Efficacy and strategy of pneumatic dilatation in achalasia

We read with interest the article by Eckardt et al. regarding the long term results of pneumatic dilatation in achalasia.1 A different approach was chosen—that is, treatment consisted of one or more pneumatic dilations under conscious sedation in order to achieve stable clinical remission, defined as persisting one year after treatment. To this end, close follow up was performed in the first year after dilatation (scheduled assessments at three and 12 months). Thereafter, clinical and manometric assessments were performed yearly for six years. The clinical score was according to Eckardt et al. Five patients needed one (30 mm diameter Rigiflex dilator) and six needed two (30 and 35 mm diameter) dilations. No complications occurred. All patients remained in clinical remission and their lower oesophageal sphincter pressure decreased to <10 mm Hg and remained unchanged over time.

There are similarities in the results of the two studies. However, the outcome of our 11 patients was comparable with that of the eight patients of Eckardt et al with a lower oesophageal sphincter pressure of <10 mm Hg who had a remission rate of 75% at six years; and (2) the observation that the six patients in our series who needed a second dilatation all relapsed within one year of the first dilatation agrees with the data by Eckardt et al, showing that most relapses occur within 12 months. However, our dilatations were more successful and, importantly, a second dilatation led to a sustained remission in all patients. We do not know the reasons for this difference but we believe it may be at least partly related to our use of the non-compliant Rigiflex dilator, which is currently considered the best choice, although there are no adequately powered comparisons with the Browne-McHardy dilator in the literature. Similarly to our result, a recent paper has shown very good efficacy of a second dilatation with the Rigiflex dilator in patients who had relapsed. Another possible reason is the use of conscious sedation during the procedure which allowed us to complete all dilatations; Eckardt et al, who used topical anaesthesia only, had to prematurely terminate 17% of the procedures.

In conclusion, our published experience and our current clinical practice, involving treatment and follow up of 10–15 new achalasia patients each year, suggest that performance of one or two dilations until stable clinical results is a valuable strategy, and that pneumatic dilatation under conscious sedation with the Rigiflex dilator is an effective long term treatment in most patients with achalasia.

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Conflict of interest: None declared.

References

Authors’ reply
Penagini and Cantù should be congratulated for the remarkable results they were able to obtain in 11 patients with achalasia treated by pneumatic dilatation. To my knowledge, not a single study has so far produced similar results. A review of prospective studies in patients undergoing pneumatic dilatation with the Rigiflex dilator indicated that approximately 80% will have a good or excellent short term response. However, if such patients are observed for prolonged periods, the results obtained do not differ significantly from those observed following treatment with the older balloons. In a recent study, in which 56 patients were treated with the Rigiflex dilator and observed for more than 10 years, the long term success rate was 55%. Thus it is my impression that differences in treatment results are not so much related to differences in technique and operator experience but rather to the number of patients investigated, duration of follow up, and finally the quality of the study design. It is hoped that carefully designed randomised studies, which are now in progress, will tell us whether we should continue to offer pneumatic dilatation to the great majority of patients with achalasia or whether we should advise them to undergo surgery instead.

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References

Probiotics in IBD: mucosal and systemic routes of administration may promote similar effects

We read with considerable interest the paper by Sheil et al (Gut 2004;53:694–700) who reported the successful application of the subcutaneous route for probiotic attenuation of colitis.

We agree with the corresponding commentary of Ghosh et al (Gut 2004;53:620–2) regarding the need to study mechanisms underlying probiotic interactions. Recently, we further standardised a method to compare the anti-inflammatory potential of orally administered lactic acid bacteria (LAB) in a murine model of acute 2,4,6-trinitrobenzene sulphonic acid (TNBS) induced colitis.1 This model allowed us to discriminate “protective” strains, showing between 30% and 70% reduction of inflammatory score, from strains which did not significantly attenuate experimental colitis. We could select highly performing strains of Lactobacillus salivarius and Lactobacillus rhamnosus that consistently lowered colitis. In comparison, in a model of TNBS induced colitis, Lactobacillus acidophilus, Lactococcus lactis, and Streptococcus gordoni did never show any improvement. For all five strains, we investigated the protective effect of a single intraperitoneal injection of 3 x 10^7 live microorganisms, 24 hours prior to induction of colitis. Surprisingly, protection by the LAB strains via this systemic route closely matched the efficiency of the oral route (fig 1).

When evaluating both routes simultaneously, the anti-inflammatory effect was of comparable magnitude. Moreover, the prophylactic impact of the intraperitoneal Lactobacillus salivarius strain was established up to two hours before TNBS administration. It is noteworthy that two delayed injections could lead to protection but caused marked weight loss (25% (p=0.05) vs 15% and 11%, respectively, for control and oral route groups) with alleged fever.

Our findings clearly confirm those of Sheil et al (Gut 2004;53:694–700) showing strain specific in vivo probiotic effects on the target tissue, suggesting a relationship between the type of LAB (or LAB components) and peritoneal immunocompetent cells. Pereyra and colleagues’ reported transient dose dependent induction of IFN gamma in serum of intraperitoneal injected Lactobacillus bulgaricus while Streptococcus thermophilus did not. Recent
observations showed that heat treatment of an orally administered cocktail killed the colitis protection in a DSS model, while irradiation improved it.

Consequently, cellular integrity appears to be necessary to explain at least some part of the effect, although cell walls and peptidoglycans of killed bacteria cannot be considered as passive. Possibly both “good” and “bad” signals are given out by LAB, and the immune system is integrating all of them. Those “mixed” signals will no doubt be specific for each strain as well as dose dependent. Differences in physicochemical status could explain the mortality seen by Shell et al., especially when using heat treated bacteria. Pereyra and colleagues established that the maximal non-lethal quantity of injected live LAB was $5 \times 10^7$ but it can be hypothesised that toxicity may also differ with strain and viability status. Both pro- and anti-inflammatory components of probiotics have been reported to interact with systemic immune cells, showing effects comparable with other well known anti-inflammatory or therapeutic molecules. It is therefore most probable that systemic delivery of specific live or killed probiotics may influence the delicate balance between Th1 and Th2 immunity, and subsequently have an impact on local immunity. Clear relationships, however, are not obvious. A first example is the case of subcutaneous CpG DNA that promoted a Th1 response and was able to alleviate some symptoms of DSS colitis but caused inflammation when administered after the onset of colitis. Secondly, different experimental models of colitis support a potential benefit of probiotic DNA, although it seems very premature to restrict this probiotic effect to nucleic acids only.

As emphasised by Gosh and colleagues (Gut 2004;53:620–2), approaches involving fractional studies are essential tools to complete the knowledge obtained from in vitro and ex vivo models and assist in understanding the interactions between LAB and the immune system. These studies may reveal common mechanisms active in inflammation, tolerance, and allergy models. Even if this study confirms the importance of the systemic route for certain probiotic activity, we cannot neglect the possible influence of local and innate immunity, the general health of the gut flora, and the role of epithelial cells in the cross talk between both.

Acknowledgements

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References


Mutations in anionic trypsinogen gene are not associated with tropical calcific pancreatitis

Pancreatitis is considered to be an autodigestive disease due to premature activation of trypsinogen inside the pancreas. Its genetic basis has recently been established with the identification of causal mutations in catonic trypsinogen gene (PRSS1) in patients with hereditary and non-hereditary pancreaticitist. Mutations in other genes such as SPINK1 (encoding pancreatic secretory trypsin inhibitor) and cystic fibrosis transmembrane conductance regulator (CFTR) genes have also been associated with the disease. Tropical calcific pancreatitis is a type of idiopathic pancreatitis, reported particularly in the tropics. Recently, we and others demonstrated absence of PRSS1 mutations but significant prevalence of the N34S mutation in the SPINK1 gene in these patients. Our study raised two important questions: firstly, the exact role of SPINK1 mutations in disease causation as cationic trypsinogen is normal with an intact autolysis site; and secondly, the cause of the disease in the remaining patients negative for both PRSS1 and SPINK1 mutations.

Of the nine members of the human trypsinogen gene family, only PRSS1, PRSS52, and PRSS3 are functional genes coding for cationic, anionic, and meso-trypsinogens, respectively. The anionic form accounts for about one third of the total trypsins in pancreatic juice. We investigated whether mutations in the anionic trypsinogen gene may contribute to the pathogenesis of tropical calcific pancreatitis. We chose patients without mutations reported to date in the PRSS1 gene, 17 are clustered in exons 2 and 3 only. The remaining three are in the promoter region but reported in isolated patients. Hence we initially screened exons 2 and 3 of the anionic trypsinogen gene in 68 well characterised Indian patients with tropical calcific pancreatitis. Subsequently, we also sequenced the promoter, complete coding region, and the flanking region in an attempt to look for any novel mutation.

Owing to the extremely high sequence homology between PRSS1 and PRSS52, a nested polymerase chain reaction (PCR) was used to ensure specificity. The primers were selected from the published study of Chen and colleagues and all of the exons of PRSS52 were PCR amplified, purified, and sequenced on both alleles using internal sequencing primers and the Big Dye terminator cycle sequencing approach. However, we did not find any of the reported or any novel mutations in the coding region or in the splice site junctions, except a synonymous polymorphism A90A (GCA>GCG) in exon 3 of the anionic trypsinogen gene. This variation was observed in both the heterozygous
Elevated plasma protein C levels correlate with the presence of fatty liver (NASH and NAFLD)

The clinical implications of non-alcoholic fatty liver disease (NAFLD) are derived mostly from its common occurrence in the general population and the potential of the condition to progress to fibrosis and cirrhosis. Markers that help in making an early diagnosis and treatment decisions are warranted. Protein C is a vitamin K-dependent glycoprotein that functions as a circulating anticoagulant through proteolytic cleavage and inactivation of the coagulation factors Va and VIIIa. Whether or not protein C levels increase in patients with NAFLDs has not been assessed.

We measured protein C levels in 44 patients (28 men and 16 women; mean ages 45 (11) and 49 (12) years, respectively; 15 patients with fatty liver (FL), 15 with non-alcoholic steatohepatitis (NASH), and 14 with chronic viral hepatitis B+ C (CH). All were diagnosed by histology and liver technetium scan or ultrasound. Ten healthy subjects were used as controls. Obesity, hyperlipidaemia, and diabetes were present in 60%, 73%, and 25% of cases, respectively; 64% of patients had elevated liver enzyme tests (alanine aminotransferase 45 (21) IU/l in FL and 43 (18) IU/l in NASH). Mean protein C levels were significantly increased in patients with NAFLD (n = 30) compared with those with chronic viral hepatitis (140 (36)% v 101 (24)%; p < 0.0009) and healthy individuals (140 (36)% v 120 (12)%; p < 0.04).

No significant difference in protein C levels was noted between simple fatty liver and NASH (149 (34)% and 130 (37)% respectively; p = 0.97). A significant correlation was found between protein C and extent of fatty infiltration (r = 0.63; p < 0.001) (fig 1), insulin resistance index (r = 0.3; p < 0.01), and triglyceride levels (r = 0.45, p < 0.001). Protein C could discriminate correctly between NAFLDs and chronic viral hepatitis in 82% of cases. No significant association was found between protein C and aminotransferase levels.

In conclusion, protein C was elevated in patients with NAFLD. The underlying mechanism remains unknown. Agevall et al suggested an increase in hepatic synthesis of protein C due to increased hepatic insulin resistance. Increased levels have been reported in patients with diabetes, hypertriglyceridaemia, and nephrotic syndrome, with the use of anabolic steroids, oral contraceptives, and alcohol, and with increasing age. Diabetes and hypertriglyceridaemia are predisposing conditions to fatty liver and were present in 23% and 73% of cases, respectively. The remaining conditions were excluded by clinical and biochemical findings. Although more studies are needed, these preliminary findings suggest that elevated protein C levels together with elevated liver enzymes may be used as markers for NAFLD and may obviate the need for liver biopsy.

Coexistent chronic idiopathic intestinal pseudo obstruction and inflammatory bowel disease

Chronic idiopathic intestinal pseudo obstruction (CIP) is a severe condition presenting with abdominal pain and dysmotility. Inflammatory or degenerative changes of the autonomic nervous system or of the muscles of the bowel have been observed in CIP. As patients with inflammatory bowel disease (IBD) may show clinical and histological signs of autonomic neuropathy and dysmotility, the aim of this study was to examine whether there is an association between CIP and IBD.

Six patients at our hospital presenting with signs and symptoms of intestinal dysmotility were diagnosed with CIP based on clinical, endoscopic, and histological features, antroduodenojejunal manometry, and full thickness biopsies (table 1). Patient No 1 had an acute erosive colitis some years previously with bloody diarrhoea and an enhanced sedimentation rate, which was treated with steroids, and patient No 2 had relapsing proctitis treated with 5-aminosalicylic acid (5-ASA). Patient No 3 was
totally and patient No 4 partially colecto-
mised because of slow transit constipation.
Patient No 6 was proctocolectomised due to
refractory colitis. The patients were further
investigated with magnetic resonance (MR)
terenceptography and video capsule enteroscopy
to establish whether there were any signs of
IBD. If these examinations showed any
pathology, push enteroscopy and ileocolon-
scopy were also performed. All biopsies
collected over the years were re-evaluated.

MR enterography did not reveal any
pathological changes in any of the subjects.
In three patients (Nos 1, 3, and 4), video
capsule enteroscopy revealed Crohn-like
ulcerations/erosions in the stomach and
small intestine. Further examination of
patient No 1 by push endoscopy confirmed
the erosions in the stomach and one third of
the proximal small intestine. In patient No 3,
capsule endoscopy showed aphthous ulcers
typical of Crohn’s disease throughout the
distal jejunum and ileum (Fig 1A).
Ileocolonoscopy showed the same picture in
the ileum and ileorectal anastomosis.

Histopathological examination of the full
thickness biopsies from patient Nos 1 and 2
showed visceral degenerative neuropathy,
combined with wall thickening of the intes-
tinal cells of Cajal (ICC’s). In patient Nos 3 and
6, lymphocytic ganglioneuromatosis was found
in both neural plexa of the resected colon and
ileum (Fig 1B), with signs of neurone
degeneration, and 50% and 80% reduction of
ICC’s in the submucous ICC-plexus and
deep muscular plexus of the circular muscle
layer, respectively. Patient No 4 had a normal
biopsy, and patient No 5 was not biopsied.
Examination of mucosal biopsies from
patient No 1 revealed focal active inflamma-
tion in the duodenum and caecum, and
chronic inflammation in the rectum; patient
No 5 had multifocal mild antral cryptitis, and
both patients were diagnosed with suspected
Crohn’s disease. Colon biopsies from patient
No 6 revealed epithelioid cell granulomas and
multinucleated giant cells, as well as multi-
focal transmural lymphoid hyperplasia con-
sistent with Crohn’s disease.

In three patients (Nos 1, 3, and 4),
dysmotility preceded the mucosal changes.
In patient Nos 2 and 5, these two entities
occurred simultaneously, while in patient No 6,
dysmotility developed after proctococe-
tomy. Ganglioneuromatosis in patient No 3 could
have been caused by Crohn’s disease before
other symptoms of the disease developed.
Treatment with 5-ASA has reduced her
abdominal pain. The normal histology of the
sigmoidum in patient No 4 does not exclude the possibility of ganglionitis in other
parts of the bowel due to the known patchy
involvement of the gut in Crohn’s disease.
The present observations indicate that
artery from inflammation, even purely degen-
erative neuronal and ICC’s changes seen in
CIP can occur in patients who also have IBD/
an IBD-like condition. At present, it is not
known whether the observed abnormalities
are part of IBD or independent of each other.
This small patient sample prevents us from
drawing any definite conclusion regarding
this question. Further observations are
needed to establish whether or not this
connection is causal.

Table 1 Summary of the findings in our patients

<table>
<thead>
<tr>
<th>Patient No:</th>
<th>Debut age/CIIP</th>
<th>Main symptoms</th>
<th>Clinical diagnosis</th>
<th>Endoscopic pathology</th>
<th>Histopathology</th>
<th>Antroduodenal manometry</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>23/F</td>
<td>16/22</td>
<td>Pain, bloody diarrhoea</td>
<td>Crohn’s disease, CIIP</td>
<td>Small and large bowel</td>
<td>Degenerative neuropathy</td>
</tr>
<tr>
<td>2</td>
<td>26/F</td>
<td>15/25</td>
<td>Pain, vomiting</td>
<td>Proctitis, CIIP</td>
<td>Rectum</td>
<td>Degenerative neuropathy</td>
</tr>
<tr>
<td>3</td>
<td>35/F</td>
<td>Teenage/29</td>
<td>Constipation, dyspepsia</td>
<td>Crohn’s disease, CIIP</td>
<td>Small and large bowel</td>
<td>Ganglioneuritis</td>
</tr>
<tr>
<td>4.4/F</td>
<td>35/39</td>
<td>Constipation, pain</td>
<td>Crohn’s disease, CIIP</td>
<td>Suspected Crohn’s disease, CIIP</td>
<td>Normal</td>
<td>Normal</td>
</tr>
<tr>
<td>5</td>
<td>55/M</td>
<td>39/41</td>
<td>GORD, later pain and diarrhoea</td>
<td>Suspected Crohn’s disease, CIIP</td>
<td>Large bowel</td>
<td>Suspected Crohn’s disease</td>
</tr>
<tr>
<td>6</td>
<td>67/M</td>
<td>61/64</td>
<td>Pain, weight loss</td>
<td>Crohn’s disease, CIIP</td>
<td>Abnormal</td>
<td>Ganglioneuritis, Crohn’s disease</td>
</tr>
</tbody>
</table>

CIIP, Chronic idiopathic intestinal pseudo-obstruction; GORD, gastro-oesophageal reflux disease.

Figure 1 Patient No 3. (A) Capsule endoscopic view of the terminal ileum showing an aphthous ulceration in the ileum. (B) Moderate lymphocytic infiltrate around and within the myenteric ganglia (haematoxylin-eosin x100).

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6 Manousos ON, Salem SN. Abnormal motility of the small intestine in ulcerative colitis. Gastroenterology; 1965;104:249–57.
Cannabinoid hyperemesis: not just a problem in Adelaide Hills

We read the article by Allen and colleagues (Gut 2004;53:1566–70) with interest and would like to report a case of probable cannabinoid hyperemesis seen in a district general hospital in the UK.

A 21 year old chef was admitted to our hospital on seven occasions over a two year period (April 2001 to December 2002) with profuse vomiting. Apart from a history of migraine as a child, he was fit and well. He smoked cannabis. Physical examination was unremarkable. The observation that the patient wanted to take regular baths because he had found that bathing eased the sickness was documented in the nursing notes but its significance was not appreciated. Investigations during attacks disclosed neutrophilia but blood urea, electrolytes, liver biochemistry, and serum amylase were normal. Abdominal x ray was also normal. Upper gastrointestinal endoscopy showed grade I oesophagitis and gastritis. Gastric biopsies were histologically normal. An abdominal ultrasound scan and small bowel barium follow through examination were normal. Additional normal or negative investigations included: autoantibodies and immunoglobulins, C reactive protein, and urinary porphyrin screen. Computed tomography scan of the brain was also normal.

Following his last admission, the patient’s girlfriend showed us an article published in an Australian newsletter which she had obtained via the internet, in which Dr JH Allen had raised the possibility of a link between recurrent vomiting and cannabis abuse. With the aid of the internet we traced and contacted Dr Allen who shared his experience of this condition with us.

Reviewing the patient’s history, he freely admitted to smoking cannabis and experiencing the compulsive desire to bathe during bouts of vomiting. Following his last admission in December 2002, our patient stopped smoking cannabis and has remained free of symptoms. The clinical presentation was almost identical to the cases described by Allen et al, together with the response to cessation of smoking cannabis, supports the view that our patient was suffering from cannabinoid hyperemesis and that this condition is international.

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Inflammatory bowel disease stimulates formation of carcinogenic N-nitroso compounds

In patients with inflammatory bowel disease (IBD), an increased incidence of colorectal cancer is observed.1 Although severe inflammatory conditions per se represent a risk factor for neoplasia, we would like to draw attention to the possible role of increased activity of inducible nitric oxide synthase (iNOS), as found in IBD patients,2 in the endogenous formation of carcinogenic N-nitroso compounds (NOC). In healthy individuals, relatively small amounts of NOC are formed by the interaction between NOC precursors (NOCPr), present in dietary items such as meat and fish, and nitrating agents derived from dietary nitrate. It has been proposed that endogenous formation of NOC may explain the link between meat consumption and colon cancer risk found in epidemiological studies.3 We hypothesised that as a result of chronic inflammatory conditions in the large intestine, increased colonic iNOS activity may produce an excess of NO, nitrogen oxides, and nitrite, which in turn react with NOCP present in the colon to produce relatively high levels of NOC. Increased formation of NOC in IBD patients may thus contribute to the relatively high incidence of colorectal cancer associated with this disease.

A recent population based case control study showed that in cases with a history of IBD, increased exposure to drinking water nitrate was associated with an increased risk of colon cancer whereas no such association was found in the overall population.4 This clearly indicates that the risk of colon cancer, in IBD patients is not only determined by the disease itself but dietary factors known to influence the endogenous formation of NOC are also associated with an increased risk in these patients. Although both the increased formation of NOC found in mice with chemically induced colitis2 and increased levels of NO and nitrite found in the colonic lumen of patients with ulcerative colitis5 support this hypothesis, NOCP levels in IBD patients have never been investigated in IBD patients.

Therefore, we collected faecal samples from 17 patients diagnosed with ulcerative colitis and 17 healthy controls, and determined levels of N-nitrosodimethylamine (NDMA), a predominant carcinogenic NOC, using gas chromatography-mass spectrometry, as previously described.6 The study was approved by the medical ethics committee of the Maasland Hospital, Sittard, the Netherlands, and all patients gave their consent. In 41% of patients, we found levels of NDMA above the detection limit of 1 ng/g faeces, compared with 35% of controls. Comparison of concentrations in NDMA positive samples showed that the average concentration in patients was significantly higher than that in the control group (table 1). When IBD patients were subdivided into hospitalised and non-hospitalised cases, the difference between the non-hospitalised group and controls was even more pronounced, whereas NDMA concentrations in hospitalised patients and controls were similar. All hospitalised patients received only liquid nutrition (Nutricia; Nutricia, UK) with additional intake of NOCP rich dietary foods, whereas the non-hospitalised group and controls were fed by mouth. The faeces of all hospitalised patients received only liquid nutrition (Nutricia; Nutricia, UK) with additional intake of NOCP rich dietary foods, whereas the non-hospitalised group and controls were fed by mouth. This supports the hypothesis that the increased NOCP levels in IBD patients may be present a risk factor.

Most research on endogenous NOC exposure has focused predominantly on the intragastric formation of these compounds in relation to the gastric cancer risk. However, we now report that faecal NDMA levels in IBD patients are considerably higher than those we reported previously in gastric juice (0.25 (0.3) ng/g),7 which indicates that NOC exposure may be even more relevant in colon carcinogenesis. Based on these results, we conclude that the colon of IBD patients is exposed to relatively high concentrations of this carcinogenic compound, probably as a direct consequence of continuous NO production by the inflammatory process. As this exposure may strongly contribute to the increased colon cancer risk associated with IBD, dietary recommendations for IBD patients, avoiding high NOCP intake, seem warranted.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Faecal N-nitrosodimethylamine (NDMA) concentrations in patients with inflammatory bowel disease (IBD) and in healthy controls</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Controls (n=17)</td>
</tr>
<tr>
<td>%NDMA positive</td>
<td>35</td>
</tr>
<tr>
<td>NDMA (ng/g)*</td>
<td>1.4</td>
</tr>
</tbody>
</table>

*Average concentration of NDMA positive samples.

tp<0.05, tpp<0.01: significantly higher compared with the control group (Mann-Whitney U test).

tp<0.05: significantly lower compared with non hospitalised cases (Mann-Whitney U test).

Reference


Hepatocellular carcinoma occurring after successful treatment of childhood cancer with high dose chemotherapy and radiation

Hepatocellular carcinoma (HCC) is one of the world's most common malignancies and accounts for more than 90% of all primary liver cancers. A number of different risk factors have been identified for the development of HCC.1 Hepatitis B carrier state, environmental toxins, chronic hepatitis C virus infection, hereditary haemochromatosis, and liver cirrhosis of almost any cause are well known risk factors for HCC. In addition, environmental toxins such as aflatoxins and contaminated drinking water may contribute to the pathogenesis of HCC, especially in Asia and underdeveloped countries. Finally, a number of HCC cases have occurred after the use of thorotrast for diagnostic procedures, and survivors of the atomic bomb of Hiroshima were also at higher risk for HCC development,4 indicating that radiation might also induce the development of HCC. Herein we describe a rare case of HCC occurring in a patient 17 years after successful treatment of peripheral neuroectodermal tumour (PNET).

A 32 year old female presented with pain in the right upper quadrant of her abdomen. Seventeen years prior to presentation in our hospital this patient was treated for a PNET with a combination of high dose chemotherapy (vincristine, adriablastin, ifosfamide, and actinomycin D) and surgical removal of the 10×5 cm tumour from her right chest followed by combined radiation (60 Gy) and chemotherapy. There were no signs of any recurrence of the tumour observed on her last check up 12 month earlier. Physical examination of the patient in our clinic showed typical signs of late radiation damage (erythema of the skin and an underdeveloped right breast) (fig 1). A firm 3–5 cm mass was palpable at the lower edge of the liver. Laboratory tests showed elevated a-fetoprotein (4188 μg/l). Hepatitis serology was positive for CD activity whilst being hepatitis B surface antigen positive.

Radiation therapy has been shown to be associated with an increased risk of solid tumours 10–15 years after treatment and later.7 There is one report in the literature of a radiation induced hepatoma in a patient with a non-malignant haemangiomata,6 which occurred 20 years after radiation of the liver with 28.5 Gy. To date, the molecular mechanism of hepatocarcinogenesis is not completely understood. The main causative agents—Hepatitis B virus, Hepatitis C virus, and aflatoxin B1—have been identified, which together are responsible for approximately 80% of all HCC in humans. This series of cases clearly supports the notion that secondary HCC can follow not only radiation therapy of children but also high dose chemotherapy, and may prompt careful follow up examinations of the liver in patients with a possible risk for the development of HCC.

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References


Biologics in inflammatory disease: infliximab associated risk of lymphoma development

In their excellent overview of currently available biologic compounds that are in use or under investigation for Crohn's disease (CD), Sandborn and Faucomier (Gut2004;53:1366–73) reconfirm the unique standing of infliximab. They also note the ongoing discussion concerning the increased occurrence of lymphoproliferative disorders in patients who received infliximab.

Recently, we followed a 61 year old patient with a 31 year history of relapsing CD. Initial treatment was with steroids but after 19 years of ulcerations and multiple rectovesic- cular fistulas. Non-Hodgkin lymphoma was absent in the histologic material. Because of a poor response to conventional treatment, including azathioprine (100–200 mg/day), infliximab was added 22 months before the current admission. Total infliximab therapy included three doses of 400 mg (5 mg/kg) within two months and resulted in a marked reduction of CD activity (azathioprine was maintained). On admission 10 months after the last infliximab infusion, the patient relapsed again with ulcerations and multiple rectovesicular fistulas. Biopsies showed a polymorphous tumour infiltrate. Tumour cells were positive for CD30 and negative for T and B cell markers as well as the anaplastic large cell lymphoma kinase (ALK) and Epstein-Barr virus (EBV) associated proteins. A multiplex polymerase chain reaction approach revealed a clonal T cell population and an oligoclonal B cell population. Based on these results, the diagnosis was ALK negative anaplastic large cell lymphoma with null/T cell phenotype. Clinical stage was IAE. CHOP-chemotherapy resulted in complete clinical and histological remission, which was evidenced by computer tomography, positron emission tomography, and negative rectal histology. Polymerase chain reaction analysis of the rectal biopsies revealed no T cell receptor rearrangement.

Three months later, the patient presented with postobstructive pneumonia. Bronchial biopsies showed a diffuse large B cell lymphoma. In contrast with the preceding rectal biopsies, bronchial tumour cells were positive for CD20, EBER, EBNA2, and LMP-1, indicating EBV infection of latency type III, were detected in tumour cells.
Table 1: Patients with infliximab therapy and development of lymphoma

<table>
<thead>
<tr>
<th>Age</th>
<th>Sex</th>
<th>Disease</th>
<th>Dose</th>
<th>No of infusions</th>
<th>Lymphoma</th>
<th>EBV</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>50</td>
<td>M</td>
<td>5 mg/kg</td>
<td>3</td>
<td>Burkitt lymphoma</td>
<td>NR</td>
</tr>
<tr>
<td>2</td>
<td>50</td>
<td>F</td>
<td>5 mg/kg</td>
<td>3</td>
<td>Hodgkin lymphoma</td>
<td>NR</td>
</tr>
<tr>
<td>3</td>
<td>50</td>
<td>M</td>
<td>5 mg/kg</td>
<td>3</td>
<td>Non-Hodgkin lymphoma</td>
<td>NR</td>
</tr>
<tr>
<td>4</td>
<td>50</td>
<td>M</td>
<td>5 mg/kg</td>
<td>3</td>
<td>Mixed cell NHL</td>
<td>NR</td>
</tr>
<tr>
<td>5</td>
<td>50</td>
<td>M</td>
<td>5 mg/kg</td>
<td>3</td>
<td>NK cell lymphoma</td>
<td>NR</td>
</tr>
<tr>
<td>6</td>
<td>50</td>
<td>M</td>
<td>5 mg/kg</td>
<td>3</td>
<td>Metachromatic lymphoma</td>
<td>NR</td>
</tr>
</tbody>
</table>

ALCL, anaplastic large cell lymphoma; CD, Crohn's disease; DBC, diffuse large B cell lymphoma; DM, dermatomyositis; NHL, non-Hodgkin lymphoma; NR, not reported; RA, rheumatoid arthritis.

However, tumour cells were negative for CD30 and ALK protein. Molecular analysis demonstrated a monoclonal immunoglobulin heavy chain rearrangement in the absence of a T cell receptor rearrangement, confirming the diagnosis. The tumour was neither reactive to CHOP-Rituximab nor to the ensuing second and third line chemotherapy. When the patient presented for fourth line chemotherapy, spontaneous partial remission was seen, persisting now for 10 months up to the last clinical follow up in September 2004.

We can now add a unique case of a metachronous duplex non-Hodgkin lymphoma of initially T and then B cell phenotype. Unbalanced transformation of T lymphocytes may have acted as a key feature in this patient as the development of CD and the EBV related B cell non-Hodgkin lymphoma were both closely related to T lymphocytes. This links the case to infliximab as proapoptotic effects on T lymphocytes caused by infliximab have been described. Therefore, the recommendation to routinely give infliximab maintenance therapy and concomitant immunosuppressive treatment to minimise the formation of antichimeric antibodies seems to carry a theoretical risk of elevating the incidence of lymphoma above the background rate. Infliximab was approved by the US Federal Drug Administration five years ago, and until April 2004 approximately 500,000 patients have been treated. Based on medwatch data, an incidence of 6.6/100,000 treated patients was estimated in 2002, which still seems valid if compared with published cases. However, our current knowledge does not allow definitive conclusions to be drawn about the association of infliximab and lymphoma.

Genotypes 677TT and 677CT+1298AC of methylenetetrahydrofolate reductase are associated with the severity of ulcerative colitis in central China

Increased blood levels of homocysteine have been found to be associated with inflammatory bowel disease (IBD) in several studies. The main genetic determinant associated with elevated plasma levels of homocysteine (t-Hcys) is the MTHFR 677CT gene polymorphism of methylenetetrahydrofolate reductase, a critical enzyme involved in the remethylation pathway of homocysteine. An association of the MTHFR 677TT allele with IBD has been reported in Northern Europe but not in three other populations from Italy and France.


Conflict of interest: None declared.

References

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that differed significantly between patients and controls were determined by logistic regression analysis. A p value < 0.05 was considered to indicate statistical significance.

The main clinical characteristics are summarised in table 1. Most of the cases were recently diagnosed. None had any thrombotic disease. In contrast, we found a decrease in enzyme activity, seemed to be more significantly associated with extension of disease than with the primary risk, at least in central China.

In conclusion, our study showed that the genotypes of MTHFR, associated with a decrease in enzyme activity, seemed to be more significantly associated with extension of disease than with the primary risk, at least in central China.

| Table 1 Clinical characteristics and methylenetetrahydrofolate reductase (MTHFR) and transcobalamin (TCN) polymorphisms in 72 patients with ulcerative colitis (UC) and 111 controls from central China |
|----------------------------------|-----------------|-----------------|-----------------|
|                                  | Ulcerative colitis | Controls | p Value |
| n                                 | 72               | 118          |       |
| Sex (F/M)                         | 35/37            | 58/60        | 0.9423 |
| Age (y) (mean (SD))              | 41.15            | 40.13        | 0.4809 |
| Age of onset (y) (mean (SD))     | 38.14            |             |       |
| Current smoker (n (%))           | 1 (1.4)          |             |       |
| Extent of UC (n (%))             |                   |             |       |
| Rectum                           | 40 (55.6)        |             |       |
| Left colitis                      | 15 (20.8)        |             |       |
| Right colon                      | 11 (1.4)         |             |       |
| Total colon                      | 15 (23.6)        |             |       |
| Treatment (n (%))                |                   |             |       |
| S-ASA/SASP                       | 53 (73.6)        |             |       |
| Steroids                         | 15 (20.8)        |             |       |
| Antibiotics                      | 13 (18.1)        |             |       |
| Intestinal resections (n (%))    | 1 (1.4)          |             |       |
| Genetic polymorphisms (n (%))    |                   |             |       |
| MTHFR 677TT allele               | 50 (34.7)        | 91 (41.0)    | 0.2286 |
| MTHFR 677T allele                | 10 (13.9)        | 21 (18.9)    | 0.3707 |
| MTHFR 1298C allele               | 18 (25.8)        | 41 (36.8)    | 0.2889 |
| MTHFR 677CT/1298AC               | 4 (6.2)          | 15 (13.7)    | 0.0755 |
| MTHFR 677IT/CT+1298AC            | 14 (21.2)        | 38 (34.9)    | 0.0659 |
| TCN 776G allele                  | 62 (86.3)        | 138 (60.0)   | 0.5709 |
| TCN 776G+GG                      | 42 (58.5)        | 89 (77.4)    | 0.2236 |
| MTHFR 677IT/CT+1298AC            | 7 (43.7)         | 7 (41.0)     | 0.0162 |
| TCN 776G+GG                      |                   |             |       |
| Total colon                      |                   |             |       |
| Less extended UC                 |                   |             |       |

References


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The original article by Cosnes et al (Impact of the increasing use of immunosuppressants in Crohn’s disease on the need for intestinal surgery. Gut 2005;54:237–41), published in the February 2005 issue was incomplete. Figure 2 was missing from the proof. A corrected version of the pdf can be viewed at http://gut.bmjournals.com/cgi/data/54/2/237/DCI/1, and the missing figure can be seen here.
Probiotics in IBD: mucosal and systemic routes of administration may promote similar effects

B Foligné, C Grangette and B Pot

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