currently using balloon dilatation as opposed to bougies, in the hope that shearing stress on the fragile mucosa is reduced, but repeat dilatation after each technique seems to be equally common. Thirdly, we feel that oesophageal replacement should be avoided, owing to the particular problems of surgical and anaesthetic management. Strictures do not always recur after dilatation and none of our 258 patients has needed oesophageal surgery. Lastly, it is worth noting that an ‘inverse’ form of dystrophic EB exists, probably with recessive inheritance, in which oropharyngeal and oesophageal involvement may be severe, but skin lesions relatively mild.

The management of such difficult problems requires a multidisciplinary approach, with cooperation between dermatologists, gastroenterologists, ENT surgeons, plastic surgeons, anaesthetists, radiologists, and dietitians.

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Limitations of faecal chymotrypsin as a screening test

Str.—We read with interest the paper by Riedel et al (Gut 1991; 32: 321–4) on the levels of chymotrypsin in the stools of South African patients with chronic pancreatitis and apparently healthy people. There are some points that we would like to make. Firstly, we wonder if the faecal chymotrypsin test should be regarded as a screening test for chronic pancreatitis. This is in part due to the characteristics of the disease: chronic pancreatitis is rare enough not to make a diagnosis in the asymptomatic phase practical; moreover, we have no proof that early treatment can modify its course. On the other hand, the faecal chymotrypsin assay itself is not a good screening test, since it is consistently abnormal only in patients with advanced exocrine impairment. We, for example, found normal levels in only four of 31 patients with exocrine insufficiency, but in all of 13 patients with chronic pancreatitis. In our opinion, therefore, the test should be considered as a test for pancreatic insufficiency only. This is not simply a semantic problem. It implies (i) that control subjects should be patients with chronic pancreatitis without exocrine impairment, rather than asymptomatic subjects from the general population; (ii) that we should choose the cut-off point that best distinguishes between patients with and without insufficiency (malabsorption or severely impaired secretin-pancreozymin test) rather than between asymptomatic control subjects and patients with pancreatitis. We wonder therefore, what was the specificity of the test for pancreatic insufficiency considering this lower cut off point.

We found the relation between faecal chymotrypsin and stool pH interesting. The correlation was found only in the control subjects. If we have correctly interpreted the data, the chronic pancreatitis patients were studied while on a hospital diet, whereas all the controls were outpatients. The large fibre intake in controls might have induced a large faecal bulk with possible diluting effects on faecal chymotrypsin. All the references in the paper argue against a distuting effect by faecal bulk on faecal chymotrypsin dealt with the effects of fat malabsorption in Western patients with chronic pancreatitis on a low fibre diet, which represents a different condition. Moreover, different time periods are likely to have elaped between the bowel movements and stool pH measurement in controls (one morning) and in chronic pancreatitis patients. When we measured stool pH immediately and one and six hours after the bowel movement, a progressive reduction in pH was found in five of six chronic pancreatitis patients (from mean (SEM) 7·03 (0·18) to 6·85 (0·11) to 6·7 (0·12)). We wonder, therefore, if both the low pH and chymotrypsin values in some controls may represent hydrolysis by intestinal bacteria for the longer elapsed time in a warm and sunny country. Again, this would argue against the use of the assay as a screening test in the general population, but not in inpatient settings.

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Reply

Str.—We welcome the opportunity to reply to the letter from Drs Cavallini and Benini. Certainly, faecal chymotrypsin in a test to assess exocrine function. The diagnostic value of the test for screening for chronic pancreatitis by showing exocrine pancreatic insufficiency has been suggested by others and was not the aim of our study. It has been clearly shown that chronic pancreatitis disease is too often missed.7 Most patients with chronic pancreatitis presenting to our unit have advanced disease with exocrine insufficiency. In these patients faecal chymotrypsin determination is a valuable screening test provided faecal pH is taken into consideration. The suggestion that control subjects should be patients with chronic pancreatitis but without insufficiency is of interest but was not the objective of our study. We emphasise that the question posed was the effect of faecal pH on faecal chymotrypsin.

It is correct that we found a correlation between chymotrypsin and stool pH only in control subjects. Patients with chronic pancreatitis and control subjects were not on a hospital diet. They were studied as outpatients on free living diets. It should be noted that the dietary fibre consumption of urban and rural blacks has decreased. In fact in urban blacks dietary fibre consumption is much lower than in Western populations.8 This makes it unlikely that faecal bulk was an important factor. There was no time lapse between bowel movement and stool pH measurement in control subjects and patients. In all subjects stool was put on ice and pH was measured within six hours. Samples were then deep frozen and faecal chymotrypsin was measured within 10 days. Faecal chymotrypsin activity has been shown to be very stable over several days at room temperature.

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BOOK REVIEWS


The basis of this annual book, with over 60 contributors, is the continuation course in surgery at the University of Minnesota. Its purpose is to provide an update on the specific but fairly broad areas of general surgery. The course from which this book was generated, dealt with the liver, biliary tract, and pancreas. Despite the relative paucity of its coverage in the literature, the book has demonstrated that there is more medical in orientation but the book does not lose value from that. For example, the chapter by Dame Sheila Sherlock on ‘Viral hepatitis and the surgeon’ is a model of its kind. The authors have brought together a surgical talent, including Henri Bismuth, Martin Adson, Babs Moosa, Seymour Schwartz, Frank Moody, and Ben Eisenman. Books such as this are essentially ephemeral, but with the rapid pace of development in this field, even encyclopaedic tomes are usually of only temporary interest. The particular value of this book is that all the contributions are brief, written attractively, and well illustrated.