It was not our intention to imply that cytotoxic events only start with bacterial adhesion. It is self evident that the loss of microvilli which precedes and facilitates close attachment must be a manifestation of cellular injury. It seems, however, that cell adhesion is required for more severe cytotoxic effects and possibly the induction of an immune response. This could explain the finding of H pylori in the mucus layer of normal stomach corpus mucosa in some cases of antral gastritis. We do not agree that bacterial adherence is likely to be a late event after epithelial injury sufficient to cause mucin depletion and cellular degeneration. On the contrary, we were surprised by the lack of degeneration seen ultrastructurally in surface cells bearing anation. On the mucin late event after furthermore, the attachment to there would be 1
1 Avery Jones, Francis SIR,-In various London teaching course in for the first time. The rounds, collaborators distinguished at I
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Obscure anaemia and hepatic dysfunction in Castlemann's disease

SIR,—The fascinating case of Castlemann's disease described by Featherstone et al (Gut 1990; 31: 834-7) bears a striking similarity to that of a young woman under our care. She had a long history of vague ill health from the age of 20. Clinical examination was normal but she was found to have moderate anaemia (Hb 9-2 g/dl), hyperglobulinaemia (IgG 55-8 g/l, IgA 6-2 g/l, IgM 3-6 g/l) and a raised erythrocyte sedimentation rate (100-130 mm in the 1st h). Bone marrow examination was essentially normal and a haematological diagnosis of anemia of chronic disease was made. The patient continued to complain of malaise and the abnormal laboratory tests persisted.

Teradaya et al (Hepatology 1989; 9: 1011-7) described five Japanese patients with Castleman's disease and malignant lymphoma who had presented with anaemia, elevated liver enzymes and hypogammaglobulinaemia. This entity was said to have characteristic blood and bone marrow findings. These patients had a strong male preponderance and the lesions were seen in the liver, spleen, and lymph nodes. The author speculated that there might be a subgroup of Castleman's disease with a more malignant course.

Two years later, 13 years after the initial presentation, the patient developed menorrhagia. An ultrasound scan of the pelvis showed a large paraaortic mass with a 10 cm retroperitoneal tumour. At laparotomy, by a 10 cm retroperitoneal tumour. At laparotomy, the mass was lobulated and had multiple areas of echogenicity. The mass was removed and histology revealed a large lymph node mass with a central necrotic area. The patient has been well since surgery and has no evidence of recurrent disease.

In our patient, as in the patient described by Featherstone et al, there was a long history of vague ill health and unexplained anaemia, hyperglobulinaemia, and abnormal liver function tests. The diagnostic process was prolonged, which is unfortunate in view of the gratifying results of surgical excision. This diagnosis should be considered earlier in a young patient who presents with these features.

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Role of computed tomography, endoscopy, and echoendoscopy in the management of alimentary tract lipomas

SIR,—We read the paper by Kang et al about the role of computed tomography and endoscopy in the management of alimentary tract lipomas (Gut 1990; 31: 550-3). They describe the management of four cases of alimentary tract lipomas and recommend the use of endoscopy and computed tomography in the diagnosis. Recently it has been stated, in different studies, that echoendoscopy was a better procedure in the assessment of alimentary tract subepithelial tumours than computed tomography,1 digestive tract lipomas being visualised as a hyperechoic mass in the digestive tract.1 Echoendoscopy uses an echographic transducer at the tip of an endoscope. Its use is increasing. We use the side viewing echoendoscope, Olympus EU M3.1 With this echoendoscope the exploration of patients 3 and 4 (lipomas of the sigmoid and oesophagus) would have been possible. For patients 1 and 2 (lipomas of colon and ileum) the use of the side viewing echocoloscope, now available, would also have given a correct diagnosis. In the patients reported on by Kang et al, the tumours were over 3 cm in diameter. Some lipomas may be smaller and hardly capable of being seen on computed tomography. Therefore, we think that today the pretherapeutic assessment of alimentary tract lipomas should be done with endoscopy and echoendoscopy.

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Reply

SIR,—We thank Drs Roseau and Paolaggi for their comments. We have no personal experience of echoendoscopy but agree that it should be superior to computed tomography in the evaluation of submucosal lesions. This modality, however, unlike computed tomography, is as yet of limited availability. Our comments on computed tomography relate to large lesions since those smaller than 1-2 cm may not be able to be visualised.

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