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. describes that dysplasia at a distance from the cancerous lesion occurs in only 50% of colectomy specimens. This paper was based on histological blocks of 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 tumor 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 colectomy specimens with cancer in colitis at St Mark’s Hospital has shown dysplasia at a distance from the tumour in 87%. Dr. Wade 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, 1 one reflecting the fact that there has been cancer death and in which the three tumours treated surgically were at an early stage (Dukes’s A).

Like Dr. Gyde, we would welcome the development of a new marker of neoplastic potential in colitis. Apart possibly from analysis of anaeploidy, 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.

J E LENNARD-JONES
St Mark’s Hospital,
Cini Road,
London EC1V 1PS

---

**Reply**

Str.,-Professor Blum et al report the superiority of sucralfate over placebo in the prevention of gastric ulcer recurrence. They speculate that continued treatment with sucralfate may have theoretical advantages over longterm maintenance therapy with antisecretory drugs, but fail to discuss the potential risk of aluminium 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 can 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 Long-term maintenance patients may therefore have a high risk of aluminium accumulation. However, future studies of aluminium accumulation from long-term use are likely to be needed before this drug can be widely recommended as an alternative to antisecretory agents.

MILES CALLISON
Gastroenterology Unit,
Royal Infirmary,
Glasgow G31 2ER

---


---

**Book Reviews**


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