

reported in the controlled trials. It is very difficult to differentiate the diarrhoea of therapy and that of the colitis without a concurrently studied placebo group. Further research will be necessary to truly determine the incidence of this proposed complication in the general population of ulcerative colitis patients treated with olsalazine sodium.

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Reply

SIR,—We would not disagree with any of the comments in Dr Meyer's letter. Our paper reported a physiological study designed to investigate one of the possible mechanisms for the diarrhoea reported in some clinical studies using olsalazine. We did not attempt to review the rather conflicting evidence on the frequency of diarrhoea in patients taking this drug, and note with interest Dr Meyer's own experience. Our own experience is also that diarrhoea is not a frequent side effect¹ and in a further and controlled study to be published shortly as an abstract we only had one withdrawal because of watery diarrhoea among 20 unselected outpatients with ulcerative colitis given olsalazine; one of the 17 patients on sulphasalazine also withdrew because of diarrhoea exacerbation, in that case bloody.² The patients on olsalazine did, however, have more unformed stools during treatment than those on sulphasalazine. This

is not necessarily undesirable, and could be positively beneficial for the 27% of patients with ulcerative colitis who develop hard stools during exacerbations.³

We agree with Dr Meyer that there is considerable discrepancy in the reported incidence of diarrhoea on olsalazine, and its true frequency is still not clear. In our experience it is infrequent in the typical outpatient with distal ulcerative colitis, responds very rapidly to withdrawal of the drug, and is easily distinguished from the true exacerbation of colitis which can occur with any preparation which relies for its therapeutic effect on the liberation of 5-aminosalicylic acid in the colon.

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Changes in gastric alkaline secretion by ulcer healing drugs

SIR,—Professor Konturek's findings that pirenzepine does not influence gastric bicarbonate production in man¹ has been questioned by Dr Stockbrugger (*Gut* 1987; **28**: 1687) because the dose administered (20 µg/kg) is quite low compared with the normal therapeutic dosage.

Several years ago we performed experiments in 10 healthy subjects in whom HCO₃ secretion was measured by Feldman's method. Either pirenzepine 10 mg or saline were given, in randomised order, by bolus iv injection at 0 and 60 minutes during a 120 minute continuous infusion with pentagastrin (6 µg/kg/h). The results (unpublished) showed, in agreement with Konturek's recent paper, that pirenzepine exerts no direct effects on gastric alkaline secretion in man.

On the other hand, Konturek *et al* have also reported in *Gut*² that intragastric instillation of colloidal bismuth induces a significant increase in alkaline secretion by the human stomach. This remains in apparent disagreement with a recent

report by Shorrock *et al*³ who, although observing a stimulatory effect of De-Nol *in vitro*, failed to detect a similar increase in HCO₃ secretion in man. In Konturek's paper² significant results were obtained with drug concentrations of at least 10 mg/ml, but in Shorrock's experiment 10 mg/ml was still an ineffective dose.

We have recently treated 10 patients with endoscopic duodenitis (but devoid of gastric abnormalities and with normal basal values of bicarbonate secretion) with De-Nol 600 mg bid for four weeks. Basal alkaline secretion was determined, by Feldman's method, before treatment and 10 hours after the last dose of the drug. No significant changes in gastric bicarbonate output was observed.

A comparison of our results with Konturek's and Shorrock's findings seems to indicate that the stimulatory activity (if any) of therapeutic doses of De-Nol on gastric alkaline secretion in man is transient. Thus, as stated by Rees,⁴ this effect appears to have little relevance to the ulcer healing properties of colloidal bismuth.

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Book reviews

Manual of gastroenterologic procedures. 2nd ed. Edited by D A Drossman. (Pp. 266; illustrated; \$23.50.) New York: Raven Press, 1987.

This short book from the University of North Carolina Medical School aims to provide a guide to the indications, contra-indications, preparation, equipment, techniques and complications of the most commonly performed gastroenterological procedures. After a chapter on how to organise a gastrointestinal procedure unit, about 35 techniques are

concisely described under the headings tubes, endoscopy, needles, therapeutic procedures and procedures for paediatric patients. The text is clearly laid out, largely in note form, pertinently referenced and ring bound.

Unfortunately, as the editor acknowledges, the value of this as of any other compendium of clinical procedures is compromised by the impracticability of learning many techniques other than by apprenticeship, and by the inability of the instructions provided to take account of more recent methodological improvements or of differences in practice dictated by local needs and facilities. In the latter context, for instance, readers outside North America may find some of the devices and drugs recommended unfamiliar – for example, hurricane spray, unobtainable (catcher's mask) or obsolete (intravenous diazepam), and the US addresses of sources of equipment superfluous. The apparently idiosyncratic selection of procedures described perhaps also reflects the book's geographic origins. There are chapters, for example, on oesophageal dilatation but not intubation, on the PABA but not the pancreolauryl test and on the secretin tests but not the Lundh meal or calcium infusion test for pancreatic insufficiency and gastrinoma, respectively; the saline loading test for gastric emptying scarcely merits inclusion. While within these limitations most of the text is unexceptionable, individual readers will probably disagree with some of its assertions – for example, 'all patients having ERCP must be operative candidates', p 104) and regret some of its omissions – for example, no list of complications or mention of the Trucut needle in the chapter on liver biopsy.

The book is intended for physicians, nurses, technicians, and students. Clinicians learning a new technique, however, require a more critical approach and may prefer to consult larger texts and original articles. The manual's usefulness to nurses and technicians will be limited by discrepancies between the procedures as detailed here and as done in their own units. Students need a text which concentrates more on the clinical context of gastrointestinal procedures than on their practical minutiae. It may not be possible to write a wholly successful procedural guide for such a diverse readership; regrettably, this attempt cannot be recommended unreservedly.

D S RAMPTON

Pathology of the pancreas by AH Cruickshank. (Pp. 275; illustrated; £74.) Berlin: Springer-Verlag, 1986.

An occasional biopsy from a stout hearted surgeon, fine needle aspirates from a 'meddlesome' radiologist and autopsy sections too autolysed for assessment