Correspondence

A genetic predisposition for colorectal cancer in inflammatory bowel disease

SIR,—We were very interested to read the recent article of Gyde and coworkers¹ suggesting that patients with ulcerative colitis having extensive disease may have a genetic predisposition for colorectal cancer whereas in those with more limited disease even longstanding inflammation has no major effect in promoting cancer. Our review² of data on the occurrence of colorectal cancer in colonic Crohn's disease has led us to a similar approach to the problem. We found that the reported diversity of patterns in 'colorectal Crohn's carcinoma' strengthens the assumption of several more or less interrelated factors which can be grouped according to two main aetiopathogenic mechanisms: acquired and genetic. With the former the chronicity of the localised inflammatory process (fistula, stricture, perianal inflammation, etc) predisposes the colon to malignant changes, as in other organs.³ With the latter, the development of carcinoma and Crohn's disease in the same patient results from an individual predisposition, independent of age at onset and duration of previous disease. Supporting this view are those cases in which Crohn's disease and carcinoma developed separately in the small and large intestine, or in two different parts of the colon,⁴ as well as the frequency of such patients with extra-intestinal cancers^{5,6} and the high incidence of carcinoma of the colon among relatives of patients with Crohn's disease.⁷

Although our findings differ somewhat from those of Gyde *et al.*, indicating a variability in the possible manifestations of the genetic factors among patients with ulcerative colitis and those with Crohn's disease, we are in full agreement as to the importance of further studies, including a programme of typing of such patients and their relatives.^{7,8}

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Ultrasound or computed tomography for the initial investigation of biliary obstruction

SIR,—John Summerfield's leading article (*Gut* 1988; **29**: 741–5) on the management of biliary obstruction presents a reasoned and logical approach with which there is little to disagree. I fear his logic breaks down, however, when he proposes that computed tomography (CT) should be the initial radiological investigation in patients suspected of having biliary obstruction. It is true that ultrasound (US) may not be accurate in predicting the cause of obstruction particularly when due to bile duct stones but we must question whether this failing is clinically relevant. Ultrasound is every bit as accurate as CT in showing biliary obstruction, the presence of which will inevitably lead to ERCP. Endoscopic cholangiography is without doubt the most effective investigation in showing the cause of biliary obstruction. Therefore, the choice of initial radiological investigation need be made only on the basis of the ability of the investigation to show obstruction rather than its cause. Ultrasound is more widely available, quicker to do, and considerably cheaper than CT and will indicate the need for ERCP just as accurately. The most cost effective approach to investigation and treatment of the patient with biliary disease is to use ultrasound as an initial investigation followed by ERCP to elucidate the cause and to treat the obstruction. Computed tomography with contrast enhancement (which, it should be remembered can lead to morbidity and even mortality in a tiny proportion of patients) should be reserved for the evaluation of difficult cases and for those patients with malignant obstruction who require further assessment with a view to surgery.

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