the benefits when dietary treatment succeeds are well worth the effort involved.

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Reply

EDITOR,—We are grateful for this letter from the Cambridge group that brings to light a number of inaccuracies and misconceptions regarding the significance of food intolerance in the treatment and pathophysiology of Crohn's disease.

We are aware of three reports dealing with this issue.^{1-3,4,5} The first series,¹⁻³ from Cambridge concludes that most patients with Crohn's disease have food intolerances and that remissions may be 'significantly prolonged if specific food intolerances are discovered'.

Curiously a more recent report from the same unit does not support these findings.⁴ Fotherby shows clearly that such food intolerances cannot be identified by double blind food challenge. A Sheffield group also used double blind food challenges and had similar findings.⁵ Our study confirms the last two studies and refutes the former series. We have merely clarified the issue of food intolerance and not underestimated it.

It is correct that we did not follow the methods used in the earlier Cambridge studies. Rather we followed the standard and widely accepted methods for identifying food intolerance by initial open food introduction followed by repeat open challenge and then double blind challenge.⁶ It is therefore flying in the face of science to suggest that our 'studies were not carried out correctly'.

We accept that the length of time that the patient is in remission may change the occurrence of food sensitivities, a feature that has been suggested by other groups.⁷ This is precisely why all of our open challenges were performed over a period of five days. In addition it is of note that the double blind challenges carried out in the Cambridge unit were performed both early and late in the remission period and yet failed to confirm their earlier findings.⁴

We have recently had the opportunity to study the abstract quoted⁸ in full.⁹ Unfortunately this study was not a controlled trial of exclusion diet because the control group was, for some reason, treated with steroids. In addition no attempt was made to confirm the food intolerances identified. The study simply shows that gradual reintroduction of normal food is important after diet induced remission and this has been suggested by other groups.¹⁰

In conclusion our study, that of the Sheffield group, and the double blind study from the Cambridge unit itself show that although food

intolerances may occur in Crohn's disease they are not as common as previously suggested, are of insufficient importance to warrant putting all patients through elimination diets, do not change the length of remission for most patients, and are unlikely to be of prime importance in the pathophysiology of Crohn's disease.

Yes, our work confirms previous reports from the Cambridge Unit but not those reports quoted in their letter.

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Non-penetrance and late appearance of polyps in families with familial adenomatous polyposis

EDITOR,—The paper by Evans *et al* is indeed of interest (*Gut* 1993; 34: 1389-93).

We reported a similar case in which the polyps presented at the age of 58. The patient had had abdominoperineal excision of the rectum for a carcinoma when aged 35. A barium enema performed by the stoma at the age of 53 was entirely normal with no evidence of polyposis. She then presented at the age of 58 with polyps on the stoma and a further barium enema performed by the stoma showed thousands of polyps throughout the colon. More than 1000 tubuloadenomas were confirmed on the histology specimen when the remaining colon was removed.¹

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- 1 Law NW, Gilbert JM. Adenomatous polyposis arising after the age of 53. *J R Soc Med* 1987; 80: 383-4.

Bowel dysfunction in young women

EDITOR,—Bowel dysfunction in young women with urinary retention (*Gut* 1993; 34: 1397-9) may result from inefficient cortical circuits and dopamine abnormalities lateralised to the right hemisphere in which the metabolic rate is higher in women. This hypothesis is supported by reports of dopaminergic neurotransmission subserving gastrointestinal protection and genitourinary and immune functions.¹⁻³ It is also supported by the onset of bowel and bladder symptoms after a flu like illness in an 18 year old nulliparous woman, and by infectious insult blocking neostriatal dopamine receptor, producing a Parkinsonian syndrome after 'mild' influenza in a 14 year old boy.⁴ The role of a change in dopamine pathways in a shared smooth muscle disorder between the bladder and the bowel is suggested by neurovascular complications of cocaine abuse.⁵

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NOTES

Digestive endoscopy, ultrasonography, and radiology

The 5th International Workshop of Digestive Endoscopy, Ultrasonography, and Radiology will be held in Marseille on 5-6 May 1994. Further details from: Professor J Sahel, Service d'Hépatogastroentérologie, Hôpital Sainte-Marguerite, 270 Bld de Ste Marguerite, BP 29, 13274 Marseille Cédex 9, France. Tel: 91 74 40 55, 91 75 48 41; fax: 91 75 23 04.

Digestive Disease Week

The Digestive Disease Week will be held on 14-20 May 1994 at New Orleans, Louisiana, USA. Further details from: Slack Incorporated, 6900 Grove Road, Thorofare, NJ 08086-9447, USA. Tel: 609 848 1000; fax: 609 853-5991.