We have rare fibrosis to mucosal concentrations thyroiditis, sclerosing with Riedel's thyroiditis one the way, is the involvement. The Katsikas 1430-2 and agree that the combination of Riedel's thyroiditis, sclerosing cholangitis. Involvement. The setting the LB, MH, and fibrous disease. Inflammation, the article by van Du 3 Bartolo CSJ, Jayaraj JF, Pollock DI, Smitv, and Madras (India). Gut 1989; 158: 354A.

Franzin G, Scarpa A, Dina R, Novelli P. Transi-

tional and hyperplastic: metaplastic mucosa occur-
ing in solitary ulcer of the rectum. Histopa-


WINK A DE BOER

Department of Pathology, Southend Hospital, Brent BD10 5NB

1 Warren BF, Dankwa EK, Davies JD. Diamond shaped crypts and mucosal elastin: helpful diag-


Editor.—We have read the case report on multifocal fibrosis by Laitt et al (Gut 1992; 33: 1430–2) and agree that the combination of Riedel's thyroiditis with retroperitoneal fibrosis as well as sclerosing cholangitis is very rare. We have recently collected from worldwide studies 14 reports on the 14 patients with both Riedel's thyroiditis and retroperitoneal fibrosis and suggested a common pathogenetic mechanism.

In their article Laitt et al state that 'Bar-
tholomew noted an association of Riedel's thyroiditis, sclerosing cholangitis and retro-
peritoneal fibrosis in the same patient.' This is not correct. In the article by Bartholomew et al not one but two patients were described; one with sclerosing cholangitis and retroperitoneal fibrosis and the other with Riedel's thyroiditis and sclerosing cholangitis. This last patient, by the way, is the same patient as described by Woolner et al (reference 7 in the article by Laitt)

The patient described by Laitt et al is therefore not the third, but the second reported in published works with this triad of organ involvement. The only other patient was described, twice, not only by Gleeson et al (reference 2 in the article by Laitt) but once again with a longer follow up in an article by Katsikas from the same hospital in 1976.


Reply

Editor.—We are grateful to Dr de Boer for setting the record straight on the number of previous patients reported on with Riedel's thyroiditis, retroperitoneal fibrosis, and sclerosing cholangitis. We are not unhappy to learn that our patient is the second rather than the third. We are well used to coming second!

E ELIAS R LAITT

The Liver and Hepatobiliary Unit
Queen Elizabeth University Hospital*
Glasgow, Scotland

R N LONSDALE

Department of Gastroenterology
Addenbrooke's Hospital, With Road, Cambridge CB2 2QQ

Inflammatory bowel disease in Asians

Editor.—The studies by Probert et al1,2 have provided important information on the inci-
dence of inflammatory bowel disease in south Asians. Furthermore, the results have high-
lighted the fact that this is not a homogeneous group of patients, with significant differences between Hindus, Moslems, and Sikhs. The heterogeneity is perhaps not surprising because of the vast size of the Indian subcontinent, from which these patients originate.

Diet is known to play a part in the cause and subsequent course of inflammatory bowel disease. In addition to the obvious differences between European and Indian diets, there are also important differences in the diet within India. Epidemiological studies have shown that low fibre diet is a risk factor for inflammatory bowel disease.3 Areas in the south of India have a lower intake of unrefined fibre when compared with the northern regions.

Other dietary factors, such as antioxidants, may also be of importance. Recent evidence implicating oxygen derived free radi-
cals in inflammatory bowel disease.4 Healthy subjects in Madras, in south India, have been shown to have lower plasma values of ascorbic acid and it carotene than healthy subjects in England.5

Thus, some of the differences seen in the incidence of inflammatory bowel disease in people from the Indian subcontinent may be related to dietary differences. The differences in south Indians and south Asians, as well as dietary differences between the various groups from within the Indian subcontinent. It would be interesting to know if the findings of Probert et al were mirrored in Hindus, Moslems, and Sikhs within India.

P F PHILP

Medical Gastroenterology Unit, Northwick Park Hospital, Harrow, Middlesex HA1 3UJ


2 Jayanty V, Pinder CSJ, Fider D, Wicks AC, Maybery JF. Epidemiology of Crohn's disease in Indian migrants and the indigenous popula-


7 Chaloner C, Schofield D, Kay PM, Mohan V, Snehala C, Braganza JM. Xenobiotic detoxi-
fication and antioxidant profiles in healthy con-