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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 patients. (Gut 1996; 38: 788–91). I wonder however 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 adequate.

In this case, may I ask if a new colonoendoscopy performed in emergency before considering a colectomy would have ‘retrained’ the surgeon’s arm? For many years, we have advocated emergency colonoendoscopy, 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 acute large bowel inflammatory disease from those with merely acute colonic mucosal inflammation, but without deep and extensive ulcerations.

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Reply

EDITOR,—Professor Rambaud wonders whether a total colectomy was necessary in this patient and whether ‘continuing conserva-
tive treatment in similar circumstances, despite failing of medical treatment could be adequate’. He asks if a new colonoendoscopy was performed as an emergency before making the final decision about colectomy.

As outlined in our paper, two colonoendoscopies were performed. On her last admission she failed to respond to medical treatment. She remained acutely unwell with profuse diarrhoea, persistent fever, abdominal tenderness, and leucocytosis. Her plain abdominal x ray showed evidence of a total colitis with mucosal oedema. From the clinical stand-

point 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 seen as being recognised 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 anything. Their ability to point the way to 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 procedures’ – 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 endoscopists this pair have trained, 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 published 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 importance of good advice on the per-

formance of ERCP and colonoscopy is most likely ever to be bettered. Maybe we feel we know how to cope with common problems of retained splenic flexure, but it can seem difficult to explain to a trainee quite what to do. Somehow, with the skilled teacher’s instinctive gifts, 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 endoscopy 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 send enteroscopy than is described here in just two pages. In our experience, passage of the scope to the distal ileum may require a little more attention than the patient is prepared to give, much to the patient’s discomfort. 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 fibreoptic heroes have to say. It is good to know they recognise and recommend patience as a key virtue in a