

that it is only with subsequent investigations that we could find definite aetiology in 10 cases. Perhaps prognosis is good and special investigations unnecessary 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 patients with rare causes of acute 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

B MAES
P HASTIER
JP DELMONT
Fédération des maladies de l'appareil digestif,
Hôpital de l'Archet,
151 Route Saint-Antoine de Giméthière,
BP79-06202 Nice Cedex 3, France

- 1 Maes B, Hastier P, Caroli-Bosc F, Conio M, Dumas R, Demarquay JF, *et al*. Etude étiologique des pancréatites cliniquement aiguës dans la région de Nice (résultats préliminaires). *Gastroenterol Clin Biol* 1995; 19: 1043.
- 2 Sitges-Serra A, Alonso M, de Lecea C, Gores PF, Sutherland DE. Pancreatitis and hyperparathyroidism. *Br J Surg* 1988; 75: 158-60.

Reply

EDITOR,—We have read the comments of Dr Maes and co-authors and also referred to their article that has been published in abstract form.¹ They have reported on 121 consecutive cases of acute pancreatitis and the abstract includes the first 62 of these patients. In the 19 patients in whom no cause of acute pancreatitis was found on initial investigation, the authors do not state if these were first or recurrent episodes of pancreatitis. This is obviously important if comparisons are to be made with our study in which we clearly state that we have only studied patients with a first attack of acute idiopathic pancreatitis and thus our conclusions are only applicable to this group of patients. As Maes *et al* recruited consecutive patients with acute pancreatitis it is probable that a proportion were presenting with recurrent episodes.

On subsequent investigation a possible cause for acute pancreatitis was found in 10 of 19 patients in the authors' series. We are surprised that some of these aetiological factors were not identified on the first hospital admission; for instance, we would expect an antral carcinoma invading the pancreatic duct to be easily seen on the abdominal computed tomogram. The authors do not state which drug was implicated in causation of acute pancreatitis but a clinical history taken on the first admission should have identified this as a possible causative factor.

Finally, the authors state that there was a 20% recurrence rate during the follow up period but only one recurrence after the correct diagnosis was made. We are not told what specific treatment, if any, those patients with a diagnosis received and therefore it is impossible to determine if the treatment changed the natural history. It is probably only worth searching for a cause if the treatment changes the longterm outcome.

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.

ANNE BALLINGER
ELEANOR BARNES
ELSPETH ALSTEAD
PETER FAIRCLOUGH
Digestive Diseases Research Centre,
St Bartholomew's and The Royal London School
of Medicine and Dentistry, London EC1M 6BQ

- 1 Maes B, Hastier P, Caroli-Bosc F, Conio M, Dumas R, Demarquay JF, *et al*. Etude étiologique des pancréatites cliniquement aiguës dans la région de Nice (résultats préliminaires). *Gastroenterol Clin Biol* 1995; 19: 1043.

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). This patient was originally 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 (HNPCC) families have now been identified through the demonstration of germline mutations in a DNA mismatch repair gene. The affected subjects were ascertained exclusively on the basis of young age at onset of CRC.¹ These examples illustrate the inadequacy of attributing lifetime risk on the basis of family history alone.² Indeed such estimates are both crude and misleading.

The alternative approach is to offer targeted screening on the basis of the underlying genetic disorder. An approach to the correct diagnosis is achieved through the ascertainment of detailed and extended family pedigrees for which all cancer diagnoses are verified with respect to location, age at onset, and histological type. The presence of DNA microsatellite instability is an important biomarker for HNPCC, particularly when found within early onset cancers,¹ two or more cancers from the same patient or in cancers from two or more members of the same family.³ Once classic FAP, attenuated FAP,⁴ and HNPCC have been excluded, what is left? Apart from various rare forms of precancerous polyposis the literature hints at least one additional important autosomal dominant disorder. This has been described 'late onset familial CRC'⁵ or 'adenoma families'.⁶ Still poorly understood, this syndrome features cancers of the left colon and rectum, a modest increase in the number of adenomas, and an increased tendency for adenomas to become large and villous.^{5,7} No reliable marker for this putative autosomal dominant syndrome exists at this time.

A weak family history of colorectal cancer with no distinguishing clinical, pathological or

molecular features is likely to be a chance event, associated with a low lifetime risk for family members. CRC is common and affected subjects are likely to have multiple first degree relatives. Might not these relatives, perhaps representing an estimated 20% of the total population, be served through a conventional population based screening approach? Obviously this would depend on correctly assigning high risk families to particular autosomal dominant disorders. Although we currently lack full diagnostic capability in this respect, the way forward is to establish cancer family clinics that would facilitate integration of clinical, genetic, and pathological data and coordinate longterm management strategies. One shudders at the prospect of local enthusiasms linked to unlicensed gene testing outfits.⁸

JEREMY R JASS
Faculty of Medicine and Health Science,
The University of Auckland, Private Bag 92019,
Auckland, New Zealand

- 1 Liu B, Farrington SM, Petersen GM, Hamilton SR, Parsons R, Papadopoulos N, *et al*. Genetic instability occurs in the majority of young patients with colorectal cancer. *Nature Medicine* 1995; 1: 348-52.
- 2 Houlston RS, Murday V, Haracos C, Williams CB, Slack J. Screening and genetic counselling for relatives of patients with colorectal cancer in a cancer family clinic. *BMJ* 1990; 301: 366-8.
- 3 Jass JR, Cottier DS, Jeevaratnam P, Pokos V, Holdaway KM, Bowden ML, *et al*. Diagnostic use of microsatellite instability in hereditary non-polyposis colorectal cancer. *Lancet* 1995; 346: 1200-1.
- 4 Lynch HT, Smyrk T, McGinn T, Lanspa S, Cavalieri J, Lynch J, *et al*. Attenuated familial adenomatous polyposis (AFAP): a phenotypically and genotypically distinctive variant of FAP. *Cancer* 1995; 76: 2427-33.
- 5 Vasen HFA, Taal BG, Griffioen G, Nagengast FM, Cats A, Menko FH, *et al*. Clinical heterogeneity of familial colorectal cancer and its influence on screening protocols. *Gut* 1994; 35: 1262-6.
- 6 Burt RW, Bishop T, Cannon LA, Dowdle MA, Lee RG, Skolnick MH. Dominant inheritance of adenomatous colonic polyps and colorectal cancer. *N Engl J Med* 1985; 312: 1540-4.
- 7 Boutron M-C, Faivre J, Quipourt V, Senesse P, Michiels C. Family history of colorectal tumours and implications for the adenoma-carcinoma sequence: a case control study. *Gut* 1995; 37: 830-4.
- 8 Moran N. UK spurns proposed genetics regulatory commission. *Nature Medicine* 1996; 2: 139.

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.

Hobbs and coworkers found significant difference in compliance among patients aged between 50-69 (683; 61.6%), 70 or over (343; 54.3%), and 40-49 (204; 43.8%), ($p < 0.001$). They report that patients from the inner city practice were less likely to comply (55; 3.5% versus 78; 12.5%; $p < 0.001$).¹ Powe found that fatalism, in a study among 192 elderly African Americans, was the only significant predictor of faecal occult blood testing (FOBT), even when factors such as age, 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