Correspondence

Empyema of the gall bladder

Sir,

The excellent article written by Dr Thornton and colleagues about empyema of the gall bladder (Gut 1983; 24: 1183–5) raises the problem of distinguishing cholecystitis from gall bladder empyema.

The whitish, purulent-like fluid often found in a gall bladder with cholecystitis, composed of calcium and bilirubin precipitates, debris, and a few white blood cells, often with bacteria, is not very different from pus collected from a gall bladder with empyema, which often contains remarkably few white blood cells.1

Studies in Japan suggest that cholecystitis is sometimes an infectious disease from the beginning, namely when associated with bile pigment and calcium, or mixed stones, in whose origin infection with β-glucuronidase producing E coli, Klebsiella, Bacteroides, or Clostridium could play an important role.2 3 In western countries infection seems to be generally secondary to cholecystitis.1 3 Cholecystitis can be initiated by phospholipase – for example, released by trauma from a stone – which converts lecithin into lyssolecithin and activates prostaglandin.4 Acalculous cholecystitis in debilitated patients is initiated by necrosis of the gall bladder blood vessels, probably related to factor XII activation.5 Whatever the cause of the inflammation, intestinal bacteria can reach the gall bladder by the portal circulation, and then directly from the liver through the bile, or through the lymphatics between the liver and the gall bladder. Occasionally infection may reach it by the cystic artery, or through the common duct.1 The frequency of bactobilia increases during the first week of acute cholecystitis, reaching up to 75%, and then decreases slowly.6

The final outcome of empyëma, or cholecystitis, depends on the complications, including bacteraemia and sepsis and these are related to the age of the patient and the length of obstruction.6 But the clinical, as well as the laboratory differences between these two entities remain to be sharply defined and a question has to be asked: is there a real frontier between cholecystitis and gall bladder empyema?

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References


Books


As in the previous issue the fifth volume of Recent advances in gastroenterology covers the whole of gastroenterological practice including hepatology. Contributors were asked to survey the literature from 1979–1981 and to discuss significant advances. Overall they have satisfied this brief to good effect and the reader is provided with a comprehensive coverage of significant papers on the oesophagus, the stomach and duodenum, the colon, inflammatory bowel disease, the liver, hepatitis (viruses and antigens), the pancreas and the gall bladder and biliary tract. The section on the small intestine provides an exception. Hegarty and Silk have devoted most of their chapter to an excellent readable review of gut hormones and peptides. The remainder is given over to factors affecting the absorption of peptides, iron, and vitamin B12.

Paediatric gastroenterology is particularly well covered now that there are separate chapters for the liver and gastrointestinal tract. As with the contribution on the small intestine the authors have indulged themselves and extended their review of the literature beyond the period 1979–1981. It makes for particularly useful reading for the general gastroenterologist who from time to time is asked to help in the management of paediatric problems.

Inevitably there are a few gaps in this volume. Surgical aspects of gastroenterology, particularly of the colon, receive scant attention. There is little on coeliac disease or about infections and bacterial
overgrowth. Tropical gastroenterology is not covered. But overall Professor Bouchier's format for Recent advances is both useful and effective. This is a book which most practising gastroenterologists will read and use repeatedly; that is until the next edition appears in three years' time.

G NEALE


This book is a reflection of the growing interest in clinical nutrition. The rapid growth of the subject has led to confusion over the selection of the most appropriate method of providing support as well as the indications and associated complications.

This uncomplicated practical single author text based on the personal experience in establishing a clinical service is most welcome as it provides a practical guide for the provision of nutritional support in hospital.

It begins logically with a consideration of the importance of the team approach. The pitfalls and difficulties in recognising malnutrition in hospital are reviewed critically and the real indications for nutritional support emphasised. The nutritional requirements of various groups of patients are considered including the special problems of liver and kidney disease, and the increased metabolic demands of the seriously injured.

There is quite correctly considerable emphasis on enteral feeding and this section includes a useful review of the mechanisms of intestinal absorption. The complications which can occur even with the simple tube are not neglected. Parenteral nutrition is given appropriate emphasis in a very practical manner paying particular attention to the insertion and care of intravenous catheters.

The main attributes of this book are its authority and clarity which makes it particularly useful for anyone setting up or joining a nutritional care team, and there are ample references for those interested in exploring the more controversial aspects of the subject.

I D A JOHNSTON


Pancreatic cancer is now the fourth most common cause of death due to malignancy with a survival rate of less than 10% at five years. Any method of earlier diagnosis is therefore welcome. Computed tomography can certainly diagnose most malignant tumours at time of presentation but as yet has not influenced the prognosis. In pancreatitis, however, pseudocyst formation is readily uncovered resulting in a more rational therapeutic approach.

Another important aspect of diagnosis is in determining inoperability by detecting vascular encasement and metastases in liver and lung. Computed tomography, furthermore, also allows accurate percutaneous cytology and pseudocyst drainage. In most cases, however, similar assessment can be made by ultrasonography, computed tomography being used thereafter if necessary.

Irrespective of its undoubtedly clinical value the anatomical detail that can now be displayed is remarkable. The pancreas can be clearly separated from surrounding blood vessels and the many variations in size, shape, and position recognised. Nevertheless, it is uncommon to visualise insulinomas.

The present position of computed tomography is presented in a well balanced account. This is a pleasant, informative, and accurate account containing the basic information required by practising radiologists and will furnish clinicians with a reference as to the possibility of this imaging modality.

LOUIS KREEL

News

BSG Spring Meeting: Salford
The Spring Meeting of the British Society of Gastroenterology was held from 25–27 April 1984 at the University of Salford under the presidency of Dr R B McConnell. The first day was devoted to an international teaching day held jointly with the Nutrition Society. The plenary and scientific sessions of the Society were held on the following two days. The Research Medal for 1983 was awarded to Dr W D W Rees who delivered a lecture on 'the mucus-bicarbonate barrier – its role in gastric mucosal defence. The Hopkins Endoscopy Prize was awarded to Dr J Dawson. The Conference Dinner was held in the Great Hall of Manchester Town Hall and the social programme included a reception at the Salford City Art Gallery.

Notice to Conference Organisers
Organisers of conferences, symposia, congresses and courses who wish to have brief details inserted in this column for the benefit of readers of Gut are asked to note that copy should be received in the editorial office not less than four months before the desired date of publication. In general, only the title of the meeting, the dates and location, and the name and address of the organisers will be published.