Our recent paper focused primarily on describing the histological features of microcolonic colitis in case of well-defined cases. We have previously, however, studied different aetiological aspects in both lymphocytic and collagenous colitis. The importance of factor(s) in the faecal stream has also been discussed by others.

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Helicobacter pylori reinfection

EDITOR—We read with interest the article by Schütze et al (Gut 1995; 36: 831-3). It is difficult to explain the transmission of reinfection has been shown to occur for the first time with near certainty. 1 Besides transmission from the spouse, there are at least three possibilities of reinfection of the H pylori has been demonstrated in the dental plaque of patients from developed1 and developing2 countries. Furthermore, H pylori in the dental plaque persists despite its clearance from the gastric mucosa after treatment. Hence, dental plaque is considered a potential source of reinfection by the same strain of H pylori.3,4 (2) It is possible that both the patient and the spouse had acquired infection of the same strain of H pylori from a common source. Contaminated water supply is extremely unlikely as water supplies in Vienna originate from Alpine sources and are renowned for their excellent quality. The patients studied in our project were married couples without any other family members.

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Gastric emptying in patients with insulin dependent diabetes mellitus

EDITOR.—The paper by Nowak et al (Gut 1995; 37: 23-9) reports on the highly variable gastric emptying rates in patients with diabetes mellitus. The finding of accelerated (apart from the classic delayed) gastric emptying in humans with insulin dependent diabetes mellitus is consistent with previous findings.1 The authors investigated the possible correlation between gastric emptying and chronic renal failure caused by diabetes. As the values obtained in this study have a very wide distribution, the conclusion that the influence of chronic renal failure on gastric emptying cannot be estimated from their own results. However, chronic renal failure is associated with autonomic neuropathy and diabetic nephropathy. It would have been important to know the authors’ comments on the role of the autonomic nervous system in their patients with chronic renal failure due to diabetes.

In another study,3 small groups of patients with chronic renal failure of non-diabetic aetiology given longterm dialysis showed different patterns of gastric emptying, which was dependent on the involvement of the autonomic nervous system. In subjects with no autonomic neuropathy gastric emptying was faster than normal. In subjects with only parasympathetic neuropathy gastric emptying was similar to controls but in subjects with both parasympathetic and sympathetic autonomic, it was delayed. In this study gastric emptying was measured from the sonographic registration of the central gastric diameter, according to Bolondi.4 This method has a good correlation with the radioisotopic method.5 The spectrum of the gastric emptying curves of the patients studied by Nowak et al seems to be autonomic, the findings are the same. We believe that a similar focus was made on chronic renal failure resulting from diabetes mellitus will bring similar results. Indeed, as Nowak et al show, autonomic neuropathy is the main factor that changes the emptying of the stomach.

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Reply

EDITOR.—In our publication an autoreinfec-

tion has been discussed as a possibility but simultane-
ously considered as highly unlikely as the reinfection occurred as late as after 14 and 43 months, respectively.

The possibility of a common exogenous source cannot be ruled out but it seems rather unlikely and has also been discussed in our publication. The possibility of a contaminated water supply is extremely unlikely as water supplies in Vienna originate from Alpine sources and are renowned for their excellent quality.

The patients studied in our project were married couples without any other family members.

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References


associated with parasympathetic autonomic neuropathy, which is, in turn, associated with accelerated gastric emptying. As the disease becomes chronic, we hypothesise that a sympathetic neuropathy occurs as well, which manifests itself as delayed gastric emptying.

The findings of Dumitrascu et al support this notion as their study shows that patients with chronic renal failure may have accelerated, normal, or delayed gastric emptying depending upon whether the parasympathetic or sympathetic nervous systems are involved. While their findings do not exactly parallel the findings of our-study, their results do suggest that the autonomic nervous system has a variable influence on retarding or accelerating the rate of gastric emptying in either disorder.

There are, however, some real treasures here. The opening quintet of essays relating to gastrointestinal physiology are by Baron, Wold, Davenport, Wingate, and Gregory - surely some of the most beautiful writers ever to have interested themselves in the human gut. Yet each of these is surpassed by Chris Booth whose piece on 'What has technology done to gastroenterology?' is the possible finest piece of writing ever to have graced the pages of this journal (Gut 1985; 26: 1088-94). This essay is required reading for those embarking on a career in clinical gastroenterology who may be tempted to the view that skills in fiberoptic endoscopy are somehow the end rather than the means to an end.

If you can live with this book's misnomer, you will find several further treasures. Find out that both Hippocrates and Aetius the Cappadocian may have described Crohn's disease before Christ (let alone Crohn). You can learn how Benevienus (1442-1502) described the features of ileus. He was also a physician to the Borgias so had plenty of time to study abdominal problems in many guests who so frequently became fatally ill after a nice family meal. We have to move into the 18th century to learn how our colleagues of former time, Reaumur, Hunter, and Spallanzani worked out that the stomach secreted acid. They did, however, have some difficulty in determining the type of acid - phosphoric and lactic were prominent con-
tenders before the right answer emerged.

Perhaps the most refreshing aspect of the book is that we are constantly reminded that work in a specialty that is steeped in history and occasionally in antiquity. We spend so much of our time at the frontier between the present and the future, that is to say, between what is known and what is not known, that it is easy to overlook the lessons of the past.

IAN FORGACS

BOOK REVIEWS


Not only those who share Henry Ford's view of history might have somewhat negative feelings about this book. The title is astonishingly pretentious. Surely, if you are going to call your book 'The History of Gastroenterology' (note: the first word here is the definite rather than indefinite article), you would be pretty committed to ensuring that the contents lived up to the expectations so engendered.

What we have on offer here is a one page preface; 255 pages of reprints of selected joys from the gastroenterological literature; a 22 page chronology of our specialty from 30 000 BC to 1990; and a selected 16 page list of interesting publications. Surely, the very term history implies a narrative in which a series of events is recorded. This is a series of snapshots and, even if one was in a hurry (and history is emphatically not for those who feel that time moves at high velocity) the reader offered in this book would seem insubstantial.

I had rather hoped that the preface would have explained what this book was hoping to achieve. After outlining some of the reasons why gastroenterology has progressed in recent decades, the editors suggest 'When so much has happened a taking of stock is warranted. The appreciation of our present successes directs our attention for a backward look'. If I have understood this correctly, the authors feel it is time to call a (temporary) halt to progress so we can look over our shoulder at where we are going. I think that is a strange justification for a book format. Surely, the curious among us need no excuse to study the past and learn what lessons it may have for the pre-

For nearly 30 years, 'Scheuer' has been the pre-eminent bench book available to pathologists for help with the interpretation of liver biopsy specimens. The book in which this was published in 1968, set a standard that was very hard to follow. Although there is now a number of competitors in the field, Professor Scheuer has always maintained his position by judiciously publishing an ever better new edition every five years or so. This, the fifth edition, has perhaps undergone more changes than any other. Most importantly, Peter Scheuer has been joined as a coauthor by another distinguished pathologist, Professor Dr J Leifkowitz of Columbia University, New York.

The book is so well known, rightly described by Dame Sheila Sherlock in its foreword as the 'bible of liver biopsy interpretation', that the job of the reviewer is a little different from the traditional one. Here, readers will wish to know how it has changed, and if it is improved by those changes.

The book is now published by Saunders, as volume 31 in the Major Problems in Pathology series, and has taken on a new enlarged (B5) format. I was surprised to discover how much this has helped. The much wider use of gloss changes, the more space and the larger typeface, has improved the overall feel of the book. There are only a few more pages than in the fourth edition, but this one includes about 20% more illustrations and the number of colour pictures has trebled (now forming about one third in all). All of the photomicro-
graphs have significantly increased in size, and many, using the same originals as in the previous addition, appear altogether clearer. As before, colour reproduction has been used mainly where it has clear advantages. The reference numbers now appear in the text.

It remains strictly a bench book and does not attempt to compete with larger texts. The overall structure of the chapters is familiar to regular readers, but transplantation has now graduated to a chapter of its own, making 17 in all, and that on electron microscopy has been expanded by the inclusion of other new techniques such as PCR and in situ hybridis-
tion. The text remains as concise and to the point as one has come to expect and the references are extraordinarily up to date; a large proportion having been published since the fourth edition. As before, each chapter also includes a valuable list of general reading.

In conclusion, yes, the fifth edition is even better than the fourth. This remains the best and most authoritative manual on the inter-
pretation of liver biopsies, as well as being highly competitively priced. It is a must for anyone involved in liver biopsy diagnosis.

D G WIGHT


Fatty acids are the major product of bacterial fermentation of dietary carbohydrates in the gastrointestinal tract, and constitute the route through which energy can be extracted from carbohydrates and protein, and absorbed in the small intestine. Research suggests that they may protect against large bowel disease and may also exert a modulatory role in the control of blood sugar and cholesterol, but what their overall role is remains unknown.

This comprehensive and authoritative volume looks at the importance of the production of short-chain fatty acids and their metabolism and health of humans and other animals. It literally contains all you ever wanted to know about short chain fatty acids but were too scared to ask and contains contributions by almost everybody who is anybody in this area ranging from biochemists through ruminen and colonic physiologists, nutritionists and clinicians. There is a recent proliferation of work on short chain fatty acids, with the rare plant adapted for certain specialist grazers and browsers. It is not a book for the generalist. Although certain aspects are vitally important it will appeal only to those curious scientists and physicians who have ever looked up from their endoscopes to speculate on the multifarious roles of the treemillion billions of colonic bacteria.

Women may have been the dark continent for Freud, but the gastroenterologist’s dark continent is the colon; we can only but guess at the variety of its functions and marvel at its adaptability. The colon works in series with the liver to ferment the carbohydrate molecule that the body might be exposed to. It uses anaerobic and reductive mechanisms to breakdown complex macromolecules while...