Epithelial dysplasia is frequently seen adjacent to cholangiocarcinoma in the intra- and extrahepatic bile ducts and carcinoma of the gall bladder which has a similar epithelial lining. Extensive severe epithelial dysplasia involving the gall bladder, cystic duct, and common bile duct, associated with adenocarcinoma of the common hepatic duct, was recently reported in a patient with primary sclerosing cholangitis and chronic ulcerative colitis, diseases which, like Caroli’s disease, are associated with an increased risk of cholangiocarcinoma. These findings, and that of epithelial dysplasia unassociated with carcinoma in Caroli’s disease, provide evidence of the premalignant nature of biliary epithelial dysplasia. Because such dysplasia is usually detected only in surgical specimens, we agree that early resection of localised forms of Caroli’s disease may be necessary to prevent late complication by cholangiocarcinoma.

Figure: Severe dysplasia of epithelium in dilated bile duct.

In the discussion the author refers to our article ‘IgA class antibody against human jejunal in sera of children with dermatitis herpetiformis’ (J Invest Dermatol 1986; 87: 703-6). It follows: “... the IgG type of reticulin antibodies reacting with human liver and spleen has also been described previously and already Seah et al1 and Eterman et al2 showed that such antibodies can react with human jejenum, a finding recently confirmed also by Karpati et al3. Here we described for the first time IgA type antibodies binding to human jejenum and that they may be related to reticulin antibodies. An IgG type reticulin antibody reacting with human small bowel was seen by Eterman et al4... the IgG type of reticulin antibodies were reported of low frequencies (18-46%) and low specificity (75-85%) in coeliac disease. In contrast, IgA class antibodies may be more sensitive and specific. (From the introduction of Dr Hallstrom’s paper.)

Jejunal antibodies have distinctive characteristic signs compared with other IgA type reticulin antibodies: they bind to the small bowel, which is the damaged organ in gluten sensitive enteropathy and they bind at the site of gluten absorption which is the precursor of the disease. In addition, the binding site of IgA jejunal antibody corresponds to or is very similar to the extraacellular IgA deposition detected in the diseased jejenum of patients with gluten sensitive enteropathy. Because of the damaged structure of jejunal jejunum, this similarity can be ascertained by investigating the diseased small bowel of patients with almost normal villous structure: (a) jejunal biopsy samples taken several hours to one to two days after gluten challenge in coeliac patients who have recovered on gluten free diet; (b) we found IgA deposits in the small bowel of dermatitis herpetiformis patients with almost normal jejunal structure.

In the present work Dr Hallstrom found both the endomysium, and IgA type reticulin antibodies to be very important in the diagnosis of gluten sensitive enteropathy, and by absorption studies the endomysium antibody (sub-stratum eosinophagis) was related to the human subtype of reticulin antibodies and was distinguished from that of rat subtype. We think that anti-human antibodies are important in considering the pathogenesis of coeliac disease, they must be related to the IgA type antibodies reacting with human jejenum.

We conclude that one of the reticulin antibodies category mentioned does not correspond to the pathological concept of the IgA jejunal type antibodies supplied in our study.

BOOK REVIEW


Common problems in gastrointestinal surgery is one of a series produced by Year Book Medical Publishers on a variety of surgical subjects. The contribution in question is edited by Joseph Fischer, chairman of surgery at the University of Cincinnati. The approach is refreshing and novel. Each chapter is introduced by a specific clinical problem: four to eight line case history, one or more consultant is then asked to comment. Most contributors are pithy and to the point. Their comment usually consists of a brief overview of the literature, some reference to pathophysiology followed by the contributors own view on management. The book is largely, I suspect, designed to assist the private practitioner in North America to provide optimum clinical management based upon the views of experienced clinicians. The layout, diagrams and artwork are pleasing. Only key references are provided. The contributors: 66 in all are household names in GI circles, a few have retired from practice for a variable time but most are regarded as contemporary experts in their disciplines. Only three are not from the USA (two from the UK and one from Canada). The reader must therefore expect a US bias and a practical approach. Surprisingly the section on oesophageal and thoracic problems does not include any contribution on oesophageal carcinoma which

common with the development of endoscopic endoluminal ultrasonography, the growing recognition of early oesophageal cancer and the impact of low morbidity bypass, 347-8, and laser therapy on palliative therapy. I find it curious to come across two breast problems in the thoracic section.

The gastroduodenal section includes a single contribution on GI bleeding. The emphasis, as is prevalent throughout the book, is on surgical treatment without even reference to endoscopic assessment or the role of endoscopic therapy. The medical/surgical divide is a real one in North America and the concept of joint management is not one that flavours this book.

The hepatobiliary section is varied and interesting, but it is difficult to do justice to all that has occurred over the last decade in liver transplantation by reference to a single case report.

The endocrine section makes interesting reading, but the gastrointestinal component of many case reports is enigmatic.

There is some unfortunate duplication in the colorectal section particularly with reference to diverticular disease and regional enteritis. The important clinical problem of major colonic haemorrhage takes no account of rapid bowel preparation and therapeutic endoscopy or the impact of intraoperative panendoscopy on surgical strategy. This is a bold and attractive approach to a surgical update. In gastroenterology it must include joint management with gastroenterologists. The experiment has been a good one