became available in seven of the DU patients. No specific mention was made of corrections for pyloric losses or duodenal reflux. Their chief findings were statistically significant falls in basal, maximal, and GRP stimulated secretion in the seven patients with dual tests. They suggest that H pylori, by increasing sensitivity to gastrin, increases parietal cell mass and that this is the cause of the well-known increased maximal acid output in DU patients compared with controls.

This paper, at odds with the pages from this department that demonstrated that H pylori positive subjects, both patients with non-ulcer dyspepsia and patients with DU, had lower maximal gastric secretion (in response to continuous intravenous histamine) than H pylori negative patients of the corresponding diagnostic groups. Our study was performed in 64 subjects. Corrections were made for pyloric losses and duodenogastriac reflux (both especially important when low secretion rates or small differences in secretion rates are being measured).

The GRP stimulated responses seen by Harris et al were clearly submaximal, because they were only 40-70% of the pentagastrin responses. The latter were also possibly submaximal (intramural route, one shot injection). Therefore it is possible that the phenomenon they have described (if it is confirmed in a larger number of patients with correction of collection errors) represents an effect of H pylori that primarily reduces parietal cell mass, and thereby increases sensitivity to gastrin (GRP or pentagastrin). This alternative hypothesis was discussed and referenced in our article. The important point is that the findings described by Harris et al do not necessarily indicate that H pylori increases the parietal cell mass.

Oshowo and Hobley state that they suggest that H pylori, by increasing sensitivity to gastrin, increases parietal cell mass. We actually suggested that ‘the increased PAO$_2$ (an indirect measure of the parietal cell mass) in H pylori positive patients with duodenal ulcer may be caused by a combination of exaggerated gastrin secretion and acid response to gastrin but not purely as a result of a change in sensitivity to gastrin.

Our finding of reduction of PAO$_2$ after eradication of H pylori has since been confirmed and we look forward to Professor Hobley’s study of his patients with duodenal ulcer after eradication of H pylori with ‘a large number of patients with correction of collection errors’.

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Ultrasound for gastroenterologists

EDITO—I read with interest the leading article by Dr Derrick Martin (Gut 1996; 38: 479-80) in which I believe he makes a very good case for not training gastroenterologists in ultrasound.

The argument in favour of training gastroenterologists is, I believe, a weak one based on an increasing waiting time for ultrasound in radiology departments. Radiology is an important requirement of the European Union of Medical Specialities, and the perceived attractiveness of an ‘instant’ diagnosis at the first outpatient clinic attendance.

These arguments are far outweighed by many reasons in favour of maintaining and constantly improving radiology services. As a radiologist, Dr Martin concedes that ultrasound is ‘a difficult technique, technical artefacts in the image abound and can cause diagnostic confusion’. What defence is there when a renal tumour is missed, an aortic aneurysm recognised, an ovarian cyst undetected or pleural effusions not looked for? The high level of training of the radiologist enables him or her to search routinely for all of these potential pitfalls. Dr Martin states that many radiologists are keen to train others. This is certainly true but there is some evidence that they are keen to train gastroenterologists. Without doubt, training would be requisite to be thorough and systematic.

The leading article calls for well-adequately equipped and with the need to make efficient use of expensive resources. ‘You get what you pay for’ is certainly true and high quality ultrasound requires the appropriate level of investment in equipment. How is it possible therefore to justify the purchase of expensive ultrasound equipment for the gastroenterology clinic based on a throughput of perhaps 20 cases per week (or less!), which is equivalent to two radiology ultrasound sessions per week.

Dr Martin readily acknowledges the unpredictable nature of the gastroenterology workload and the variable conditions of those intending to use ultrasound. This is a further good reason for focusing ultrasound in the radiology department with its dedicated centralised staff and resources. There have been previous precedents in which hospitals have accumulated expensive ultrasound equipment outwith the radiology department in renal units, urology departments, cardiology units and stroke units, which stands unused for most of each week. Furthermore equipment located outwith the radiology department runs the risk of infrequent or inadequate maintenance. Excellent hard copy facility is essential if we are to reach a logical conclusion that it is unlikely that the high cost of expensive laser printers could be justified outwith the radiology department.

Formal reporting of ultrasound images has many pitfalls and the gastroenterologist is at a particular risk of meeting one or more of these.

‘The issue of waiting lists in radiology departments is an important one. Whenever a Trust makes a clinical decision, it needs to ask a question “What service department (including radiology) consequences will this appointment inevitably bring with it?”

There is an increasing tendency within radiology departments to have branches, power Doppler, and tissue characterisation are most likely to flourish in the hands of dedicated radiologists. It would be completely inappropriate for me to have any involvement in breast screening mammography or endoscopy, and I do not believe that training gastroenterologists is a wise use of resources.

The decere of the European Board of Gastroenterology that training should be included is not necessarily a wise one and in any case is probably relevant to comparatively few UK gastroenterologists.

Elsewhere Dr Martin highlights the benefits of the patient focused approach to diagnosis and therapy, but surely the way forward is to focus ultrasound services within the imaging department ensuring that the highest possible standard is established and maintained with respect to rapid, accurate and complete diagnosis, instant reporting, education, and research.

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Reply

EDITO—I am grateful to Dr Vallance for his comments, as this is clearly a topic where debate is essential if we are to reach a logical conclusion that allows the fulfilment of ambi-

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tion for both radiologist and gastroenterologist, as well as providing a prompt service with appropriate quality.

In my heart I know that the comments by Dr. Vallance will highlight the potential difficulties and drawbacks that may result from ultrasound examinations being undertaken by practitioners other than skilled trained radiologists. In my head, however, I recognise that there are other arguments that must be resolved. Some gastroenterologists and indeed clinicians in other specialties, do genuinely wish to provide an ultrasound service and this wish has been given validity by the declaration of the European Board of Gastroenterology that ultrasound should be part of the training programme for gastroenterologists. Neither radiologists individually nor collectively through their Royal College, are in a position to prevent non-radiologists from using ultrasound for diagnosis and therefore we find ourselves in a position in which we can adopt one of three responses.

Radiologists can ignore the needs of non-radiologists to train in ultrasound and decline to be involved in such training. In doing this we will deny to non-radiologists an understanding of our own skills, which contribute to the clinical care we and may thus contribute to the poor quality non-radiological service which we fear.

Radiologists may believe that because non-radiological ultrasound training is in vogue, that we should simply keep our heads down for a while in the hope that the fashion will pass, but again we risk the development of a second rate service without our contribution.

Thirdly, we could permit our non-radiologist colleagues access to our skills. Of course we do this already by providing a service for them and their patients, but we should extend this to the provision of training, so that the service which non-radiologists provide is of sufficient standard to fulfil radiologists’ definition of quality. Additionally the links forged between radiologist and non-radiologist during training should contribute to more open communication, which must be to the ultimate benefit of our patients.

I believe that the responsible and logical reaction of radiologists to the wishes of some non-radiologists to train in ultrasound, is to provide them with sensible achievable guidelines for training so that radiologist and non-radiologist can work together to provide what the patient needs, a rapid ultrasound service of appropriate quality.

**Peptide YY and electrolyte homeostasis**

**EDITOR,—**We wish to comment on the article by Playford and coworkers which he highlights potential difficulties and drawbacks that may result from ultrasound examinations being undertaken by practitioners other than skilled trained radiologists. In my head, however, I recognise that there are other arguments that must be resolved. Some gastroenterologists and indeed clinicians in other specialties, do genuinely wish to provide an ultrasound service and this wish has been given validity by the declaration of the European Board of Gastroenterology that ultrasound should be part of the training programme for gastroenterologists. Neither radiologists individually nor collectively through their Royal College, are in a position to prevent non-radiologists from using ultrasound for diagnosis and therefore we find ourselves in a position in which we can adopt one of three responses.

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**Reply**

**EDITOR,—**We are grateful to Professor R J Playford and Dr C E MacDonald for drawing our attention to this research. It supports the view that peptide YY is important in the short bowel syndrome. While the main reason for a high output from a jejunostomy is the loss of the normal daily secretions produced in response to food, low plasma concentrations of peptide YY may exacerbate the situation by increasing the rate of liquid gastric emptying and small bowel transit,1 and may increase water and electrolyte secretion. High plasma concentrations of peptide YY occur in patients with a short bowel and a retained colon, thus it is beneficial to preserve some colon when a major bowel resection is performed.

**J M D NIGHTINGALE**

**M A KAMM**

**J E LENNARD-JONES**

**St Mark’s Hospital, London**


**BOOK REVIEW**


Books reviewing proceedings of meetings are often a patchwork of contributions and indeed can be awkward and patchy quality. This book is an exception. To begin with the book was a pleasure to handle; an attractive cover, solidly bound and on high quality paper. A glance through it revealed abundant ill-tempered tables, and uniformity of style. Dipping into the book and reading in more depth revealed a systematic authoritative and in depth coverage of the molecular biology of pancreatic diseases, acute pancreatitis, chronic pancreatitis, and pancreatic cancer.

On the basis that it is a reviewer’s privilege to select items for commendation or condemnation (I have nothing to offer here) I will select a few gems from the text. Weber and Jensen have given a masterly insight into the genetic and molecular biological aspects of pancreatic endocrine and carcinoid tumours. This reviewer learnt a lot from reading the various sections on chronic pancreatitis and any student of this condition callow or seasoned should read it thoroughly for its comprehensive coverage of the literature and conclusions.

The Japanese contributors at last gained exposure contributing an exhaustive analysis of the European versus the Japanese approach to surgery in this condition. In my view the star chapter was that of Herrmann describing the pathology of pancreatic cancer culminating in the new WHO classification.

Who should buy this book? It is relevant to the practice of any serious pancreaticologist, it is an essential reference for any researcher in the field and the editor is to be congratulated.

A N KINGNSORTH