target biopsy specimens can be obtained from an abnormal area.

It is true that a small proportion of patients develop carcinoma in colitis without dysplasia elsewhere in the colon and that dysplasia, when present, is usually patchy. The paper by Rasonhoff et al. however, is quoted as evidence that dysplasia at a distance from the cancerous lesion occurs in only 50% of coloectomy specimens. This paper was based on histological blocks from only 22 specimens with cancer in colitis, complete resections were performed in only 11 of the patients, and more than five blocks were available from only 13 of the specimens. Some dysplasia at a distance from the tumour was found in 73% of specimens and high grade dysplasia in 50%. The authors suggest that one reason why the incidence of dysplasia was less than in other reports may have been due to limited sampling. Careful examination of 62 coloectomy specimens with cancer in colitis at St Mark's Hospital has shown dysplasia at a distance from the tumour in 87%.

Dr Rasonhoff selected three clinical studies for comment and we appreciate her remarks about the importance of high levels of follow up and of clinical care in regard to our surveillance programme. It is a pity that she made no reference to two excellent Swedish series, one report on the risk of carcinoma in which there has been cancer death and in which the three tumours treated surgically were at an early stage (Dukes' A).

Like Dr Gyde, we would welcome the development of a new marker of neoplastic potential in colitis. Apart possibly from analysis of aneuploidy, which is complex and expensive, no such marker has been identified. Despite its limitations, dysplasia is still the only thoroughly tested marker we have and it should not be rejected.

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3 Butt JH, Konishi F, Morson BC, Lennard-Jones JE, Kitchin DM. Macroscopic lesions in dyspla-
5 Berrentor C, Löfberg R, Öst A, Reichard H. Cancer in ulcerative colitis: a population-based study of patients with longstanding ulcerative colitis: a clinical, endosco-

Reply

Sr.,—Professor Gyde and Lennard-Jones make several important points in their letter concerning screening for colorectal cancer. Firstly, while the term 'screening' or 'surveillance' is the appropriate term, given that the population screened are not 'healthy' members of the population. Ulcerative colitis patients benefit from regular follow up or 'surveillance' directed at the disease process itself. Gastroenterologists add this to their 'surveil-

ance' a screening test for colorectal cancer (for which these patients are at high risk) in the form of colonoscopy and multiple biopsies to detect 'dysplasia'. As far as colorectal cancer is concerned these patients are 'healthy' and the screening test is introduced (as with any other screening test for cancer elsewhere in the body) to detect either precancerous changes or cancer at an early stage. To call this screening procedure 'surveillance' confuses the issue, since it is no different from either 'screening' procedures for cancer.

The other major issue is whether a randomised controlled trial is usually a practical proposition. Professor Lennard-Jones suggests that patients might not agree to participate in such a trial, and that a survey among patients at St Mark's Hospital showed that few would accept random allocation. This might or might not prove to be the case but would become apparent in any event in the pilot study. A trial might be a daunting prospect but given European collaboration, the necessary numbers could be recruited quickly. In my view there would be little value in following self selected groups since, whatever differences in survival between the two groups were found, it would not be possible to tell whether the differences were due to selection biases between the two groups or whether the differences were due to 'screened' versus 'non-screened'. Random allocation is an essential prerequisite for meaningful results.

It could be argued that screening for cancer in ulcerative colitis patients is screening a small group relative to, for example, population screening for colorectal cancer. The costs and workload generated are therefore relatively small and a colonoscopy may be little more than a flexible sigmoidoscopy. Also very few patients come to any harm from the procedure itself. The situation, however, is still unsatisfactory whilst screening remains of no proved benefit.

There must be many district general hoso-
bilists in the United Kingdom with limited facilities and many patients who would will-
ingly forego the procedure if they knew it was not of proved benefit.

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Long-term maintenance treatment with sucralfate

Sr.,—Professor Blum et al report the super-
ority of sucralfate over placebo in the prevention of gastric ulcer recurrence. They speculate that continued treatment with sucralfate may have theoretical advantages over longer term maintenance therapy with antisecretory drugs, but fail to discuss the potential risk of alumin-
imum accumulation. Administration of sucralfate (1 g twice a day) will result in a daily intake of 414 mg aluminium. The aluminium moiety of sucralfate can dissociate at a low pH, and short-term administration of 4 g daily may lead to appreciable increases in serum and urine aluminium concentrations.1,2 Long-term administration of sucralfate (1 g twice a day) did not result in statistically significant increases in plasma aluminium in either of two small maintenance studies3,4 but animal experiments indicate that bony accumulation of aluminium may occur in the absence of raised serum concentrations.5,6 Sucralfate may prove to be effective and safe for the prevention of gastric ulcer recurrence.

However, further studies of aluminium accumulation from longterm use are likely to be needed before this drug can be widely recommended as an alternative to antisecretory agents.

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Reply

Sr.,—MC Allinson mentions in his letter experi-
ments in rats which showed an increase of bone aluminium concentrations. This finding, how-
ever, could not be confirmed in patients receiving 4 g sucralfate daily for 8-10 weeks before total hip replacement. There was no increase of bone aluminium concentration compared with a control group.1 Aluminium toxicity is mainly discussed in connection with uraemic patients and the application of high dose aluminium hydroxide as a phosphate binding agent. There is no evidence that longterm maintenance treatment with sucralfate in the recommended dosage in patients with normal kidney function will lead to unwanted side effects.

It should finally be mentioned that sucralfate is approved for the maintenance treatment of duodenal ulcer in several countries; recently it was approved for this indication also by the Federal Drug Administration in the USA.

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BOOK REVIEWS


This monograph written by Starzl and Demetris is an up to date summary of liver