
Reply

sir—We would like to thank Castañeda *et al* for pointing out our apparent omission of five other cases of protein losing enteropathy (PLE) with systemic lupus erythematosus (SLE) previously recorded in the literature. We felt, however, that certain other points which they raised were not entirely valid.

Firstly, although it is true that our patient does not quite fulfil the modified ARA criteria for SLE, clearly she does not have clinical features of any other connective tissue disease and cannot therefore be categorised as mixed connective tissue disease. This is a situation which frequently arises in practice and such patients are therefore best classified within the SLE syndrome. The presence of RNP antibodies and absence of DNA antibodies is quite compatible with a diagnosis of SLE. Secondly, we feel that it is fairly obvious from our list of negative investigations that reasonable steps were taken to exclude the other possible causes of PLE. Thirdly, it is also clearly stated that our comments about the pathogenesis of the oedema are purely speculative and we do indeed refer to the possibility of an immune complex-mediated vasculitis as a possible mechanism. There was, however, no clinical evidence of vasculitis elsewhere.

Finally, our patient is of Anglo-Saxon origin.

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Reference


Coeliac disease presenting with intestinal pseudo-obstruction

sir,—Thank you for the opportunity to comment upon Dr Cluysenaer and Dr van Tongeren’s letter (Gut 1985; 26: 538). Our findings do not support their hypothesis because although we did not measure vitamin E levels, there was no evidence of ceroid deposition in full thickness biopsies of the jejunum, ileum and colon of our patient (Gut 1984; 25: 1003–8).

Ceroid accumulation has long been recognised in association with proven or suspected coeliac disease but its presence is generally considered to give rise to no symptoms. In only one previous case was pseudo-obstruction a reported feature. Ceroid deposition has also been recorded in a case of pseudo-obstruction associated with scleroderma. As focal muscle atrophy with fibrous replacement can account for the motility disturbance of this condition, however, there seems little need to invoke a role for the ceroid pigment, especially as its presence has not been documented in other reports. Furthermore, ceroid has also been shown in cystic fibrosis, biliary atresia, and cirrhosis in childhood and in chronic pancreatitis in adults, all conditions which could result in malabsorption of vitamin E, but which are not associated with pseudo-obstruction. Thus, the presence of ceroid pigment may merely be a reflection of the vitamin E status of a patient rather than be causally related to intestinal motor dysfunction.

A role for vitamin E deficiency per se in pseudo-obstruction still remains a possibility, especially as such deficiency in animals may produce central nervous system effects and nutritional muscular dystrophy. The mechanism of vitamin E deficiency is ill-understood, some effects being reversible by antioxidants, others by selenium and yet others responding only to vitamin E replacement. Any possible effect of vitamin E on neuromuscular dysfunction in coeliac disease might thus be independent of the finding of ceroid deposition which is thought to accumulate because of the antioxidant deficiency.

The association rediscovered by Cluysenaer and van Tongeren is potentially important, but further studies are required to clarify any relationship between vitamin E deficiency, ceroid deposition, coeliac disease, and pseudo-obstruction. It would thus be important to know, for example, how many of their patients without ileus had ceroid deposition, and whether there was any correlation between this, vitamin E or selenium concentrations, and intestinal transit time.

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References

Books


This is an excellent if somewhat expensive little book with 60 clear, colour illustrations. It has, however, some of the most appalling line drawings that I have seen in any textbook from west of the iron curtain. A lot of thought has gone into the production of the text. It is a great pity that as much thought did not go into the selection and production of the illustrations. Some of the early illustrations are naively simple with anatomical details that are reminiscent of the words of the song 'The thigh bone is connected to the hip bone'! The book is extensively illustrated with amateurish line drawings by Mr T S Quinn. There is a certain attraction in the drawings of an enthusiastic amateur but it is difficult to forgive the appalling reproduction. The publishers John Wright say that the book was printed in the United States of America. It certainly does not live up to the standard that one would expect from that country. Not only are the line drawings tiny and indistinct but the print type used for the Tables has an old fashioned look about it. Some of the choices of illustration are so poor as to be laughable; the biggest laugh of the book comes on page 115 in which the whole page is taken up by a sexy, sultry, nude tailors-model sitting uncomfortably on a hospital bed about to start colostomy irrigation. The model’s expression and pose are so provocative that the reader cannot resist drawing a balloon coming out of the model’s mouth and adding his or her amusing caption.

Having been scathing about the illustrations let me hasten to redress the balance by praising the wisdom of the practical tips to occasional stoma surgeons and to stoma therapy nurses. All of these will read this book with profit.

There are certain surprising omissions. There is relatively little about continent ileostomies and nothing about continent colostomies, not even condensation. There is far too little about the physiology of colonic irrigation or about the physiological effects of the continent nipple valve ileostomy.

I suspect that the book has been a long time in gestation. In a short addendum at the end of the book there are cryptic references to ‘modern advances’ such as perineal pouches with ileoanal anastomoses and stomahesive rings replacing karaya gum. These ‘addenda’ suggesting that the manuscript of the book was finished at least five years ago.

Having picked it up and browsed through it at a book stall, I do not think I would spend £35 to buy it, but I would suggest to my stoma therapist that we included it in the gastroenterological unit library.

J ALEXANDER-WILLIAMS


It is always refreshing to look at a medical book which is in no sense a textbook. Controversies in Gastroenterology certainly does not come into this category. It consists of debate by experts concerning areas of gastroenterology where there are differing opinions about the correct therapy or mode of investigation necessary for patients with a variety of gastrointestinal disorders. The contributors are all distinguished American clinicians – though one is from industry – and the editor is Gary Gitnick, Professor of Medicine UCLA.

The topics that have been chosen for debate include aspects of the treatment of Crohn's disease, alcoholic hepatitis, chronic hepatitis B, pancreatitis, the place of endoscopy in intestinal bleeding, immunisation of needle stick patients with hepatitis B immune globulin, perioperative nutritional support, etc – 10 in all. In each case the therapeutic manoeuvre or investigation is first supported and then attacked by two different clinicians, and a