Correspondence

Potential hazards of intraoperative cholangiography in patients with infected bile

SIR,—I write to comment on this interesting article by N J Lygidakis (*Gut* 1982; **23:** 1015–8). I do not feel that the suggested conclusions drawn from the study are substantiated by the facts presented. Firstly, the trial had a totally non-randomised selection method thereby not allowing true comparability between the groups. Secondly, the postoperative bacteraemia incidence is higher in the group who received the uncontrolled pressure cholangiography. It is stated that in this group the 'injection pressure was high'. There is no mention in the article of any pressure measurements being undertaken in this group. Were the pressures recorded or is it just an assumption that the pressure was high?

The value of any prophylactic antibiotic regime is that it results in therapeutic drug levels in the tissues and circulation at the time when bacteria are inoculated into the operation site. That 80% of the organisms isolated on blood cultures were sensitive to the combination of antibiotics used surely indicates tht insufficient drug was present in the blood at that time. This is a failure of the dosage and timing of administration, not the drugs themselves.

Despite these criticisms the article raises the important question of pressure at cholangiography, but surely firm conclusions can only be drawn from a randomised trial with pressure measurements recorded in each group.

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SIR,—The article by Lygidakis (*Gut* 1982; **23:** 1015–8) concludes that all on table cholangiography should be done under manometric control to reduce septic complications even if prophylactic antibiotics have been used. In the study of Strachan and his colleagues,[1] however, all the patients had on table cholangiography and in the group given one preoperative dose of cephazolin only 3·2% developed wound sepsis and in his total of 214 patients studied, 65 of whom received no antibiotics, there were no deaths and no intraperitoneal sepsis. There were no jaundiced patients in Strachan's study compared with 49 of the 194 patients in Lygidakis's study. Most jaundiced patients, however, have their ductal system visualised during preoperative investigations to elicit the cause of the bile duct obstruction and consequently they do not need on table cholangiography.

The dose of gentamicin used by Lygidakis would not have procuded adequate serum concentrations in many of his patients although the dose of ampicillin was adequate. The timing of the doses though may have been inappropriate. It is of no benefit and undesirable to start prophylactic antibiotics 12 hours before surgery and unnecessary to continue them for five days.[1] Furthermore, in the Lygidakis study anaerobes comprised 20% of isolates from the bile, an unusual finding,[2] and *B fragilis* was isolated from the blood of the two patients who died. The antibiotics used were inappropriate to provide prophylaxis against anaerobic flora.

We do not believe, therefore, that Lygidakis's report should induce surgeons to routinely undertake manometric surveillance of on table cholangiography. We would suggest that the author should follow the basic tenets of antibiotic prophylaxis and use adequate doses of an antibiotic appropriate to the bacterial flora given peri-operatively only.

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References

1 Strachan CJL, Black J, Powis SJA *et al.* Prophylactic use of cephazolin against wound sepsis after cholecystectomy. *Br Med J* 1977; **1:** 1254–6.
2 Keighley MRB, Burdon DW. *Antimicrobial prophylaxis in surgery.* London: Pitman, 1979: 71.

Books

Stomas *(Clinics in gastroenterology)* Edited by B N Brooke, K F Jeter, and I P Todd. (Pp. 435; illustrated; £10.75). Eastbourne, Sussex: Saunders, 1982.

The creation and the management of intestinal stomas has long been one of the Cinderella subjects of surgery. Outside the specialist centres where many stomas are created, recreated, and revised,

patients who have to have stomas often receive little attention and advice. Therefore it is timely that an edition of *Clinics in gastroenterology* should be devoted entirely to stomas and their care. The editors have planned their edition wisely and have produced a very attractive table of contents, including such important appendices as details about international ostomy associations and the list of manufacturers of ostomy aids.

When there are 23 contributors on a relatively small subject repetition is inevitable. There are 10 nurses or nurse/stoma therapists all contributing on minor variations of the main stoma theme and so repetition makes the nursing sections rather tedious, particularly if they are read consecutively. In general the chapters by the surgeons are better written and scientifically more valid than those by the nurses. I do not wish to appear carping or chauvinistic, but I was struck by this difference in almost all the sections. Presumably the surgeons have very much more experience in writing and in having their views criticised than do the nurses. Most of the nursing section are reminiscent of articles written for stoma association news letters rather than for scientific journals. In the section on the sexual implications of stoma surgery the first chapter by a surgeon is well written, sensitive and extremely helpful. The second section by a nurse/stoma therapist adds nothing to the preceeding chapter and could well have been omitted. The nurses also present some information that, I feel needs editorial comment. One of the nurse/enterostomal therapists appears to recognise a stoma called a 'wet colostomy'. In this, one or both ureters is implanted into a colostomy. She says 'The colon then drains faeces and urine giving a liquid output; this produces problems in management such as leakage and odour'. One would hope that such stomas are never created anywhere in the world. If they are, the editors should have commissioned a special chapter telling surgeons which stomas should never be performed including 'wet colostomies'! I think that the editors should make it clear that whenever it is necessary to divert urine and colonic faeces, this must be done separately with a 'dry colostomy' and a separate urinary conduit with an everted stoma to which a urostomy appliance can be stuck.

In another chapter a nurse/stoma therapist tells us about squamous metaplasia, which is the encroachment of epithelial cells onto the stomal mucosa. She says that this condition resolves in the presence of antibiotics, but relapses when they are withdrawn. For severe metaplasia she says that 'penicillin 200–250 mg may be prescribed twice daily; once started this treatment must be continued permanently'. I find this a fascinating concept and, if it is true, would be most interested to know the mechanisms involved. If there is published scientific evidence on this subject then the appropriate reference ought to be cited. On the other hand, if it is an unsubstantiated opinion, the editors should have insisted on this being made clear.

I have read and re-read sections of this book with great interest and profit. If I criticise it as being only good in parts, the good parts are very good and overall it is well worth buying.

JOHN ALEXANDER-WILLIAMS

Drugs and appetite Edited by T Silverstone. (Pp. 187; illustrated; £14.20). London: Academic Press. 1982.

I found this a useful little book, editorially tight, with a good team of 10 contributors. There is inevitably some artificiality in separating out the mechanisms of food intake and its regulation by drugs from the larger issue of energy balance and also the influence of such factors as food on intake. Nevertheless, within these clear limits the book contains excellent up-to-date reviews of research and concepts by Smith on the effect of food intake on feeding, and by Blundell on the behavioural pharmacological approach. The editor weighs in with excellent reviews of recent attempts to measure hunger in the human experiment and of the clinical pharmacology of appetite. Those interested in treating obesity with drugs will also value the cautionary and realistic chapter on this subject. Szmukler takes on the daunting task of reviewing the drug treatment possibilities for anorexia nervosa and does it competently. I was disappointed to learn that there is not yet a drug that is specific for the pathological desire to slim which seems to be at the heart of the condition!

The book is well-introduced and indexed, and provides some good bibliographies.

A H CRISP

Kidney disease: 3 Hepatorenal disorders By S P Wilkinson. (Pp. 208; illustrated; SFr98.) New York: Marcel Dekker, 1982.

The title of this book might encourage potential readers who are neither nephrologists nor hepatologists to hope that it might clear the fog surrounding the term 'hepatorenal syndrome'. The author does this by disposing of the term altogether and attempting to classify the cause and different types of renal failure seen in liver disease. Though this task is completely achieved, the murk remains,