

LETTERS TO THE EDITOR

Colorectal adenoma-carcinoma sequence

EDITOR,—I read with interest the article by Fernandez-Banares *et al* (*Gut* 1996; 38: 254–9). These authors demonstrated novel significant differences in tissue fatty acid profiles when they compared diseased and paired normal mucosa of adenoma and carcinoma patients.

My one concern about this study is the author's comparison between tissue fatty acid profiles with plasma fatty acid concentrations that only reflect recent intake and give no information on the longterm dietary intake of n3 fatty acids. I feel that it would be more appropriate to compare their tissue fatty acid profiles with red cell fatty acid levels.^{1 2}

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- 1 Brown AJ, Roberts DCK, Pritchard JE, Truswell AS. A mixed Australian fish diet and fish oil supplementation: impact on plasma lipid profile of healthy men. *Am J Clin Nutr* 1990; 52: 825–33.
- 2 Von Shacky C, Fisher S, Weber PC. Long term effects of dietary marine omega-3 fatty acids upon plasma and cellular lipids, platelets function and ecosanoid formation in humans. *J Clin Invest* 1985; 76: 1626–31.

Reply

EDITOR,—Mr Khosraviani points to the necessity of assessing longterm fatty acid intake in our patients by measuring the red cell fatty acid profile. However, the observed changes in the fatty acid profile in the diseased mucosa from both adenoma and carcinoma cannot be attributed to different dietary intake, because we compared it with the fatty acid profile of the normal mucosa surrounding both adenomas and carcinomas – that is, the comparison was made between two tissues obtained from the same patient. In any case, the fatty acid profile in the normal colonic mucosa probably gives better information about longterm dietary intake than the fatty acid profile in red cells, which is more influenced by plasma fatty acid concentrations.

It should be also emphasised that we did not compare, as Mr Khosraviani states, plasma versus tissue fatty acid profile. We merely described the fatty acid pattern in plasma phospholipids, which is a reflection of recent fatty intake and also of tissue fatty acid values and metabolism.

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Proximal colonic motility

EDITOR,—We were most interested by the manometric method developed by Lemann *et al* for studying proximal colonic motility

reported in the journal (*Gut* 1995; 37: 649–53). We must take issue however with their statement that 'the placement of recording probes introduced through the anus with the aid of colonoscopy requires premedication, air insufflation, and prior preparation to ensure vacuity of the colon'. The method used in this department for over 10 years for studying distal colonic motility has been the placement of four perfused manometry catheters 15 to 50 cm into the colon by flexible sigmoidoscopy without sedation or bowel preparation. Following placement the position of the catheters is checked using fluoroscopy. This method is associated with a high rate of success and produces little discomfort. Studies using this method have been published in this journal^{1–3} and elsewhere.⁴

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- 1 Rogers J, Henry MM, Misiewicz JJ. Increased segmental activity and intraluminal pressures in the sigmoid colon of patients with the irritable bowel syndrome. *Gut* 1989; 30: 634–41.
- 2 Rogers J, Raimundo AH, Misiewicz JJ. Cephalic phase of colonic pressure response to food. *Gut* 1993; 34: 537–43.
- 3 Bowling TE, Raimundo AH, Jameson JS, Rogers J, Silk DBA. The effect of enteral feeding on colonic motility. *Gut* 1993; 34 (suppl 1): F254.
- 4 Jameson JS, Rogers J, Misiewicz JJ, Raimundo AH, Henry MM. Oral or intravenous erythromycin has no effect on human distal colonic motility. *Aliment Pharmacol Ther* 1992; 6: 589–95.

BOOK REVIEWS

Techniques in the Management of Gallstone Disease. Edited by A Darzi, P A Grace, H A Pitt, D Bouchier-Hayes. (Pp 251; illustrated; £69.50.) Oxford: Blackwell Scientific, 1995. ISBN 0-632-03675-3.

The medical and scientific communities are already well served with original articles, reviews, book chapters, and monographs on gall stone disease. That being the case, when a new volume on this topic appears, one must ask: is it needed, what is new, and who will benefit from it? Despite some undoubted virtues, the answers to these rhetorical questions are far from clear.

The title of the book may be misleading as it deals with much more than 'techniques'. Although it is written predominantly by surgeons, it is not just about operative methods. Rather, in its 23 chapters, it covers a broad range of topics written by many distinguished contributors. Although two of the editors are now working in the United Kingdom, their FRCSI diplomas suggest that

they have a common training in Ireland. Indeed, no less than 14 of the 41 contributors have degrees and diplomas that suggest a background in the Emerald Isle, which may well explain the matching green colour of the book.

The volume begins with a chapter on pathogenesis, which is well written and liberally documented with references – albeit with a surgical, rather than a medical or basic scientific, bias. The second chapter is entitled 'Natural History' but it seems to stray outside this term of reference with a rather superficial repetition of pathogenesis, which, arguably, is not relevant to natural history. It also contains unusual statements, which, sadly, are not referenced – including the controversial suggestion that gall stones may fragment spontaneously, and that the stress of surgery is a 'stasis-promoting' factor.

Once again there is a surgical bias that ignores, for example, data on natural history gained from more than 300 patients given a placebo in the National Co-operative Gallstone study (which cost the US taxpayer \$12 million). Contrast this with near anecdotal accounts cited in the chapter of the natural history of stones based on four 'series' of 11, 17, 23, and 25 patients, or with information about intravenous cholangiography in 11 000 patients studied by the author of the chapter himself. From this position of undisputed strength, the author returns to rather superficial comments about the influence of hormones on gall stones in women, and a distinctly 'thin' account of the natural history of common duct stones. One is struck by the difference in the choice of references cited in corresponding 'medical' reviews. For example, the important contributions of Sum Lee from Seattle on biliary sludge, seem to have been ignored.

The inclusion of a curious chapter on classification of gall stones based on ultrasound, seems odd in a book devoted to 'techniques'. The Japanese authors of this chapter are almost unique in suggesting that ultrasonography is a reliable way of predicting stone composition. Most investigators believe that it does not reliably distinguish between gall stones of different type. One has much sympathy for authors writing in a language that is not their own but with the backing of a prestigious publishing company, such as Blackwells, it would have been hoped that technical editors would have ensured that references were quoted accurately and that spelling errors of authors names would be avoided – Suerbruch for Sauerbruch and Soenfield for Schoenfield.

Chapter 4 deals with lithotripsy but strays into very incomplete information on gall stone prevalence. The citation of one

reference to gall stones in male civil servants from Rome, hardly paints a complete picture.

In a multi-author book, some duplication of information is inevitable and may even be desirable. However, an important task of editors is to ensure that repetition is kept to an acceptable minimum. Unfortunately, this is not always the case with this book. For example, we read, repeatedly, that the first cholecystectomy was carried out by Langenbuch in 1882 (chapters 1, 4, 5, 8, 9, 10, and 11). There is also duplication of many references – for example that to Ransohoff *et al*. On the other hand (and surprisingly in a text written mainly by surgeons), the originator of laproscopic cholecystectomy (Philippe Mouret from Lyons) is not given credit for his innovation.