intact stomach', but this is well known and obvious because duodenogastric reflux is a physiological event, which takes place in all the subjects as well as in all the H. pylori positive ones. In contrast, in my opinion, because of these methodological reasons the statement that ‘data suggest that H pylori may induce DGR’ is apodictical and needs to be proved by examined order series and using more adequate methods.

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Calcium and colorectal epithelial cell proliferation

EDITOR—There is still much debate whether calcium can prevent colorectal cancer in patients with an increased risk of the development of such tumours. Calcium intervention studies, using epithelial cell proliferation as an intermediate endpoint, have produced inconsistent results. Most studies have focused only on the effect of calcium on the rectal epithelium. Several open uncontrolled studies have shown a reduction of rectal epithelial cell proliferation during calcium supplementation, but small placebo controlled studies are not as uniform in their conclusions. Recently Weisgerber et al (1996; 38: 396-402) considered this aspect of sample size, as well as the fact that studies were performed with biopsy specimens from the rectum. With respect to the small size of patient populations, two recent studies involved a large number of subjects. Bostick et al, performed a randomised, double blinded study in sporadic adenoma patients.8 Patients received placebo (n=66), 1 g calcium/day (n=64) or 2 g calcium/day (n=63) for six months. Rectal biopsy specimens were obtained at baseline, and at one, two, and six months. In this study no difference in proliferation was observed between the three groups. However, calcium normalised the distribution of proliferating cells in the crypts, which is supposedly beneficial with respect to cancer risk. Rothstein et al9 published a preliminary report on a very large study in which adenoma patients were randomised to receive 1-2 g calcium (n=173) or placebo (n=160). Before and after six to nine months supplementation rectal biopsy specimens were taken. Calcium had no effect on proliferation and, in contrast with the previous study, no effect on the distribution of proliferating cells either. With respect to the effect of calcium on proliferation of colonic mucosa, Weisgerber et al10 suggested in their recent paper that, apart from one open uncontrolled study,11 this has not been studied before. In another open uncontrolled study we unexpectedly observed an increase of proliferation in the sigmoid of adenoma patients after 12 weeks 1-5 g calcium/day.12 Weisgerber et al11 performed a randomised, double blinded study and did not find any effect of longterm calcium supplementation on sigmoidal cell proliferation. This is in line with a to a great extent our recently reported findings in a randomised, double blinded study in 30 first degree relatives of patients with hereditary non-polyposis colorectal cancer.13 These subjects were shown to have an increased epithelial cell proliferation rate,13 which responded to calcium in two open studies.13 The subjects received 1.5 g calcium/day or placebo. To elucidate the potential site specific effects of calcium in the colorectum, biopsy specimens were obtained from the H. pylori positive colon and before and after three months. In none of the three parts of the colorectum was a significant effect of calcium on proliferation observed compared with placebo. The only noticeable difference between the two groups was a decrease of proliferation rate in the luminal crypt compartment in the rectum during calcium compared with placebo, a finding similar to that of Bostick et al.

In summary, from this small sized, double blinded studies reported, the following conclusions can be drawn: (1) in the rectum calcium supplementation may normalise the abnormal distribution of proliferating cells in the crypt without affecting overall proliferation rate; (2) no appreciable effect of calcium supplementation on proliferation in the sigmoid can be observed, and the same seems to be true for the descending colon. Based on this conclusion, the ongoing study doubt should arise on the value of calcium supplementation for the prevention of colorectal cancer in people with an increased risk of this disease.

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controlled intervention study with supple-

Emergency endoscopy

Editor,—I read with interest the paper by Dr Bowling et al showing the apparently narrow relations between collagen and lymphocytic colitis, and describing the possibility of severe clinical episodes in the medical conditions (Gut 1996; 38: 788–91). I wonder whether a total colectomy was necessary in this patient. Indeed, the pathological finding of the usual features of lymphocytic colitis, without any sign of severe alteration of the colonic wall, led the authors to consider whether 'continuing conservative treatment in similar circumstances, despite failing of medical treatment, could be a sound triate'. In this case, may I ask if a new colonicoscopy performed in emergency before considering a colectomy would have 'restrained' the surgeon's arm? For many years, we have advocated emergency colonoscopy, in severe episodes of inflammatory colitis.1 Provided the endoscopist has the necessary experience, this procedure is safe in patients with severe clinical symptoms for distinguishing those with true anaemia and severe exerts of those from whom only acute colonic mucosal inflammation, but without deep and extensive ulcersation.

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Reply

Editor,—We thank Kleibeuger et al for their supportive comments about our recent paper (Gut 1996; 38: 396–402). They highlight the latest evidence with regard to the effect of calcium on rectal and colon cell pro-
liferation in different patient groups. We very much agree with their concluding summary and wish to add some additional points. The value of calcium supplementation in the prevention of colorectal cancer seems questionable under conditions of adequate calcium intake, accompanied by impaired calcium absorption as typically observed in elderly people.

Importantly, if there is indeed some beneficial effect in the rectum but not in the colon, then this seems rather incompatible with an intraluminal effect of calcium such as binding and precipitating bile acids and fatty acids for the following reasons: (1) The rectal mucosa is in far less direct contact with intestinal digesta than the colon and is therefore comparatively unlikely to benefit more from a lower concentration of potential carcinogens in the intestinal lumina; (2) chelation by calcium of long chain fatty acids (there is no direct evidence that calcium chelates bile acids in vivo) at least, seems to occur at the favourable alkaline pH of the upper small intestine2 and therefore should have a beneficial effect along the whole of the large bowel in terms of cell proliferation. Unfortunately the calcium bile acid hy-
thesis has until now relied too heavily on inappropiate assumptions made from in vitro animal experiments, animal models, and short-term uncontrolled human studies.

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Reply

Editor,—Professor Rambaud wonders whether a total colectomy was necessary in this patient and whether 'continuing conserv-
ervative treatment in similar circumstances, despite failing of medical treatment could be appropriate'. He asks if a new colonicoscopy was performed as an emergency before making the final decision about colectomy.

As outlined in our paper, two colonoscopies were performed. On her last admission she failed to respond to medical treatment. She remained acutely unwell with profuse diarrhoea, persistent fever, abdominal tender-
ess, and leucocytosis. Her plain abdominal x ray showed evidence of a total colitis with mucosal oedema. From the clinical standpoint this was clearly a serious situation and indeed life threatening and on clinical grounds an emergency sub-total colectomy was advised and carried out. There was no question in this case of needing to refrain 'the surgeon's arm'. The advantages of working in a combined medical and surgical gastro-
enterology unit is that decisions about surgery in acute inflammatory bowel disease can be made jointly between the physicians and surgeons concerned and that was the case here.

One of the reasons for presenting the case report was that this patient had to come to surgery and as outlined in the paper she made an excellent recovery and has remained well for years later.

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It is perhaps a rather arbitrary matter to define when a trainee endoscopist can be considered to have completed their training. At a time when trainees are being asked to be aware of what is happening more closely than ever before, there are obvious limitations in defining proficiency in terms of numbers of procedures performed. Any gastroenterologist who has had the privi-
lege of helping junior colleagues to acquire endoscopic skills will know that they may show considerable variation in the gradient of the learning curve. To some extent, the shape of this curve depends on the teacher's skills as much as any. Their ability to cope as part of the trainee. Furthermore, there are few of us so endowed with natural endoscopic talent that we have reached a stage when there is nothing more to learn ourselves. All practicing gastroenterologists - whether they know which end of the instrument to introduce into the patient or whether they have carried out 'tens of thousands of proce-
dtures' - will learn from the latest edition of Cotton and Williams. These two titans of the endoscopic firmament have updated a book that is packed end to end with practical advice. I have no idea how many hundreds of endoscopies this pair has performed but their students are fortunate indeed. The rest of us can just share in the experience from their book.

This is a practical manual that is illustrated by superb line diagrams, which have become one of the hallmarks of this excellent publish-
ing house. It would be entirely appropriate for every gastroenterologist to have studied the first four chapters before wielding a scope for the first time. The inclus of a number of pieces of how to perform ERCP and colonoscopy are most unlikely ever to be bettered. Maybe we feel we know how to cope with these and other problems of a more technical nature, but it can seem difficult to explain to a trainee what to do. Somehow, with the skilled teacher's distinctive gift, Cotton and Williams articulate just what to do and why - in terms of the anatomy of the gut and the manoeuvrability of the endoscope. Obviously, one cannot learn a practical skill from a book but it would be a very fine teacher indeed who could not use a book of this quality.

As upper and lower gastrointestinal endo-
scopy is dealt with so comprehensively, it does come as rather a disappointment that small bowel endoscopy is covered so superficially in just four pages. There is much more to be said about push and sonde enteroscopy than is described here in just two pages. In our experience, passage of the sonde scope to the distal ileum may require a little more attention than is given. As for the other end of their pipe, the technique of enteroscope withdrawal jus-
tifies more than eight lines of text.

This, however, is the book's only weakness. I found myself nodding in agreement with much of what these fibrecopic heroes have to say. It is good to know they recognise and recommend patience as a key virtue in a