staff is to deprive them of the opportunity to ask questions or seek reassurance. “If you are the doctor . . . undertaking an investigation it is your responsibility to discuss it with the patient . . .” although the job may be delegated to an appropriate person.

Giving information by post is desirable: requesting signed consent by that route is not.

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EDITOR,—Shepherd and colleagues (Gut 2000;46:37–39) offer a timely and thoughtful contribution to the increasingly loud debate throughout the country agree with our authorship has had, many other colleagues problem and that, judging by the response the correspondence regarding “informed consent” may not to sign the consent form at home; they have the option of informing consent lies with the patient who has any doubt or concern not to satisfy NHS guidelines for obtaining informed consent lies with the endoscopist who is to perform the procedure...” But as the GMC concedes, “Where this is not practicable you may delegate (this responsibility)... to a person whom you consider is trained and qualified; has sufficient kno...edge...and understands the risks...”

The difficulty with open access endoscopy lies with the shared responsibility. The GP has assessed the patient and usually remains responsible for obtaining informed consent. As Dr Bruce points out in his very supportive commentary, we think misses the point happens during the patient’s consultation with the general practitioner. It was foreseen many years ago that once an open access endoscopy service was made available it would become a high volume service, which can leave both endoscopists and patients vulnerable. Protocols for endoscopy have been in patient selection but they are not always available. We think it must be regarded as a minimum standard of care that the consent obtained for these procedures is as informed as it can possibly be made, within the practicalities surrounding the delivery of service. Furthermore, we suggest that this booklet is the first to openly address this problem and that, judging by the response the authorship has had, many other colleagues throughout the country agree with our approach.

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Increased prevalence of methylenetetrahydrofolate reductase C677T variant in patients with IBD

EDITOR,—We read with interest the paper by Mahmud et al (Gut 1999;45:389–394). The study showed an increased prevalence of methylenetetrahydrofolate reductase (MTHFR) C677T variant in patients with inflammatory bowel disease (IBD). The C677T polymorphism is a known genetic cause of mild hyperhomocysteinaemia (hyper-Hcy) and may be associated with a variable degree of risk for thromboembolic disease in patients with IBD.

To confirm a higher prevalence of the C677T polymorphism, we investigated 99 patients with established IBD for this polymorphism compared with 1084 unselected newborns. DNA samples were genotyped for the MTHFR (C677T) mutation. Patients were categorised as homozygous for the thermolabile variant (TT), heterozygous for the wild-type variant (CT), or homozygous for the wild-type (CC).

Difference in prevalence between IBD patients and controls was compared using the χ² test. Differences in onset of disease between patients with Crohn’s disease (CD)
and those with ulcerative colitis (UC) were compared using the Mann-Whitney test. A total of 16.2% (16/99) of IBD patients were homozygous for the C677T variant compared with 8.3% (90/1084) in the control group. This difference was statistically significant (p=0.009). When patients were stratified according to CD and UC, we found that homozygosity for the MTHFR C677T variant (TT) was present in 14.0% (7/50) of patients with CD and 18.4% (9/49) of those with UC. Both results were independently significantly higher than in the background population.

Onset of disease in carriers of the (TT) variant in CD and UC was 33.8 and 40.6, respectively, compared with 34.4 and 43.3 in non-carriers. This difference was not statistically significant. There was no correlation between disease activity indices of the IBD patients (Crohn’s disease activity index for CD and clinic activity index for UC) and carriers of the (TT) variants. Also, C reactive protein levels in IBD patients was independent of MTHFR gene prevalence.

Genome-wide linkage screen of a large population of IBD patients found evidence of linkage of IBD to the short arm of chromosome 1 in all families investigated. It is interesting that the MTHFR gene is located on chromosome 1 (1p36.3). Additional loci on chromosomes 3, 7, and 16 are linked to IBD. The genetic basis of IBD is non-mendelian in nature and very complex. Unrecognised factors may therefore be important in the aetiology of IBD. Further investigation of other factors is being carried out in our laboratory at present.

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Reply

Editor,—Thank you for the opportunity to comment on the letter of Dr Nielsen and colleagues. We are pleased that their data have confirmed our findings, as previously reported (Gut 1999;43:389–94). We agree with their comment that the genetic basis of inflammatory bowel disease (IBD) is very complex. One point needs to be emphasised, namely that serum homocysteine levels were increased in our patients compared with controls, even when those patients who were homozygous for C677T polymorphism were excluded. This elevated level was present even when the effect of folate deficiency was excluded. This suggests that other polymorphisms as yet undiscovered may be present in one or other of the three enzymes responsible for removal of homocysteine in internal metabolism, namely methylenetetrahydrofolate reductase, methionine synthase, and cystathionine synthase. Accordingly, it is important to conclude that all patients with IBD should receive regular therapy with 400 µg of folic acid daily.
management and then the “meat” of the chapter reviews therapeutic options for ulcerative colitis and Crohn’s disease. The approaches to treatment in North America and in Europe were remarkably similar. International journals and meetings have narrowed the Atlantic Ocean to a trickle.

The chapter on non-vascular GI bleeding by Lichtenstein also provides remarkably consistent intercontinental advice, which is practical and appropriate and wherever possible evidence based. The detail is remarkable—for example, he has researched the history of iced saline lavage and concludes that water at room temperature is perfectly acceptable!

I particularly liked the section on therapeutic endoscopy, which is a model of clarity and brevity.

Whichever chapter is selected, the information is consistent, reliable, and well researched. The chapter by Nicholas La Russo on primary sclerosing cholangitis opens with an excellent and brief review of the genetics, pathogenesis, clinical features, diagnosis, and natural history, and then considers potential therapy of cupreusis, immunosuppressant agents, antifibrogenesis, cholestatic agents, surgery, and transplantation.

Even in complex areas such as the contribution by John Del Val, concerned with the treatment of neuro endocrine tumours, for each specific syndrome there is a crisp, clear summary of recommended treatment.

In summary, this is a remarkable, formidable achievement with consistent structure and advice, which is reliable and well based. Inevitably for a book of this size, the turnaround time results in the latest references by John Del Val, concerned with the treatment of neuro endocrine tumours, for each specific syndrome there is a crisp, clear summary of recommended treatment.

What of the next edition? This would be an ideal CD-ROM based book with regular updating. Many of the older references could be stripped out to make way for the new, and if we are still buying textbooks then layout and presentation will need improvement.

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R N ALLAN


Kurt Isselbacher’s foreword to this volume indicates that it was not written for the medical specialist, but rather for the family practitioner and general internist. True, this is not YAMADA. Nevertheless, despite being unreferenced and weighing in at only one quarter of the size of this gold standard text, I believe he is appropriately modest on behalf of the editors and authors. Although a specialist readership may not have been the primary target, those involved in the daily care of alimentary tract and hepatic diseases will find this book an invaluable addition to the departmental shelves.

The format is that now commonly adopted for digestive disease textbooks—that is, an initial section dealing with presenting clinical features followed by organ based accounts of specific diseases and syndromes. The final chapters are more broadly based, covering systemic aspects of drug therapy, and nutritional support. The emphasis is on presenting the current aetiopathogenetic concepts of hepatic, pancreatic, and gastrointestinal diseases and their management, whilst historical and epidemiological perspectives are dealt with more briefly.

The editorship is in the hands of five very eminent continental Europeans, and only 15 of the 103 authors are from the British Isles. Euro sceptics might be concerned that with a list of authors a priori prepared Chelsea team sheet, the resulting product might be an uncomfortable read with limited relevance to British practice. Nothing could be further from the truth. The text flows easily, which is a great credit to those authors not writing in their first language. The chapters have a remarkable uniformity of structure, perhaps not surprisingly as this can be readily imposed by the editors, but also of quality, which is predictable in light of the distinguished authorship, and of style. The last of these can have been achieved only by diligent editorial skills, and, I suspect, extensive rewriting. Although the authors are predominantly European, the spelling and approved drug names are from the opposite side of the Atlantic—a concession one assumes to the major potential market.

Mercifully, guidelines and patient care pathways are not favoured, whilst algorithms are sparingly dispersed. By contrast, the text is regularly punctuated with summarising tables and figures. These will be of particular interest to junior doctors preparing for their Power Point presentations. Hard pressed consultants will be no less enthusiastic, as the book provides a resource for rapid but comprehensive “revision” prior to a training session with the junior staff.

The chapters covering large bowel polyps and colorectal cancer will be of special value and interest to non-surgeons who have failed to keep abreast of the last decade’s developments in the classification and management of these tumours. Recommendations for endoscopic surveillance are discussed, though the authors admit that not all of these are fully supported by adequate evidence yet.

Similarly, non-specialists requiring a review of liver transplantation and its place in the final year of the millennium, will be grateful to Ringe and his colleagues for their adroit contribution. The account of ulcerative colitis is a medicosurgical collaboration, which is a feature of many chapters. Medical therapeutic options are fully discussed, but one gains the impression there may be a lower threshold for elective surgery in German centres than in the United Kingdom. This, however, is a rare example of the possible divergence between British and continental practice. Neville and Axon offer a balanced account of non-ulcer dyspepsia, but, regrettably, the editors have not taken the opportunity of giving this confusing terminology the red card. My men of the match are the Oxford trio for their chapter covering Crohn’s disease. I doubt there is a better succinct account currently in print.

A minor criticism is the rarity of speculation about future developments. It surely would have been timely to have made a few forays into the new millennium.

Although this book may not be in the champions’ league class, it is a thoroughly premiership performance by a team that consistently has its eye on the ball.

M J LANCASTER SMITH


The last dinosaur disappeared from Earth over 66 million years ago, wiped out in some cataclysm that changed the world and its climate for ever.

Mankind gradually evolved, competing in a hostile environment, winning because of brain and hands. Knowledge and writing gave power; mankind strode on, erect, dignified. The pinnacle of hand-eye coordination, thoughtful and wise, stepped forth the surgeon.

Evolution continued, specialising, improving, learning, until from the chrysalis emerged the ultimate epiphany, a colorectal surgeon. Hungry, needing to learn, to understand the background, the proud evolution, the way of the tribe.

How to learn? Vast, illuminated, biblical scroll, or virtual, instant, ephemeral quantum world? Wonderful, musky smell, comforting weight, swishing flick of page, light low, old knowledge enters old eyes, stimulates old satisfaction, reveals new comprehension. But taut skin, restless energy, young ambition seeks flickering screen, a virtual world. A conundrum.

I am old, and thinning; a user of computers, but no bedfellow. At the frontier, I use journals and the library; for reading, smaller books, concise, portable, incisive. However, for reference, to support an opinion, pursue a prejudice, grind an axe, to gainays, then a large, lovingly written, luxuriously arranged book—a book and a half (indeed, two books); beautiful, admired, essential—just such books as these.

But I feel a gulf. I sit on the written side of that gulf, but close by I see a new generation, turning away, evolving further. Will they want such a book? There is no CD-ROM. Will they use other ways?

Although science changes rapidly, society and culture take much longer to adjust. Reading and book owning are as much cultural as they are efficient means of imparting knowledge, pleasantly, savouringly, to be admired also on the shelf. I am confident they will read, they will own books, big books, books such as these books—fascinating, informative, a congratulation, and not the last dinosaur.

ROBIN PHILLIPS
Increased prevalence of methylenetetrahydrofolate reductase C677T variant in patients with IBD

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