than 7%,¹ at the time of diagnosis. The authors note, however, that two patients within the Northern Region Register presented with right sided colonic polyps but no evidence of rectal polyps. Despite this finding, they still advocate rigid or flexible proctosigmoidoscopy as an adequate screening procedure of 'at risk' family members.

We feel it should be emphasised that within this high risk population, a large subset of patients present with 'rectal sparing' at initial diagnosis. As many as 20% of patients with familial adenomatous polyposis present with numerous colonic polyps in the total absence of rectal polyps.² Furthermore, invasive colorectal carcinoma has been noted in up to 8% of this group, with no evidence of rectal polyps.³ This was recently reinforced to ourselves, when a young man presented with invasive colorectal carcinoma and extracolonic manifestations of the syndrome, but no macroscopic evidence of polyps on rigid proctosigmoidoscopy. As illustrated in our own experience, we believe that rigid proctosigmoidoscopy is too limited an investigation to adequately screen the colorectal mucosa of these at risk family members, as rigid proctosigmoidoscopy alone has a potential false negative diagnostic rate as high as 20%, which may delay prophylactic colectomy and allow progression to colorectal malignancy in screened subjects.

We suggest that first degree relatives identified as carriers of the abnormal familial adenomatous polyposis gene (as detected by haematological screening for linked genetic DNA markers), should be screened every 12 months by flexible sigmoidoscopy as a minimum, and colonscopy as the ideal, and every 3 years in family members with negative linkage markers. The role of rigid sigmoidoscopy should be confined to regular long term follow up of patients at risk of rectal carcinoma following subtotal colectomy and ileorectal anastomosis.

Screening 'at risk' family members with flexible sigmoidoscopy or colonoscopy will minimise delays in diagnosis of affected subjects, and therefore reduce the incidence of colorectal carcinoma within the screened population.

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5 Bleeding varices in the elderly

EDITOR,—I read with interest the leading article by Triger (Gut 1992; 33: 1009-10) on the management of bleeding oesophageal varices in the elderly. I was surprised that he did not mention transjugular intrahepatic portosystemic shunting (TIPS), a new, minimally invasive interventional radiological technique for the treatment of bleeding varices. A tract is created between the hepatic vein and portal vein and patency is maintained by placement of an expandable metallic stent. The procedure is performed through a 10 French (3-3 mm diameter) sheath site in the internal jugular vein. Early results using this procedure have been very encouraging.

Unlike surgical portosystemic shunting, TIPS has low procedure related morbidity and mortality. Five patients of the first 59 reported have died in the first thirty days following the procedure; three had Child’s Stage C disease and two had sepsis unrelated to the TIPS procedure.¹ The oldest patient to undergo a successful TIPS procedure was 78 years old.¹ Encephalopathy following TIPS has been reported in one patient.¹ A recent editorial in the Lancet advocates a controlled trial of TIPS for injection sclerotherapy for the treatment of bleeding oesophageal varices.³ All gastroenterologists should be aware of this procedure.


Replication

Editor,—I am grateful to Dr McDermott for drawing attention to my omission of transjugular portosystemic shunting (TIPS) in my editorial. While this technique offers exciting prospects for a new therapeutic approach to variceal haemorrhage, I would urge some caution in its uncritical adoption. Results reported to date have been based on relatively limited experience from the few specialist centres and, as McDermott points out, no controlled trials have yet been undertaken to compare it with endoscopic sclerotherapy. It is somewhat surprising to describe the technique as being 'minimally invasive'; the procedure frequently takes as long as three hours to perform, and there have been several reports of fatal haemoperitoneum because of traumatic rupture of the portal vein liver.

Anecdotal reports of TIPS being successfully used in elderly patients should not be taken as evidence that the procedure should be readily adopted as an alternative treatment without careful evaluation. Whereas the elderly should not be denied any form of treatment simply on account of their age, it is equally important to ensure that new therapeutic manoeuvres are adequately assessed before being applied to them.

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Liver Disease

The XVIIIth International Update on Liver Disease will be held at the Royal Free Hospital School of Medicine, London on 8–10 July 1993. Further information from Professor Neil McIntyre, University Department of Medicine, Royal Free Hospital, Pond Street, London NW3 2QG. (Tel: 071 794 0500 extn 3969; fax: 071 435 5003.)

Gastrointestinal Motility

The 14th International Symposium on Gastrointestinal Motility will be held on 29 August to 3 September 1993 at Minnet, Muskoka, Ontario, Canada. Further information from Dr N E Diamant, Chairman, c/o Mrs Diana Valdez, Symposium Co-ordinator, Toronto Hospital (Western Division), 12-419 McLaughlin Pavilion, 399 Bathurst Street, Toronto, Ontario, Canada, M5T 258. Tel: 416 369 5075; fax: 416 369 6204.