Correspondence

F NAMDARAN

1157

Dept of Community Medicine,
Lothian Health Board,
Edinburgh

sir,—The paper by Mayberry et al is interesting and
also a timely reminder of what significant pathology
may exist undetected in our communities.

It would be interesting to know how the Nottingham
group decided to manage these asymptomatic
patients and how well their patients complied
with any treatments suggested.

J A R SMITH

Northern General Hospital,
Sheffield

Reply

sir,—We would like to thank both correspondents
for their comments. The use of ‘age specific rates’ for
the previously published data reported in Table 4
would have been inappropriate as they refer to the
prevalence of inflammatory bowel disease in whole
populations. Unfortunately, as discussed in the
article published, age specific prevalence rates for
populations aged 50-74 are unavailable.

Both patients with Crohn’s disease underwent
surgical resection. This would not be our routine
practise in asymptomatic patients but there was
concern that the abnormalities detected on radi-
ological examination could have been tumours. All
patients with ulcerative colitis were treated with
sulphasalazine and are now regularly followed in an
inflammatory bowel disease clinic.

J F MAYBERRY AND K C BALLANTYNE

Leicester General Hospital,
Leicester and
Queens Medical Centre,
Nottingham

Comparison of forceful dilatation and oesophagomy-
tomy in achalasia

sir,—The paper in the March issue (Gut 1989; 30: 299–
304) by Csendes and colleagues is of great interest.
Pneumatic dilatation for the management of achalasia
in their hands did not perform as well as surgical
management though as they admit their results using
the pneumatic method are not as good as those of
others. We have now followed up a much larger group
of patients than they refer to with the results remaining
as good. ‘Their disappointing results may be related
to the much lower inflation pressures which they use.

My impression is that many physicians/gastro-
enterologists are managing achalasia non-surgically. I
consider this a welcome development for the very

debits. It may, however, damage external surfaces
and in particular the rubber and plastics of the
insertion tube so instrument manufacturers do not
recommend immersion. Casemore and Blewett pro-
vide evidence that it is fully effective if crypto-
sporidial oocysts are exposed for 30 minutes. Flush-
ing and shorter times may not be sufficient.

There are problems with the four other disinfect-
ants listed and which are said to be partially effec-
tive. Exspor in preliminary tests against polio virus
and herpes simplex virus has shown rather poor
activity compared with glutaraldehyde (Ayliffe G. —
personal communication). One per cent ammonia is
not suitable for bacterial disinfection, sodium hypo-
chlorite damages endoscopes and sodium hydroxide
may do also.

Although in immunocompetent individuals
cryptosporidium causes a transient diarrhoea, the
infection may be life threatening in the immuno-
suppressed. While there have been no reports of
endoscopic transmission we would agree that a
new disinfectant, active against cryptosporidium,
is needed for use before endoscopy in immuno-
suppressed patients. At present we recommend
thorough mechanical cleaning followed by immers-
ion for one hour in 2% activated glutaraldehyde
before and after endoscopy on immunocompromised
patients. This is to ensure that atypical mycobacteria
are not transmitted to immuno suppressed patients
and that M tuberculosis is not transmitted from
a symptomatic patient with HIV infection to an
immunocompetent patient.

Casemore and Blewett provide evidence that 30
minutes in 2% glutaraldehyde is not effective for
cryptosporidium. We stress in our report that
thorough mechanical cleaning with detergent is the
most important part of the disinfection procedure. It
would seem that we have to rely on this until there is
an alternative disinfectant. We hope that the work
underway by Casemore et al will contribute to final
recommendations.

1 V D WELLER, A T R AXON, AND D J JEFFRIES

Gastroenterology Unit,
General Infirmary,
Leeds

Epidemiological study of asymptomatic inflammatory
bowel disease

sir,—Dr Mayberry and colleagues (Gut 1989; 30:
481-3) used prevalence rates in the above article in a
rather misleading way. For instance, comparisons in
their Table 4 do not state which age groups the
prevalence rates refer to in the various studies which
they have compared. The use of age specific rates
would have overcome this difficulty.
Correspondence

Mediators of vasopressin induced natriuresis in cirrhosis – possible role of atrial natriuretic factor
SIR, – Lenz et al (Gut 1989; 30: 90–6) recently reported increased natriuresis and diuresis in patients with cirrhosis and ascites after vasopressin infusion. The authors suggested suppression of sympathetic nervous system activity as an important mediator of the beneficial effects of vasopressin. Neither this nor other mechanisms discussed, however, could satisfactorily explain the observed improvement of renal function.

For further elucidation of the interesting results reported by Lenz et al, investigation of the atrial natriuretic factor (ANF) might be helpful. The role of this first well defined natriuretic hormone in volume retention of cirrhosis is being controversially discussed,1 with some authors reporting a relative deficiency of ANF plasma concentrations or impairment of ANF release in patients with cirrhosis and ascites.2 In rats, infusion of vasopressin has been shown to increase ANF plasma concentrations and ANF-induced natriuresis was found potentiated by vasopressin administration.3 Observations of an inhibition of vasopressin release by ANF4 lends further support to the contention that both hormonal systems are closely related. Thus, determination of ANF plasma concentrations might reveal ANF as a mediator of the vasopressin induced natriuresis in patients with cirrhosis and ascites.

ALEXANDER I. GERBES

Department of Medicine II,
Klinikum Grosshadern,
University of Munich,
Munich, Federal Republic of Germany

References


Reply

SIR,—We are grateful to Dr DelliPiani for his interesting comments.

The inflationary pressures that we use vary from 12 to 15 pounds per square inches (250 to 300 mmHg metric) which we believe are high pressures.

We have not used diazepam sedation because the pain that is usually seen with pneumatic dilatation, could be masked. We always perform radiological control of dilatation, however, and could therefore use diazepam.

Cooperative randomised studies are needed, but it will not be an easy task.

ATILLA CSENDES

Hospital Clinico
‘Jose Joaquin Aguirre’,
Santiago, Chile

References