Pigbel-like syndrome in a vegetarian in Oxford

EDITOR,—We were interested to read the case report by Farrant et al (Gut 1996; 39: 336–7) as we too have had a similar recent case of unexplained ischaemic or necrotising enterocolitis. In our patient also the terminal ileum and caecum were primarily affected, and Gram positive organisms were identified on Gram staining. However, despite the background of tropical exposure we do not agree with Farrant et al’s interpretation of the findings as being consistent with Pigbel syndrome. The pathology of this condition is well described by Cooke and seems to affect the jejunum in a patchy fashion along the antimesenteric border and rarely involves the ileum, but never the colon. It is classically described as occurring rapidly following the ingestion of fish in the setting of protein energy malnutrition, and the requirement for dietary trypsin inhibitors seems to be at the time of toxin ingestion rather than three months previously. The finding of Gram positive organisms in the bowel wall is not conclusive as clostridial species are ubiquitous in faecal flora, and indeed we have demonstrated their presence in the tissues of colectomy specimens with infection due to vascular thrombosis. The fact that Pigbel syndrome has been well controlled by the introduction of vaccination to the Clostridium perfringens type C β-toxin2 suggests that the presence of this organism or its toxin is necessary to make this diagnosis. The mere presence of Gram positive organisms in this case without toxicological proof, given the unusual circumstances and the unlikely distribution of the lesion, made the presumptive diagnosis of Pigbel syndrome somewhat tenuous.

We would suggest instead that the clinical picture is more that of a "non-occlusive mesenteric ischaemia"-like syndrome which is known to have a predilection for the terminal ileum and caecum3 as in this case and has been associated with diarrhoea, ileus,4 vasoconstrictors such as cocaine,5 hypovolaemia, haematological malignancies,6 and even Marathons running.8 Although in such cases are rare and the aetiology obscure, the presence of splanchic vasoconstriction and diminished circulating volume would seem to be critical and could have occurred in this case due to the combination of infective diarrhea and physical training.

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Bone disease after liver transplantation should not be underestimated

EDITOR,—In their leading article on bone disease after liver transplantation (Gut 1996; 39: 505–7), Losowsky and Hussaini rightly emphasise the pathological role of pre-existing osteopenia and osteoporosis. However, the suggestion that post-transplantation bone disease is "becoming less of a problem" does not accord with our own experience or that of others, who have reported new fractures incidentally between 20 and 30% in the first year after transplantation.1,2

The clinical significance of post-transplantation bone disease lies in the morbidity associated with fragility fractures, and the emphasis on bone mineral density as an indicator of disease may be misleading in this group of patients. During the early phase of bone loss, there is an increase both in bone turnover and the depth of cavities created by osteoclasts,3 changes which will result in trabecular thinning and penetration in cancellous bone, reducing its mechanical strength and increasing fracture risk. Although bone mineral density measurements performed in the lumbar spine and proximal femur may overestimate the bone loss in parts of the skeleton—especially the thoracic spine. These considerations emphasise the importance of using fracture, not bone density, as the main outcome of post-transplantation bone disease; the majority of fractures occur in the spine and, since as many as two thirds of vertebral fractures may be asymptomatic, vertebral radiographs both before and after transplantation are required to establish the existence of fracture accurately. Losowsky and Hussaini state that in the study of Hawkins et al,4 no patient showed radiological or clinical evidence of vertebral collapse or hip fractures after transplantation, bone mineral density measurements performed post-operatively in only 50 (61%) patients and fracture incidence may thus have been underestimated. The recent report from Leeds5 containing no data on fracture incidence and the clinical significance of this disease changes in bone mineral density is thus unclear.

In common with the Leeds group, we have found that the reduction in bone mineral density after liver transplantation is less than that reported in clostridium perfringens disease, possibly as a result of the smaller doses of glucocorticoids now used for immunosuppression. Nevertheless, the incidence of fractures during the first postoperative year remains high, resulting in significant long term morbidity and the development of effective prophylactic strategies in these patients should be regarded as an important research priority.

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My first reaction on receiving this book was "Not another book on bile duct stones". I read the preface and remarks and recognised myself on the large numbers of black and white radiographs of the biliary tree taken by all kinds of techniques: laparoscopy and ERCP in particular. There were also quite a few colour photographs of taken during laparoscopy which could have been of better quality. I scanned one chapter and noted three things that irritated me: the author consistently confused the common bile duct with the common hepatic duct and C with F; B most irksome was to refer to radiological contrast as a "dye" (visions of my teenage children and what they do to their hair). I put the book to one side.

Later, I went through the list of the 24 multidisciplinary contributors drawn principally from North America but also Europe, Australia and South Africa - it was a distinction that pushed the stage beyond the use after all. After digesting several chapters (I rarely read a book in sequence), I realised that my initial unfavourable impressions were misplaced.

Gastroenterologists frequently give the view that the therapeutic revolution of bile duct stones with the widespread introduction of ERCP was final. But then at one point (only five years ago) ESWL was believed to be the only answer to gallstone problems. Laparoscopic bile duct emptying was developed. Then, slowly there emerged laparoscopic bile duct extraction. Many surgeons view this as a gimmick. Moreover, gastroenterologists often castigated the innovation by saying that three undertaking a laparoscopic cholecystolithotomy when this could be done by ERCP in "five minutes". Any such negative views are effectively destroyed by this book.

For the 'theoretical' gastroenterologist this book defines multiple areas in which ERCP should be used and brings together powerful arguments for the primary use of laparoscopic bile duct extraction (notwithstanding the established roles of ERCP in acute cholangitis and in acute pancreatitis, in elderly unfit patients and in patients with a repaired or recurrent bile duct stone). For the surgeon, it is an outstanding technical manual.

For the practising gastroenterologist, it is extremely valuable in helping to understand the kind of problems that may be created by laparoscopic surgery and how to deal with these problems. It is a useful guide to the use of laparoscopic and non-laparoscopic techniques for the treatment of common bile duct stones with surgical versus endoscopic techniques and also make this book a must for practising gastroenterologists.

J P NEOPTOLEMOS


Magnetic resonance cholangiopancreatography (MRCP) is relatively new diagnostic investigation that is becoming quite rapidly used in clinical practice. This book aims to convey details of the techniques, results and clinical indications. This is quite a challenge given the huge volume of information in this book. The potential to replace diagnostic ERCP in many situations is illustrated. This is reinforced in the chapter on choleclocholedochilithiasis which puts MRCP in the context of other diagnostic techniques. Although I was surprised to see a discussion of CT contrast cholangiographic methods. Benign and malignant biliary stenoses are well covered and the particular diagnostic advantages of MRCP in "mapping" the biliary tree are illustrated. The book also receives less attention, reflecting the problems of spatial resolution and of correlating anatomical changes with clinical features of pancreatic cancer, although pseudocyst demonstration by MRCP may well be of value in clinical practice. The value of MRCP in relation to laparoscopic cholecystectomy is appended somewhat as an afterthought and this is an area still lacking in large trials, preventing proper evaluation.

Strong points are the copious good quality illustrations and the numerous up to date references. A debatable point is the emphasis on the particular techniques that have been used although this does not detract from their overall conclusions. The not infrequent grammatical, translation and spelling errors are irritating and can make the text somewhat challenging to read. An additional chapter on the potential limitations of the technique would have been helpful for the clinician and some feel for the likely future technical developments such as the "breath-hold" method will be perfectly appropriate. Overall, this is a timely snapshot overview of a new diagnostic technique that will be of value to those involved in the investigation and management of pancreatic and biliary disease.

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