that it is only with subsequent investigations that we could find distinctive aetiology in 10 cases. Perhaps prognosis is good and special investigations are not necessary in 'true idiopathic pancreatitis' but how to know if it is a 'true idiopathic pancreatitis' without doing investigations? In the study of Ballinger et al., the pancreatitis was labelled idiopathic retrospectively and the causes of idiopathic pancreatitis were excluded from the study. We think that prospectively, it is often difficult to distinguish between 'true idiopathic' and rare causes of acute pancreatitis at the time of admission and that specialised investigations are often needed to separate them. 'Idiopathic pancreatitis' is a rare diagnosis that can be accepted only after specialised investigations. We outline that three of our patients had acute pancreatitis revealing a carcinoma and that hyperparathyroidism is sometimes caused by a cancer.2

In summary, the data presented in the authors' letter and their original abstract do not change our conclusions and recommendations for the treatment of first attacks of acute idiopathic pancreatitis.

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Screening for familial colorectal cancer

EDITOR.—Based upon their findings using an immunological faecal occult blood test, Cripps and Heald (Gut 1996; 38: 421–5) make recommendations for screening of colorectal cancer (CRC) on the basis of a positive family history. However, current knowledge calls for a more targeted and scientifically founded approach.

Their recommendations are intended for subjects who do not have a family history suggestive of an autosomal dominant condition predisposing to CRC. How is the distinction to be made between a 'dominant pedigree' and a less than dominant pedigree? For example, one of their patients was found to have familial adenomatous polyposis (FAP). The patients were assigned with a low lifetime risk by virtue of the single affected first degree relative, yet the patient's true original risk was 1:2 not 1:17. Single case hereditary non-polyposis colorectal cancer (Lancet 1995; 346: 1203–11). Lynch HT, Smyrk T, McGinn T, Lanspa S, Cavalier J, Lynch J, et al. Attenuated familial adenomatous polyposis (APAP): a morphologically and genetically distinctive variant of FAP. Cancer 1995; 76: 2427–33.


Screening for colorectal cancer

EDITOR.—The article by Cripps and Heald made for interesting and informative reading (Gut 1996; 38: 421–5). Their compliance rate of 60% was indeed impressive, comparing it with most other screening studies for detecting colorectal cancer. In this context, we would like to draw attention to some additional data relevant to this subject.

Hobs and coworkers found significant differences in compliance among patients aged between 50–69 (683; 61%), 70 or over (343; 54%), and 40–49 (204; 43%); (p<0.001). They report that patients from the inner city practice were less likely to comply with the test (78; 12%), versus (p<0.05) versus (p<0.02). They also found that fatalism, in a study among 192 elderly African Americans, was the only significant predictor of faecal occult blood testing (Davis et al. Gut 1993; 36: 97–103). The authors argue that education, and poverty, and education were controlled.2 Another study found significantly higher compliance (72.8% versus 51.8% (p<0.01) among 153 patients when dietary restrictions were