Surgery was considered on days two and six. The knee–elbow position reversed the radiographic appearances, however, and changed the treatment of our patient's colitis. The use of this simple and safe manoeuvre probably spared our patient from surgical intervention.

The use of this simple Letters
of the use of the knee–elbow position to decompress the bowel in toxic megacolon.

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Acid and gastric metaplasia in the duodenum

Acid load to the duodenum with subsequent mucosal injury. On the basis of these findings, the common belief that gastric metaplasia in the duodenum is induced by hypersecretion of gastric acid is questionable.

The finding of the lack of regression of gastric metaplasia in the bulb after 12 months of eradication of H pylori has been explained by the authors by the fact that gastric acid secretion is not changed by treatment of the infection and therefore, the persistent high production of acid helps to maintain the histological duodenal alteration. As acid hypersecretion is not the rule in duodenal ulcer, however, and is not present in functional dyspepsia, it is again difficult to claim this physiological abnormality as the main cause of maintenance of gastric metaplasia in the long term.

Thus, it seems that the presence of H pylori, by itself, is the main factor in the development of duodenal ulcer, although the mechanisms of this action are far from clear.

We also suggest that the mucosal production of cytokines and specific toxins released by the bacterium might be possible ulcerogenic factors, independent of gastric metaplasia. The persistence of this epithelial change in patients where H pylori has been eradicated who show a dramatic reduction in ulcer relapse, seems to diminish further its pathogenetic relevance.

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Reply

We welcome the correspondence on our case report, which gives us the opportunity of further discussion of the use of postural manoeuvres for bowel decompression. ‘Rolling’, as described by Dr Present et al, entails turning the patient to the prone position, on a flat bed. This position is clearly different from the knee–elbow position we have reported in which the patient is positioned head down with hips, knees, and elbows flexed.

A crucial point needs to be made with respect to the ‘rolling’ regimen, as described by Present et al in their series of 19 patients: in addition to turning the patient prone, a long enteral tube was passed for aspiration of gas and enteral fluid. Consequently it is difficult to discern what the individual contribution of the intubation-aspiration versus the postural manoeuvre was, in decompressing the bowel. We also note that in five of their 19 cases, a probably spurious was required to facilitate evacuation of gas that had not been forthcoming. The uppermost position of the rectum and anus in the knee–elbow position permits easy passage of flatus and could obviate the need for rectal catherisation.

The early and longterm follow up results from Dr Present’s uncontrolled series are impressive. Nevertheless, the effect of bowel decompression by postural manoeuvres on the outcome of toxic megacolon should be confirmed by prospective, randomised, controlled trials.

We remain unaware of any previous reports

EDITOR.—Panos et al (Gut 1993; 34: 1726–7) describe the knee–elbow position for the relief of bowel distension in patients with toxic megacolon. They suggest that their use of this therapeutic manoeuvre is new. In 1988 Present et al published their experience with ‘rolling’ 19 patients with toxic megacolon into the prone position every two to three hours for 10 to 15 minutes. They concluded this was a helpful addition to the standard treatment for this serious condition.

Both groups are describing the same phenomenon – the prone position redistributes colonic gas and fluid into the lower bowel leading to easier evacuation. We have been using this technique for several years at the Stanford Medical Center.

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Reply

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