LETTERS TO THE EDITOR

Helicobacter pylori and cholecystectomy

EDITOR,—The paper by Abu Farsakh *et al* reported a reduced prevalence of *Helicobacter pylori* in gastric mucosa after cholecystectomy, which they attributed to increased duodenogastric reflux (*Gut* 1995; 36: 675–8). Could treatment with antibiotics or bismuth containing compounds in the perioperative period or in the time to follow up assessment (up to 30 months later) provide an alternative explanation?

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Reply

EDITOR,—With regard to the comments raised about the use of antibiotics in the study group after cholecystectomy and any possible effect on the clearance of *H pylori* in the follow up period, I would like to state that no difference was found in patients who received antibiotics from those who had not. Bismuth compounds were not prescribed to any patient in the study group.

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Pancreatic vascular regulation

EDITOR,—We read with interest the paper by Widdison *et al* (*Gut* 1995; 36: 133–6), where the authors investigated pancreatic vascular regulation in chronic pancreatitis. Vascular resistance in this model can only be calculated if total blood flow and the changed arteriovenous pressure gradient are known. The hydrogen gas clearance method was used to measure pancreatic blood flow. This measures microvascular blood flow in contrast with total blood flow. We know from previous experiments that interstitial pressure is increased in the chronic pancreatitis gland when compared with the normal gland.¹ Yet, basal portal venous pressure and arterial pressure in the chronic pancreatitis and normal glands were the same. Thus, it is unlikely that small changes in intrapancreatic venous pressure in the left lobe of the pancreas are reflected by a change in portal venous pressure. It is therefore difficult to extrapolate from these results the effects on vascular resistance, and to comment on regulatory mechanisms in the pancreatic vasculature.

On considering the basic pathophysiology of a compartment syndrome, an increase in interstitial pressure will produce a corresponding increase in venous pressure (Laplace's law). As blood flow is determined by the local arteriovenous pressure gradient and the local vascular resistance this increase in venous pressure results finally in a decrease of blood flow.² The authors showed that in the normal feline pancreas small increments in portal pressure had no effect in blood flow until portal pressure increased above

15 mm Hg. In cats with chronic pancreatitis, however, even small increments in portal pressure produced a further decrease in the low basal blood flow. Thus, their data suggest the existence of a compartment syndrome in chronic pancreatitis. Further experiments using an isolated perfused pancreas model, which allows us to change total pancreatic blood flow, has shown evidence to confirm the existence of a compartment syndrome in experimental chronic pancreatitis.³

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- 1 Karanjia ND, Leung F, Widdison AL, Lutrín F, Chang YB, Reber HA. Pancreatic ductal and interstitial pressures in cats with chronic pancreatitis. *Dig Dis Sci* 1992; 37: 268–73.
- 2 Oestern HJ. Definition, Aetiologie und Pathophysiologie des Kompartiment-syndromes. *Unfallchirurg* 1991; 94: 210–5.
- 3 Reber PU, Patel AG, Kusske AM, Toyama MT, Reber HA, Ashley SW. Pancreatic hemodynamics in chronic pancreatitis: a compartment syndrome. *Gastroenterology* 1995; 108: A 257.

BOOK REVIEWS

Constipation. Etiology, Evaluation and Management. Edited by S D Wexner, D C C Bartolo. (Pp 272; illustrated; £65.) Oxford: Butterworth Heinemann, 1995. ISBN 0-7506-0776-9.

Constipation was never a fashionable topic in gastroenterology. Although still not a glittering Cinderella that can compete with *Helicobacter pylori* and the molecular biology of intestinal cancer, it is now acknowledged as a common problem associated with significant morbidity. Developments in both diagnosis and treatment justify the emergence of important publications in this area.

It is often stated that constipation is a symptom, not a specific diagnosis. It is more than that. It encompasses the patient's subjective view of their own body as well as objective measures of bowel function. This is highlighted in a recent editorial by Devroede entitled 'Constipation – a sign of a disease to be treated surgically, or a symptom to be deciphered as nonverbal communication?'. The high incidence of laxative consumption (up to 20 per cent in the UK) in adults with neither decreased bowel frequency nor excess straining, and the high incidence of childhood physical and sexual abuse in young women presenting with constipation, are just some of the factors that underlie this question and contribute to the treatment equation. Meanwhile improved clinical and pathological techniques have identified patients with definite 'organic' myopathies or neuropathies. To a large extent these different aspects are well covered in this text, with space devoted to aetiology, epidemiology, evaluation, and treatment. There is no section on the pathology of these intestinal disorders, which I believe is an important part of the jigsaw.

Until recently no texts devoted to this topic had appeared since that by Avery Jones and

Godding in 1972. Our own book and the one reviewed here have appeared at almost the same time. In contrast with our text, this book is edited by two colorectal surgeons, and therefore brings with it a surgical emphasis. As such its greatest appeal may lie with surgeons who have an interest in this area. Surgical aspects of treatment, including operative techniques, are covered in detail. None the less diagnostic techniques for evaluating the pelvic floor and intestine, psychophysiological, and other non-operative aspects also receive comprehensive coverage. While the current trend towards 'clinical guidelines' and algorithm driven treatment might be useful for simple conditions with a single aetiology, this approach requires caution when treating such a heterogeneous condition. For example, the section on medical treatment advocates fibre supplementation as the universal first therapeutic step, an approach that is out of touch with recent views about the trialled clinical efficacy of fibre and the clinical experience that it makes many patients feel worse.

To remove a morphologically normal colon from a young, otherwise healthy woman to my mind is a sad event, with an uncertain outcome, although a small group of patients will benefit from such treatment. Surgery has now been complemented by a range of therapies, however, and biofeedback and psychological aspects do receive attention in this text. Directed behavioural treatments such as pelvic floor biofeedback have considerably improved the outlook for many patients, including some with impaired pelvic coordination and some with confirmed slow colonic transit. Future work in this area will help us distinguish between those who have an irreversible neuromuscular abnormality that requires specific drug or surgical treatment from those whose sole problem is an acquired behavioural one.

The treatment of these complex problems requires a pluralistic team approach. This book provides most of the necessary information derived from different specialists required to provide such an integrated approach. As in all functional disorders we still await the time when different treatment modalities have been compared, assessing quality of life as part of the measure of outcome.

M A KAMM

Bockus Gastroenterology (5th ed). Edited by W S Haubrich, F Schaffner, J E Berk. (Pp 3515; illustrated; £458.) Philadelphia: W B Saunders, 1995. ISBN 0-7216-3687-X.

In a rare counter-inflationary move the 5th edition of Bockus is in four volumes rather than the seven of the previous edition. None the less, at over £450, 3500 pages, and 187 chapters, let alone 12 kg, it still remains the undisputed behemoth of gastroenterological textbooks. What's in it, is it up to date, and how does it match up to its nearest competitors?

The first thing to note is that it is saddled with an inappropriate title. Volume three is a textbook of liver disease, so the price comparisons change: this book needs to be compared with, as it might be, Sleisinger combined with Zakim, Yamada with Oxford Hepatology, Bouchier with Wright, or other gastroenterology and hepatology textbook combinations; with those comparisons the price is less forbidding, but it's still at the luxury end of the market.

How good is it? With over 200 contributors, the one thing that the reviewer can state with absolute certainty is that it's uneven, and in its 5th edition it shows the Forth Bridge-type characteristics that anything under constant repair develops. Some of the initial overview chapters on signs and symptoms show their age, with mannered prose reminding that this book was first published nearly 50 years ago. Another section boldly states in footnote 'many of the references pertaining to this section are not recent . . . most findings of investigators during [1960s and 1970s] are still valid' – which really is editor-speak for 'this section should have been revised'. Some areas of 'small-print' gastroenterology – and actually, week to week, that is what people use reference textbooks for – seem to have got rather brief treatment: you won't find all you want to know about Menetrier's for example. However, each item that one can find to criticise is balanced by a state of the art chapter of superlative quality. If the trainee finds the clinical introductory chapters hard going, there's ample compensation in the overview chapters on plain abdominal radiology of the abdomen and on computed tomography. For the reviewer who tries to catch the text out, by checking for recent advances – identification of the Whipple's bacillus, molecular biology of cystic fibrosis (24 deletions tabled) or hepatitis E, treatment for chronic hepatitis C, or the latest on *Helicobacter pylori* and the pathophysiology of gastric acid secretion in ulcer disease – it is clear that when section editors and contributors recognise that they are in a fast-moving field, they've tried very hard to keep up to date. Quoting May 1993 abstracts in a textbook published in the first few months of 1995 is pretty commendable.

But of course it is striking, as the above examples show, how rapidly gastroenterology is moving as a science, and some important contributions are too late for this edition; the MALT lymphoma/*H. pylori* story isn't there for example – an association first made in 1991. In many respects, for any reference text, the best is always the most recent!

The traditional criticism of predominantly US based textbooks is that they are too theoretical, include too much pathophysiology, and lose the clinical touch that – after all – is what the specialty is all about. Avoiding that lack of balance has indeed been the main philosophy behind the British texts mentioned in this review. In comparison with its US bedmates, I think this book comes much nearer to holding the balance right, and of those US based texts this is much more of a clinician's book than its rivals. So, for the period that it remains the most up to date available, it is a marvellous resource for the deep-pocketed; whether it will age with grace depends on how rapidly scientists and clinicians can advance our subject.

H J F HODGSON

Clinical Gastroenterology CD-ROM version. By J J Misiewicz, A Forbes, A B Price, P J Shorvon, D R Triger, G N J Tytgat. (£80+VAT.) London: Mosby, Times Mirror International, 1995.

The CD-ROM disk is no longer a mere source of high quality music or of interminable lists of references confined to libraries. Even if gastroenterologists do not feel ready for the multimedia revolution to hit their desk top they can always borrow their

child's computer to dip into one of the new age textbooks. One of the first in the field is CD-ROM version of Wolf's reputed Atlas of Gastroenterology. Why should any one, who is not totally computer obsessed, choose the CD-ROM format over the more traditional glossy paper version?

In terms of content the authors present a comprehensive series of annotated illustrations of the gastrointestinal tract in health and disease from the oesophagus to the anus via biliary tree with radiological, histological, and pictorial examples of all the common and most of the uncommon disorders found. As such the contents of the atlas is the same as that in the paper version, which has been reviewed for *Gut* (1994; 35: 1775–6). The quality of the images available to the user depends in part on the computer equipment available to them. My attempts to install a CD-ROM drive in my PC to conduct this review has resulted in me buying a new machine. A myriad of current generation of computers sporting SVGA (super video graphics adaptor) screens, however, are appearing in offices in all parts of most hospitals – your manager will have one if you don't. I was surprised at the quality of the computer images of the endoscopic pictures. On the enlarged full screen images each broken optical fibre on the originating endoscope could be clearly identified, the main limitation in the quality of the images presented is the quality of the original photograph some of which are museum pieces.

To help identify lesions that may not be obvious, the click of a mouse button will overlay labels and arrows on the image or increase the size of the image to permit closer inspection. Each page of the book is represented by a screen divided in four sections. To the right a column of text to the left a picture and below it the relevant legend. At the top are 16 boxes to click with the mouse to allow access to various facilities offered by the package. As in a book there is an index, a book mark may be left at a page of interest, and the reader may leave their own comments appended to a page of the book with a computerised paper clip. Thumbing through a CD is not as straight forward or as fast as rifling through the pages of a book: browsing takes a different form from the idle turn of the page to the random click of the mouse. Finding an illustration from the index is, however, merely a question of point and click.

After reading a chapter it is possible to call up a predefined text but this is of limited value unless the chapter has been read first because the image quality is not as good.

Although these functions are very useful they are not, in terms of quality or speed of use, vastly superior to those obtainable from a book, indeed many would prefer to do their reading in a chair or in bed rather than sitting at a computer screen. It is the facility to take images from the atlas and construct slide shows or to print them or to integrate them into other software systems that makes this format so useful to anyone who has to teach, write or talk but who is always preparing their material at the last moment. In less than a minute an image can be transferred into a word processed document or printed on overhead projection film. In addition no book, certainly not a comprehensive atlas, is as thin as a CD in terms of storage space.

Those who hope that this disk will allow a legitimate opportunity to play animated multimedia games in the interest of learning will be a little disappointed by the lack of moving

images. Those wanting an easy to use desk top atlas will be more than satisfied.

C J TIBBS

Clinical Gastroenterology Companion Handbook. 4th ed. Edited by B Rigas, H M Spiro. (Pp 665; illustrated; £27.50.) New York: McGraw-Hill, 1995. ISBN 0-070-03341-2.

This pocket sized book of gastroenterology describes itself as a companion but it is not clear whether it is intended as a companion to the large text book edited by Dr Spiro or to the trainee gastroenterologist. It is certainly not a book for the middle aged. The print is small and it is one of those books that irritatingly snaps shut whenever it is put down. I prefer several volumes saying much the same thing but at greater length. There is something rather depressing about seeing one's whole life's work condensed into something the size of a Jilly Cooper novel.

There is precious little jodhpur ripping here but there are many facts and opinions. Factually there are few complaints. The whole of the gastrointestinal tract is covered apart from the oropharynx and each section on the organs of interest is complete with some physiology and a synopsis of pathology, diagnosis, and treatment of relevant diseases and disorders. The main content, as the title implies, deals with clinical management and this is aided by a few algorithms. Reading it from the point of view of a jobbing gastroenterologist I was reassured to find that I knew and agreed with much of what was said but there are some moderately surprising omissions.

No mention is made of oesophageal apoplexy as a cause of chest pain although oesophageal rupture, which in my experience is less common, does receive attention. Surgery for rolling hiatus hernias is not recommended until torsion occurs, which is rather too late. The d-xylose test is described but no mention is made of the various better permeability tests that have achieved a routine place in the diagnosis of malabsorption. In the treatment of peptic ulcer there is only a lukewarm acceptance of triple therapy while the role of antacids and H_2 antagonists in maintenance of patients with duodenal ulcer receive surprisingly generous coverage. There is nothing on the role of elemental diets in the treatment of Crohn's disease.

You can also take issue with some of the opinions. It is not my experience that angina-like pain relieved by belching is usually oesophageal nor that patients with coeliac disease are rarely taller than 5'6". I guess not many in this country would agree that you have to have 'the proverbial back against the wall' to prescribe azathioprine in Crohn's disease. The greatest surprise is the claim that anti-diarrhoeals should be regularly prescribed in ulcerative colitis and that strong laxatives should never be given. For many gastroenterologists proximal constipation is an important management problem in patients with ulcerative colitis and this receives scant attention here. Perhaps the problem is less in the United States because of lactose intolerance, which receives much mention although I guess this is of only passing interest to most British gastroenterologists. Salazopyrin is still seen to be the top dog among the 5-ASA compounds despite its occasional fatal side effects and there is no discussion of the current, mainly American enthusiasm, for increasingly larger