IBS followed cessation of vigorous exercise, but it is also possible that symptoms of IBS would deter some people from athletic pursuits. Did the authors consider the possible overlap in symptomatology between what they call ‘symptomatic diverticular disease’ and IBS?  

W G THOMPSON  
University of Ottawa, Canada  

K W HEATON  
Bristol Royal Infirmary, Bristol BS2 8BW, UK


Reply

EDITOR—Most of the points of Drs Thompson and Heaton were already considered and discussed in our article. The Health Professionals Follow Up Study (HPFS) is indeed a prospective study that began in 1986 when cohort members completed a baseline questionnaire about dietary intake, history of medical conditions, and about other risk factors. Follow-up questionnaires were sent in 1988, 1990, and 1992. The 1990 and 1992 follow up questionnaires contained specific questions pertaining to whether diverticular disease had been diagnosed during the previous two years. Over the cumulative follow up for diverticular disease was from 1988 to 1992. To maintain the prospective design of our study, we used the 1986 baseline questionnaire for the assessment of several variables such as self reported physician’s diagnosis, as this is the only strictly prospective data for all cases. It is worth mentioning that the HPFS assessed many medical conditions in addition to heart disease and cancer (please refer to the study population in the method section). In prospective studies, relevant exposures may or may not have occurred at the beginning of the study but the outcomes have not yet occurred,1 which was the case in our study. While in the retrospective studies, however, both the exposures and the outcomes of interest may have already occurred when the study began.1 Although this difference in design is very basic, it is unfortunate that such a distinction is not always appreciated.

Biased recall of physical activity was unlikely because the physical activity data were collected before the diagnosis of symptomatic diverticular disease, and we controlled for several potential risk factors such as age, dietary fibre, and other dietary and non-dietary factors. Most of these aspects were not considered in previous case control studies of diverticular disease, which therefore limited their interpretation. We have doubts that a ‘better’ and practical design to study diverticular disease as Dr Heaton once suggested ‘provided the ethical problem of regraphing normal people can be overcome, we need a large survey of the general population for diverticulosis and colon 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 disorders. It would be a formidable undertaking, but without it doubts will remain.’2 As this would not be a prospective study, the recall of diet would be subject to reporting bias.3

Drs Thompson and Heaton are again suggesting that diverticular disease may be an asymptomatic condition, and that the symptomatic presentation is due to existing irritable bowel syndrome (IBS). Strong evidence exists that the two conditions are separate entities sharing a common presentation, which is abdominal pain. We have discussed some of the evidence and emphasised in our article that as both conditions are common, some overlap between them might exist (please see the discussion section). The prevailing understanding, however, is that diverticular 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.4 Moreover, it was shown that intraluminal pressure was significantly higher in diverticular disease patients than controls, unlike patients with IBS, who had lower pressure gradients.5 High intracolonic pressure is necessary for the formation of diverticula, and with the excessive segmentation leads to intermittent colonic obstruction, which may produce pain.6 Finally, it is worth mentioning that even among the limited number of diverticular disease cases in our study who presented only with bleeding, physical activity was inversely associated with recurrent 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 as a ‘Distraction’.7

W H ALDOORI  
W C WILLET  
Department of Nutrition, Harvard School of Public Health, 665 Huntington Avenue, Boston, MA 02115, USA


BOOK REVIEWS


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 lithotripsy, Gilbert’s syndrome and benign recurrent cholestasis. 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 sciurcsa and incisura, when describing the surgical anatomy of the liver and photofier, referring to a red cell scan.

In general I would say this book was above average and worthwhile reading, especially chapters on amino- transferase and transaminase, even on the same page. I suspect these are errors of editing and no doubt the gaps can be filled in the next edition. Overall the authors 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 can not excel the original. 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 apparently donated 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 financial awards given by publishers to those 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. Those that do not, and are the postgraduate 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 specialties. It 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
key topics’ category. It should be judged in these terms, of course, as it is not a textbook of paediatric gastroenterology. The authors of the chapters are well recognised names in the community of paediatric gastroenterologists, from North America and from the United Kingdom, with one representative from continental Europe. Predictably, all have undertaken their task competently and successfully.

The success of the publication must depend on the choice of topics included. This is good in the main, but at times somewhat specialist. The generalist who sees children with gastrointestinal problems will find the chapters on oral rehydration solution, constipation, food allergy, inflammatory bowel disease, gastro-oesophageal reflux, recurrent abdominal pain, and gastrointestinal bleeding, of great interest and educational value.

The chapter on ‘when to transplant the liver in children’ fits uncomfortably; it is a very interesting question for the paediatric hepatologist or specialist gastroenterologist but of little relevance to the probable readership of the publication. The chapters on the role of gastrointestinal motility studies and of home parenteral nutrition fall in between, probably. The relevance of the book to a reader will depend on the number of children with these problems they see, and I suspect that the book will be most useful to the general paediatrician and not the general gastroenterologist.

In keeping with the ethos of counting credits, I would rate this book as being worth three credits (assuming that most generalists would probably read six chapters, and perhaps spend half an hour on each). By doing this, they are probably learning more than by earning six credits by listening to the same authors giving lectures on the same topics, and in addition they have the book on their shelves afterwards. Paediatricians should put it on their reading list for next term, as should any general gastroenterologist who sees children.

S P DEVANE

---

**NOTES**

**Wilson’s disease and Menkes’ disease**

The 7th International Symposium on Wilson’s disease and Menkes’ disease will be held in Vienna, Austria on 25–27 August 1995. Further information from: Prof Dr Peter Ferenci, Department of Internal Medicine IV, Gastroenterology and Hepatology, Währinger Gürtel 18–20, A-1090 Vienna, Austria. Tel: (43 1) 40 400 47 41; fax: (43 1) 40 400 47 350.

**Neurogastroenterology**

An International Symposium on Neurogastroenterology will be held on 10–11 November 1995 in Rome, Italy. Further information from: Dr Enrico Corazza, Cattedra di Gastroenterologia I, Clinica Medica II, Policlinico Umberto I, V le del Policlinico, 00161, Rome, Italy. Tel/fax: 39 6–4469965.

**Paediatric gastroenterology**

The 1st International Congress of Pediatric Gastroenterology will be held in Jaipur, India on 12–16 December 1995. Further information from: Dr Balvir S Tomar, Head, Department of Pediatric Gastroenterology, 4 Govind Marg, Jaipur, 302 004, India. Tel: 91 141 604040 or 605050; fax: 91 141 561788.

**Gastroenterology**

A Postgraduate Gastroenterology Course will be held in Oxford on 7–10 January 1996. Further information from: Dr D P Jewell, Gastroenterology Unit, Radcliffe Infirmary, Woodstock Road, Oxford OX2 6HE. Tel: 01865 224829; fax: 01865 790792.

**Inflammatory bowel disease**

The International Inflammatory Bowel Disease Symposium will be held in Chester on 14–16 April 1996. Further information from: Prof Jonathan M Rhodes, Department of Medicine, Liverpool University, L69 3BX. Tel: 0151 706 3558; fax: 0151 706 5802.

**ABIM announcement regarding change in training requirements for certification in gastroenterology**

The American Board of Internal Medicine announces a new policy requiring three years of accredited training in a gastroenterology fellowship programme.

This decision follows a lengthy review by the ABIM Subspecialty Board on Gastroenterology and has the support of the American Gastroenterological Association, the American College of Gastroenterology, the American Society of Gastrointestinal Endoscopy, the American Association for the Study of Liver Diseases, and the Gastroenterology Training Program Directors.

This new policy becomes effective for fellows entering gastroenterology fellowship training programmes in June 1996 and thereafter. Trainees who have questions about this policy should contact the American Board of Internal Medicine, 3624 Market Street, Philadelphia, Pennsylvania, 19104–2675, USA.

**Falk Symposia**


**Sir Francis Avery Jones BSG Research Award 1996**

Applications are invited by the Education Committee of the British Society of Gastroenterology who will recommend to Council the recipient of the 1996 Award. Applications (eighteen copies) should include:

1. A manuscript (2 A4 pages only) describing the work conducted.
2. A bibliography of relevant personal publications.
3. An outline of the proposed content of the lecture, including title.

(4) A written statement confirming that all or a substantial part of the work has been personally conducted in the UK or Eire.

Entrants must be 40 years or less on 31 December 1996 but need not be a member of the BSG. The recipient will be required to deliver a 40 minute lecture at the Spring meeting of the Society in 1996. Applications (eighteen copies) should be made to: The Honorary Secretary, BSG, 3 St Andrews Place, London NW1 4LB by 1 December 1995.

---

**CORRECTIONS**

The authors (Van’t Hof et al Gut 1995; 36: 691–5) omitted an acknowledgement from their paper and would like to gratefully acknowledge the support of the Medical Research Council, South Africa.

An author’s error occurred in the paper by Khulusi et al (Gut 1995; 36: 193–7). The second sentence under Clinical Methods should read ‘One duodenal biopsy was obtained from the ulcer margin and two from the anterior duodenum’, and on the same point the second paragraph of the Discussion should re-affirm that the three duodenal bulb biopsy specimens included ‘two from the anterior wall’.

Some editorial errors occurred in the paper by Mothes et al (Gut 1995; 36: 548–52). The tenth line of the Methods section should read ‘was stopped by the addition of 10 ml acetic acid’ and not 100 ml. In the legend to Fig 1: lane 2 should read ‘gliadin (g)’ and not ‘purified gliadin’, lane 3 should read ‘tryptic digested gliadin (t-g)’ and not ‘gliadin’. The abscissa to Fig 3 should begin with zero and not 1. The legend to Fig 4 should read ‘MHC expression by HT-29 cells – influence of gliadin (g)’, tryptic digested gliadin (t-g) (o), casein (v), tryptic digested casein (v), and β lactoglobulin (d). Culture in the presence of interferon γ without addition of food derived peptides was 100%. Means of three or four (t-g, four to seven) individual cultures are shown (*two cultures performed). For sake of clarity the SEM is given in only one direction.’

Also, ‘trypsin’ and ‘tryptic digestion’ has been printed as ‘trypsin’ and ‘trypsin digestion’ throughout the text.