LETTERS TO THE EDITOR

Radioisotope determination of regional colonic transit in severe constipation

Editor,—We were interested to see the article by van der Sijp et al (Gut 1993; 34: 402–8) on a scintigraphic method of colonic transit measurement compared with the conventional radiological method. There are, however, several points that we would like to raise. They have dismissed the method using methacrylate coated capsules as unnecessary and resulting in unnecessary there is a -notion. In an early study (30 patients, unpublished data) we examined the colonic transit without the use of pH sensitive capsules and often found overlap of the activity in the small and large bowel in the first day image. Particularly, if you have day clear gut emptying. Although this is not important in patients with severe chronic constipation, it is a problem with patients with normal or fast transit (such as some patients with inflammatory bowel disease). The method of methacrylate coating of the capsule, however, is important and in our preliminary studies using capsules with several coatings, there was delayed release in two of 10 patients. As we have modified the method of coating by reducing the number of coatings to two only in one of 130 patients studied so far has the capsule failed to open before reaching the ascending colon. One should aim for capsule release somewhere in the small intestine, having passed intact through the stomach, as activity tends to collect in the terminal ileum before its release into the colon. In our expanded imaging quality reached the whole ileum to obtain release precisely in the terminal ileum.

A fundamental problem arises in the use of 'centre of mass' (COM) to describe colonic transit and to compare the two methods of studying transit. COM is useful for examining groups of patients with colonic disorders. The radiologic and scintigraphic methods seem to be different from each other in this study as only the COM is used to compare groups for both methods. It is of limited value, however, in reporting and treating individual patients, especially when a full range of colonic motility disorders is under study. COM ignores all detailed information obtained by the scintigraphic method, which is essential for correct classification of different patterns of colonic movement. This is best achieved using parametric images.

A final point is the activity given for these investigations. We have found in a four day study sufficient to identify all patterns of colonic motility disorders even in those with severe constipation. The shorter study allows us to use smaller 111In activity (2 MBq) and still obtain good image quality, reducing the whole irradiation even further than that described by van der Sijp.

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Polyunsaturated fatty acid pattern and fish oil treatment in inflammatory bowel disease

Editor,—We read with great interest the paper by M Esteve-Comas et al (Gut 1992; 33: 1365–9). The authors claim that patients with inflammatory bowel disease have different plasma fatty acid patterns by comparison with controls, mainly characterised by an increase in n3 series and a decrease in some n6 series (20:3 n6) and that these differences are more pronounced, in an inversely proportional manner, according to the severity of the disease. These data suggest an increased polyunsaturated fatty acid biosynthesis and consumption in active inflammatory bowel disease, especially of the n3 series, raising some doubts on the use of high doses of fish oil in the treatment of acute inflammatory bowel disease. These results, however, need to be carefully considered. The authors did not separate the different lipid fractions containing the plasma fatty acids (phospholipids, triglycerides, cholesterol, and free fatty acids), by thin layer chromatography. This would have been of great benefit as the main source for the eicosanoids' synthesis is the fatty acid stored in the phospholipids and also because each fraction has different representation of each single fatty acid.1 Moreover, V Schackey et al have shown that the variability in the plasma fatty acid pattern is enormous and that the alimentary habit and the quality of lipid intake can modify the pattern in a few hours.2 For this reason an overnight fast is certainly insufficient to guarantee the stability of the plasma fatty acid pattern.

We recently quoted the plasma phospholipid fatty acid profiles in a group of Crohn's disease patients in comparison with a group of healthy controls and we did not find any significant differences. On the contrary we studied, in the same groups, the phospholipid fatty acid profiles in red blood cell membranes and we found remarkable differences: a significant decrease in all polyunsaturated fatty acids and a significant increase in the main saturated fatty acids (palmitic and stearic acids).3 Actually, the fatty acid profile in red blood cell phospholipid membranes is much more stable; six to eight weeks of a very high dose of n3 fatty acid supplementation (fish oil) is needed to modify its composition and occurs during cell formation.4 Regarding the use of fish oil in active inflammatory bowel disease, it should be noted that the incorporation of n3 fatty acids in the neutrophil membranes occurs by the replacing of arachidonic acid, the main source for LTb4 production and one of the most powerful inflammatory mediators.5 Our findings would suggest that the authors' results could have different interpretations.

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Reply

Editor,—We read the interesting comments by Belluzzi et al regarding our recent study on polyunsaturated fatty acids in inflammatory bowel disease. We are afraid that they have misinterpreted our results when stating that the differences in polyunsaturated fatty acids profile—the increase in n3 polyunsaturated fatty acids and a decrease of some n6 polyunsaturated fatty acids—were more pronounced...
in an inversely proportional manner according to the severity of the disease. In fact, the decrease in polyunsaturated fatty acids as the disease activity increases occurred for both series, although it was more noticeable for the polyunsaturated fatty acids. As a consequence of these findings, we hypothesized that inflammatory bowel disease can be prevented by nutritional means. Hyperconsuming polyunsaturated fatty acids, which is of clinical interest, would lead to an improvement in the inflammatory bowel disease, in which the role of fatty acid treatment also has to be investigated further.

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Open access gastroscopy

EDITOR.—Dr Bramble and colleagues describe a most efficient and well run open access gastroscopy service (Gut 1993; 34: 422–7). Even they, however, only achieve a mean waiting time of 17 days for open access endoscopy. Most of us would far worse and therein lies one important problem in our current endoscopy. We do deprive out symptomatic patients of effective ulcer healing treatment for 17 days so as to obtain a ‘pure’ endoscopic diagnosis but subject patients to 17 days of unnecessary symptoms and risks of complications, or do we treat patients in the knowledge that if an ulcer is present it may well have healed by the time the patient has an endoscopy, especially as it is increasingly so the general practitioner has prescribed a proton pump inhibitor.

A short outpatient visit in a general clinic or a specialist dyspepsia clinic would seem a better solution. General practitioners can be encouraged to treat patients as they see fit and the patients seen on treatment. If still symptomatic and, if it is appropriate, they can have an endoscopy immediately. If asymptomatic they can be asked to complete a treatment and arrangements made for the patient to book themselves in for endoscopy by telephone if and when their symptoms next occur before starting treatment. Additional investigations can be arranged and patients counselled as to the likely result of the endoscopy; normal endoscopy still being the single commonest finding. In our experience with this system 35% of patients will be spared endoscopy.

We found 68% of patients that had an endoscopy preferred this system to open access endoscopy despite the need for two hospital visits and if those spared endoscopy are taken into account 81% preferred the clinic appointment first.

Pressure from general practitioners to set up open access endoscopy is considerable. We feel a clinic appointment first, however, is a more logical solution and one that is favoured by the patient. The endoscopies saved may also make it more cost effective.

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Reply

EDITOR.—We are grateful for the opportunity to respond to the comments of Drs Trewby and Saunders. There is a basic misunderstanding in their letter. Our provision of an efficient open access gastroscopy service does not in any way deprive patients of effective treatment. We have not made any attempt to treat patients with dyspepsia on clinical grounds. Our guidelines point out that it is appropriate to refer patients for investigation and treatment. 'Report only' is felt that a diagnosis is more important before treatment is given or if this has happened and there has been a failure to respond after a reasonable time. The general practitioners in our district have a range of options for patients with dyspepsia and almost one in three of dyspepsia referrals are still by standard letter to a target consultant. The type of service described by Drs Trewby and Saunders is still available in Middlesbrough alongside the open access system. (In the case of open access endoscopy, the general practitioner has a further choice of asking for ‘report only’ or giving the endoscopy distortion about treatment and further investigations. 'Report only' is felt that a diagnosis is more important before treatment is given or if this has happened and there has been a failure to respond after a reasonable time. The general practitioners in our district have a range of options for patients with dyspepsia and almost one in three of dyspepsia referrals are still by standard letter to a target consultant.) The type of service described by Drs Trewby and Saunders is still available in Middlesbrough alongside the open access system. (In the case of open access endoscopy, the general practitioner has a further choice of asking for ‘report only’ or giving the endoscopy distortion about treatment and further investigations. 'Report only' is felt that a diagnosis is more important before treatment is given or if this has happened and there has been a failure to respond after a reasonable time. The general practitioners in our district have a range of options for patients with dyspepsia and almost one in three of dyspepsia referrals are still by standard letter to a target consultant.)