than 7%, 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. Furthermore, invasive colorectal carcinoma has been noted in up to 8% of this group, with no evidence of rectal polyps. This was recently reinforced to ourselves, when a young man presented with invasive colorectal carcinoma and extracollonic 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 colorectal cancer screening, and 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 colorectaloscopy as the ideal, and every 3 years for the 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.

I S TAIFT D BYRNE J C FORRESTER Department of Surgery, Ninewells Hospital and Medical School, Dundee DD1 9SY


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 porto-systemic 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 situated 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. The oldest patient to undergo a successful TIPS procedure was 78 years old. Encephalopathy following TIPS has been reported in one patient. A recent editorial in the Lancet advocates a controlled trial of TIPS in injection sclerotherapy for the treatment of bleeding oesophageal varices. All gastroenterologists should be aware of this procedure.

V MCDERMOTT Department of Diagnostic Radiology, Hospital of the University of Pennsylvania, 3400 Spruce St, Philadelphia, PA 19104, USA


Letters. Notes

LIVER DISEASE

The XVIIIth International Update on Liver Disease will be held at the Royal Free 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 5015.)

GASTROINTESTINAL MOTILITY

The 14th International Symposium on Gastrointestinal Motility will be held on 29 August to 3 September 1993 at Minett, 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, 599 Bathurst Street, Toronto, Ontario, Canada, M5T 2S8. Tel: 416 369 5075; fax: 416 369 6204.