Thompson and Heaton were already consid-

ering. We have doubts that a 'better' and practical design to study diverticu-
lar disease is as Dr Heaton once suggested 'provided the ethical problem of radiograph-
ing normal people can be overcome, we need a large survey of the general population for
diverticulosis and colonic spastic symptoms so that diet histories can be obtained from groups of people with neither disorder, with each disorder on its own and with both disor-

ders. It would be a formidable undertaking, but without it doubts will remain.3 As this
would not be a prospective study, the recall of past diet would be subject to reporting bias.

Dr Thompson and Heaton are again suggest-
ging that diverticular disease may be an asymptomatic condition, and that the symp-

tomatic presentation is due to existing irrita-
tive bowel syndrome (IBS). Strong evidence exists that the two conditions are separate

etiologies sharing a common presentation, which is abdominal pain. We have discussed

some of the evidence and emphasised in our article that both conditions are common,

overlap between them might exist (please see the discussion section). The pre-
vailing understanding, however, is that diverti-
cular can cause symptoms, which vary from a mild left quadrant pain to severe abdominal

pain, and in extreme cases perforation or bleeding. Painter has suggested that because

of the abnormal motility of the colonic muscle and the pain it is associated with, diverticular
disease may cause symptoms whether or not

diverticula are inflamed.3 Moreover, it was

shown that intraluminal pressure was signifi-
cantly higher in diverticular disease patients

than controls, unlike patients with IBS, who had lower pressures.4 High intralumin-

al pressure is necessary for the formation of the diverticula, and with the excessive seg-
mation leads to intermittent colonic obstruction, which may produce pain.5

Finally, it is worth mentioning that even among the limited number of diverticular dis-

case series in our study who presented only with bleeding, physical activity was inversely

related to the presence of diverticular disease (RR=0.46 [95% CI 0.14, 1.49]). We would

like to think of this article as a 'Diverticular Contribution' and not a 'Distraction'.

BOOK REVIEWS

Diagnosis and Management of Liver Disease. Edited by R Kirsch, S Robson, C Trey. (Pp 327; illustrated; £29.95.) London: Chapman & Hill, 1995. ISBN 0-412-57570-1. There are quite a few books on liver disease, but this medium size (327 pages) one takes an interesting approach in that each chapter is written by a member of a research unit in South Africa and then international experts were invited to complete each chapter. The result is a readable, authoritative, and clear book with a good mixture of pathophysiology and disease plus two useful chapters on immunology and molecular biology for the practising doctor. There is some transatlantic spelling.

I think the main weakness of the book, apart from too many scattered typing errors,
is that some conditions that can be important to the gastroenterologist are only mentioned, including Wilson's disease, diabetes mellitus, methotrexate induced liver disease, post-

operative jaundice, extracorporeal shockwave lithotripsy and endoscopic endolo-

gy. Gilbert's syndrome and benign recurrent cholelithiasis. There is also no description of the

lobe and acinus, which are important in an understanding of the function and anatomy of the

liver, while there were rather obscure words such as scissors and incisura, when describing the surgical anatomy of the liver and photofier, referring to a red cell scan. There should be a correction on page 30 (spelled as amy-

otransferase and transaminase, even on the same page. I suspect these are errors of editing

and no doubt the gaps can be filled in in the next edition.

I would have welcomed more diagrams and tables, while some of the scans reproduce poorly. Two radiographs of biliary ascars are no doubt prize exhibits in a slide collection but seem excessive.

In general, I therefore recommend it as a useful textbook of liver disease, although clearly a larger textbook would be required for deeper reading and reference lists.

The authors have appreciated their royalties to charity but, despite that, it seems rather expensive at close on £30 for a soft back.

Perhaps this illustrates how little the finan-

cial rewards given by publishers to their authors contribute to the overall cost of books.

R P H THOMPSON


The number of publications catering for the postgraduate medical education (that is, training after qualification) and continuing medical education (that is, keeping yourself up to date after being fully trained) market continues to increase. These publications divide into those that present brief highlights of the recent literature, and those that present an in depth review of key topics in the field. Ideas that those in the undergraduate medical education market need to consider topics that will probably appear in examinations and those for the continuing medical education market need to consider topics of interest to the generalist in the specialist vs. generalist debate, and the credibility of the journal. The journal would be interesting to know if the current interest in documenting (in the form of credits) the uptake of continuing medical education has led to an increase in the number of people reading these publications, to no change, or indeed to a decrease (how much you read is not counted in the credit tally).

The first volume of this series appeared two years ago. It fits into the 'in depth review of