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Reply

SIR,—We thank Dr Heyworth for his comments. As we mentioned in our discussion, and as our case report clearly shows, humoral immunity is very important in achieving a successful resolution of infection, as is illustrated by the protracted cryptosporidial infections which affect patients with hypogammaglobulinaemia. The point we were trying to make was that T lymphocytes are also important for successful elimination of cryptosporidial infection, and that inadequate T lymphocyte numbers results in a protracted infection.¹ We are grateful to Dr Heyworth for pointing out the recently published data indicating that the helper T lymphocyte specifically seems to be the most important cell mediating this response,² but these data were not available to us at the time and were only published after our article had been accepted by *Gut*.

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Use of elemental diets in the treatment of Crohn's disease by gastroenterologists

SIR,—Several studies have been published suggesting that elemental enteral diets may have a part to play in the treatment of Crohn's disease, and the effects may be independent of the nutritional benefit.^{1–3} A survey of British Society of Gastroenterology members was undertaken to determine the current use of elemental diets in clinical practice. Altogether,

129 questionnaires were returned by consultant members of the society in clinical practice in the United Kingdom and Eire: 59% of respondents had used elemental diets for the treatment of Crohn's disease; 19% had used them as the sole treatment in newly diagnosed disease; 33% had used them as the sole treatment in relapsed disease; 39% had used them in combination with conventional treatment in newly diagnosed disease; and 55% had used them in combination with conventional treatment for relapsed disease. The number of patients treated with elemental diets per year by respondents was very variable, with a range of 1–50 patients (median six). Respondents to this survey treated a total of approximately 750 Crohn's patients with elemental diets in the United Kingdom per year. The median length of treatment was four weeks (range 5 days–16 weeks), although 5% of respondents using the diet would continue using it until remission of symptoms. The survey questionnaire deliberately did not define the term 'elemental diet.' Originally this term was coined to describe free amino acid and glucose containing diets,⁴ and was often prefixed by the phrase 'chemically defined.' In recent years the term has embraced diets whose nitrogen sources include peptides (often called predigested diets). We believe that 'elemental diet' should be used for either type, but that for simplicity those with an amino acid nitrogen source should be called 'chemically defined elemental diets,' and those with a peptide nitrogen source 'predigested elemental diets.' 'Polymeric diets' refer to those with a whole protein nitrogen source. Generally, the energy source is of secondary importance when classifying enteral diets. Using our criteria a chemically defined elemental diet was used by 70% of respondents; 45% had used EO 28 (Scientific Hospital Supplies Ltd, Liverpool, UK), and 25% had used Vivonex (Norwich Eaton, Newcastle-upon-Tyne, UK). In the last year Vivonex has been withdrawn from the UK market for commercial reasons, and is therefore no longer available. Eighteen per cent of respondents used predigested elemental diets; 13% reported the use of polymeric diets which have been shown in uncontrolled studies to have an apparent benefit on acute Crohn's disease.^{5,6} Several respondents commented on their uncertainty about diet classification; 14% of the respondents used a range of elemental diets.

This survey shows that elemental diets are recognised by an appreciable proportion of practising clinicians to have an important role in the treatment of Crohn's disease. The results of further controlled randomised studies examining the use of enteral diets as an alternative treatment are eagerly awaited.

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Vancomycin in resistant hepatic encephalopathy

SIR,—We were interested to read the paper of Tarao and colleagues (*Gut*, 1990; 31: 702–6) on the use of vancomycin in resistant hepatic encephalopathy. Neomycin is now used only relatively rarely in this context because of anxiety about nephrotoxicity and ototoxicity.^{1,2} Furthermore, there is no convincing evidence that neomycin with lactulose is more effective than lactulose alone.³ Tarao *et al* state that vancomycin is non-absorbable, which seems to be almost literally true in normal subjects, and oral use of the drug does not seem to be a cause of ototoxicity in patients.⁴ We, however, can find no equivalently authoritative reference that reassures us that oral vancomycin could not be cumulatively nephrotoxic. Indeed, appreciable systemic absorption has been reported during vancomycin use for pseudomembranous colitis,^{5,6} with transient fever and neurotoxicity apparently the result in one anephric child.⁷ The link with pre-existing renal impairment has special importance in hepatological practice since many patients with cirrhosis have clinical or subclinical renal disease, and there is also evidence for increased intestinal permeability. It is therefore disappointing that Tarao *et al* include neither systemic vancomycin concentrations nor serial data on the renal function of their patients. We would like such data before recommending this drug for prolonged use.

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