
12 O’Sullivan KR, Mathias PM, Beantie S, O’Morain C. Effect of oral calcium supplemen-

13 Kleibeuker JH, Welber PWJ, Mulder NH, van der Meer R, Cats A, Limburg AJ, et al. Epithelial cell proliferation in the human sigmoid colon of patients with adenomatous polyps increases during oral calcium supple-

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Reply

EDITOR,—We thank Kleibeuker 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 colonic cell pro-
iferation 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.

Furthermore, 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 cocarcinogens in the intestinal lumen; (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 intestines 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-
pthesis has until now relied too heavily on inappropriate assumptions made from in vitro experiments, animal models, and short-term uncontrolled human studies.

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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 conditions (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 a viable alternative.

In this case, may I ask if a new colonoscopy 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 exudate from those with merely acute mucosal 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 con-

servative treatment in similar circumstances, despite failing of medical treatment could be a viable alternative’. He asks if a new colonoscopy 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-
ness, 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 subtotal 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’ programmes are being rationalised 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 on the trainee ability on the 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 practical gastroenterologists – whether they know which end of the instrument to introduce into the patient or whether they have carried out ‘tens of thousands of pro-
cedures’ – 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 taught, 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 drawings, which have become one of the hallmarks of this excellent publishing 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 ingenious and incredibly helpful des-
criptions of how to perform ERCP and colonoscopy are most unlikely ever to be bettered.

Maybe we feel we know how to cope with some standard problems of retroflex 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 articulately 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 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 the authors seem to give to this point.

Yet, perhaps, it is the book’s only weakness. I find 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