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

13 Kleibeuker JH, Welberg JWM, 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 supplemen-

14 Cats A, Kleibeuker JH, Kuipers F, Hardonk MJ, et al. Randomized, double-blind, placebo-
controlled intervention study with supple-


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-

liferation in different patient groups. We very much agree with their concluding suggestions and wish to add some additional points. The value of calcium supplementation in the prevention of colorectal cancer seems questionable in conditions of adequate calcium intake, accompanied by impaired calcium absorption as typically observed in elderly people.

Moreover, 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 intestine 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 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 strong

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

there is any true colitis 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 suitable' choice.

In this case, may I ask if a new colonicoscopy performed in emergency before considering a colectomy would have 'refrained' the surgeon's arm? For many years, we have advocated emergency colonicoscopy, in severe episodes of inflammatory colitis.1 Provided the endoscopist has the necessary experience, this is a safe procedure in patients with severe clinical symptoms for distinguishing those with true anaphylactic shock 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 con-
servative treatment in similar circumstances, despite failing of medical treatment could be scrupulosity'. He asks if a new colonicoscopy was performed as an emergency before making the final decision about colectomy.

As outlined in our paper, two colonicoscopies were performed. On her last admission she was 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 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.

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 is implied in the book. The technique of enteroscopy 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 fibroptic heroes have to say. It is good to know they recognise and recommend patience as a key virtue in a

BOOK REVIEWS


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 perform more procedures far 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 put over part of the trainee. Furthermore, there are few of us so endowed with natural endoscopic talent that we have reached a stage where 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 this neatly written book by P Cotton and Williams. These two titans of the endoscopic establishment have updated a book that is packed end to end with practical advice. I have no idea how many hundreds of endoscopists this pair has 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 incisive and helpful descrip-
tions of how to perform ERCP and colono-
scopy are most unlikely ever to be bettered. Maybe we feel we know how to cope with common problems of retained sphincter 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.
teacher. As pressure of the clock seems to close in on many endoscopy lists, the ability to deliver this pressure and allow trainees enough time to do sufficient to learn is a hallmark of the good teacher. Sometimes, it is necessary to speed up the pupil but, as Cotton and Williams have obviously learned from their experience, a 'slow' endoscopist with integrity can learn to excel, whereas the aggressive and erratic often remains so.

IAN FORGACS


Although first impressions are often powerful they are not always correct. Although I recognise the old adage that you only have one opportunity of making a first impression, further thought and understanding often indicate that such initial impressions are mistaken. When I first received the second edition of Liver and Biliary Diseases, I had a mild 'heart sink'. Everything appeared to be advenet; the cover of the book is unimpressive, a rather mucky green, which seemed to suggest neither deep scholarship and intellectual rigor nor the more modern folksy approaches to those text books aimed at medical students. There have been several new text books on hepatology issued in the past couple of years and this was not an auspicious start to a second edition of one of these. Inside, impressions again remained unimpressed. The quality of the paper was unexciting, the print old fashioned, and even the colour illustrations were of poor quality. Yet closer examination of the text and actually reading the textbook showed just how wrong these first impressions are.

Overall, the contents of this book are first rate. It is almost completely an American textbook with a wide spectrum of authors almost entirely working in the USA. None the less, the book is excellent. The first two sections concentrate on the structure, function, and pathophysiology of liver disease. These provide a clear and relatively up to date account of both anatomy and physiology of the liver at a level found right.

After four chapters discussing diagnostic methodologies in hepatology, there follows chapters on acute and chronic liver diseases. All chapters are well written and comprehensible. While I am not sure how much editorial rigor was imposed certainly the book reads extremely well and coherently despite some minor inconsistencies. I particularly enjoyed the approach of highlighting important data on the text. I also appreciated the lack of including references in the text. The authors have adopted an annotated bibliography and here is one of my criticisms. The bibliography, quite appropriately, refers to reviews. However, relatively few are up to date. It is inevitably a consequence of the textbook format that there is a significant delay between submission of manuscripts and publications but many of the bibliographic references are to reviews articles published before 1991. The only other criticism I have is that the colour illustrations are poorly done and the legends to the figures are not juxtaposed with the figures themselves.

Overall, I thought this was an excellent book with the right balance of anatomy, physiology, and pathology. There are plenty of illustrations, which not only break up the text but also provide information in a useful form. The price of £125, which seems a lot is certainly no greater than other comparable textbooks and I would have no hesitation in recommending it not only to hepatologists but also to those gastroenterologists who look after patients with liver disease.

JAMES NEUBERGER


This is the first volume of a series entitled Cell Adhesion and Communication edited by C Goridis. Such a series is warranted because there has been vast accumulation of knowledge concerning cell adhesion during the past decade. It has become clear that adhesion of cells to each other and to the extracellular matrix not only stabilizes a multicellular organism, but also controls cell migration, cell function, and cell differentiation. This has led to a growing scientific interest in molecules involved in these adhesive interactions that play a crucial part in many physiological processes. Furthermore, adhesive interactions are implicated in pathological processes like inflammation, wound healing and especially in cancer growth, invasion, and metastasis.

This book is described as an up to date summary of current clinical applications of adhesion molecule research focusing on the part played by adhesion molecules in cancer and inflammation. However, this goal is not reached by all the contributions. It contains 19 chapters written by 17 different groups representing a heterogeneous group of persons working in this field. It starts with a brief and excellent overview of the different classes of cell-cell and cell-matrix adhesion molecules in inflammation by M Pigantelli et al, reviewing the literature until 1993. This is followed by a detailed description of the immunohistological work on the expression of integrin and E-cadherin cell adhesion molecules in the normal human breast, non-neoplastic breast disease, and in breast cancer by the same authors. While there are several other worthwhile review articles, for example, on the role of adhesion receptors in the dissemination of non-Hodgkin lymphomas by S T Pals et al, or the regulation of integrin expression by TGF-β by J Heino, most articles describe experimental results of basic science research, the clinical relevance of which remains to be established. Thus one article describes the discovery of a novel molecule that must be further characterised, which mediates the laminin induced differentiation of a retinoblastoma cell line, and another one a new monoclonal antibody against P-selectin.

Some articles, such as the description of raised serum t-PA values in breast cancer patients versus normal controls are only tangentially related to the topic. On the other hand despite the large amount of previously published data concerning cell adhesion and the inflammatory immune response, this whole field is touched on by only two articles, both focusing on epithelial expression of cell-cell adhesion molecules.

In summary, this book presents experimental data related to the topic of cell adhesion and cancer and gives an overall impression of the diversity of experimental approaches and different disease situations. This may be of interest for scientists planning to work in this field. Because of the rapid scientific progress in cell adhesion research the volume inevitably will quickly become outdated. Given that the review content of this book is rather limited — gastroenterological tumours are not discussed in great detail and the possible clinical use of the results still remains to be investigated — it is of limited value to the broad readership of gastroenterologists.

E O RIECKEN

Paediatric gastroenterology

The 5th Congress of the Asian Pan Pacific Society of Pediatric Gastroenterology and Nutrition will be held on 10–13 April 1997 in Taipei. Further information from Conference Organiser, c/o K and A International, Co Ltd, PO Box 55-1143, Taipei, Taiwan. Tel 886-2 516 3952; fax 886-2 516 2516.

Clinical investigation

The 31st meeting of the European Society for Clinical Investigation will be held on 19–22 March 1997 in Kiel, Germany. Further information from Congress Office, PO Box 12 21, D-22882 Hamburg-Barsbüttel, Germany. Tel: 49 40 670 88 20; fax 40 670 32 83.