an important predisposing factor, but that progressive oesophageal mucosal damage may exacerbate the problem, thus establishing a vicious cycle. Fortunately, this latter component appears to be reversible by effective reflux control. In these circumstances, the association of reflux oesophagitis, not only with abnormalities of oesophageal body motility, but also with impaired gastric emptying⁶ and duodenogastric reflux⁷ suggests that gastrooesophageal reflux may well be part of a diffuse upper gastrointestinal motility disorder.

A WATSON, L R JENKINSON, AND T L NORRIS
Royal Lancaster Infirmary,
Ashton Road,
Lancaster LA1 4RP.

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Spontaneous haemoperitoneum from rupture of a primary hepatic adenoma in an adult man – an update SIR, — You recently published a case report from the Clatterbridge Surgical Unit involving rupture of a primary hepatic adenoma in a male adult (*Gut* 1987; **28**: 1170–2). In view of the interest shown in the case I feel it is appropriate to provide an update on the patient's subsequent clinical course.

After initial surgery he remained well for almost two years, but then gradually deteriorated, became jaundiced and cachexic and died from a pulmonary embolus almost two years to the day after his original laparotomy. Necropsy confirmed a pulmonary in-

farct incriminating an embolic cause of death, but showed the source to be tumour embolus in the hepatic vein. The liver had areas of hepatic adenoma as before, but in addition areas of hepatocellular carcinoma. Stains for copper, hepatitis B antigen and alpha₁ antitrypsin deficiency were negative. There were pulmonary metastases from the hepatocellular carcinoma.

Re-examination of the original histopathology specimens from 1985 reconfirmed a benign hepatic adenoma. It is impossible to say whether, or not carcinoma existed at the time of the original presentation. Hepatocellular carcinoma is usually characterised by a short clinical course of three to four months, however, and often arises from pre-existing liver disease, such as cirrhosis. The absence of cirrhosis, Wilson's disease, hepatitis and alpha₁ antitrypsin deficiency, the presence of the benign adenoma, the long symptom free interval and consequent protracted clinical course, lead me to suspect that the patient eventually developed carcinomatous change in a pre-existing primary hepatic adenoma.

P D MCINERNEY

Department of Surgery,
Clatterbridge Hospital,
Bebington,
Wirral,
Merseyside L63 4JY.

Books

Computers in gastroenterology. By E Vicary. (Pp. 224; illustrated; £52.50.) Berlin: Springer, 1988.

It was bound to happen; gastroenterologists can no more be shielded from the advance of the computer than anyone else. Like molecular biology, computer technology was not something that many of us met in our undergraduate education, but unlike molecular biology, many of us have had the opportunity to learn it from our children ('Dad, have you been messing about with my computer again?'). The great thing about computers is that they are simple NON-SYSTEM DISK OR DISK ERROR to use and virtually ENTER NEW DATE (MM-DD-YY) fool-proof. Above all, they save INVALID DATE a lot of time. Aside from their amusement value, why INVALID DRIVE SPECIFICATION do gastroenterologists need them? According to this symposium of enthusiasts, they can BAD COMMAND OR FILE SPECIFICATION simplify the construction of clinical data bases, the keeping of endoscopy records, and 54 FILE(S) 93184 BYTES FREE the