Editor,—We are grateful to Dr Whitelaw and Mr Northover for drawing our attention to recent work, some unpublished, which shows that the exact role of Nm23 in colorectal neoplasia is still unresolved. In their paper Myeroff and Markowitz report inactivation of the gene in 53 of 41 colorectal tumours, an unexpected finding for what is purportedly a ‘suppressor’ gene. While these results are not necessarily inconsistent with ‘suppressor’ function, p 53 for example is a tumour suppressor gene overexpressed by virtue of a point mutation that changes its biological activity, the finding in the same study that none of the cancers possessed mutations makes this improbable. Interestingly there has also been a paper published by Wang et al supporting the original association between Nm23 and colorectal metastasis described by Cohn et al and quoted in our review. These workers using a combination of reverse transcriptase polymerase chain reaction, sequence analysis, and Southern blotting found either allele loss or deletions of the coding sequence in four of eight metastatic cancers. This was in contrast with 12 tumours that had not metastatised at the time of surgery and that possessed an intact, wild type Nm23 gene. Recently, like Whitelaw and Northover, we could not find evidence of Nm23 deletion using CA repeats in any of 20 informative cases (Cawkwell et al, unpublished data). The significance of the changes to the Nm23 gene in large bowel cancer remains unresolved.

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Platelet activating factor and Crohn’s disease

Editor,—We read with interest the work of Ferraris et al (Gut 1993; 34: 665-8) reporting the contribution of intestinal epithelial cells to the enhanced generation of platelet activating factor (PAF) in ulcerative colitis. We would like to emphasise that PAF contributes to the pathogenesis of inflammatory damages in ulcerative colitis, it has no implication in Crohn’s disease.

We are very surprised by this conclusion. Ferraris et al can only assume that, in their in vitro model, intestinal epithelial cells or cells of the lamina propria of Crohn’s disease patients cannot produce more PAF than those of healthy controls. These data do not argue against a role for PAF in Crohn’s disease. For instance, other authors have reported increased contents of PAF in ileal and colonic mucosa of Crohn’s disease patients compared with controls.1 Furthermore, other data have reported PAF in the stool of patients with Crohn’s disease,1 and the degradation of faecal PAF content after clinical remission. At this time, it is still unclear if PAF plays an important part, or is only a non-specific marker of inflammation, in Crohn’s disease. The use of PAF receptor antagonists during inflammatory bowel disease may bring interesting data about the role of this mediator.

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Reply

Editor,—We are familiar with the work of Denizot et al on platelet activating factor (PAF) in Crohn’s disease. We completely agree with them that the exact role of PAF in inflammatory bowel disease is still unclear and that the use of PAF receptor antagonists in clinical settings might help to clarify this issue. We expected that if PAF’s contribution to the pathogenesis of Crohn’s disease is significant, its generation by both epithelial and lamina propria mononuclear cells would be enhanced in a similar fashion as we have reported for ulcerative colitis. As this was not the case, we assumed and stated that PAF’s implication in Crohn’s disease is less pronounced than in ulcerative colitis. We were cautious not to state that PAF has no implication in the pathogenesis of Crohn’s disease.

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