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 experience 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, in our patient, 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 a重点 rich meal 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-toxin 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, makes 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 caecum as in this case and has been associated with diarrhoea, ileus, vasoconstrictors such as cocaine, hypovolaemia, haematological malignancies, and even Marfan syndrome. 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 diarrhoea and physical training.

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Reply

Editor,—Dr Woodward and Sanders state incorrectly that Pigbel syndrome never affects the colon. On the contrary, any part of the small or large intestine may be involved.1 2 The time scale of the changes in diet has been misunderstood. We stated in our report that shortly before becoming ill, our patient had consumed a large amount of fish, fermented soybean and peanut butter sauce. In the discussion we covered the fact that fermented soybean and peanut butter contain anti-trypsins. We agree that serological proof would have been ideal in confirming the diagnosis. However, 50% of cases of Pigbel syndrome are serologically negative for antibody to the β-toxin of C type.3 We therefore felt justified in labelling the case “Pigbel-like syndrome”. We do not agree with the suggestion that our case was one of “non-occlusive mesenteric ischaemia”. The patient had been well until two weeks before admission. There was no preceding illness causing hypovolaemia. There was no history of use of cocaine. Her strenuous exercise predates her illness. At the time she became ill she had been resting and not taking strenuous exercise.

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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 pathogenetic 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 no increase in bone loss between 20 and 30% in the first year after transplantation.1–3

The clinical significance of post-transplantation bone disease lies in the morbidity associated with fragility fractures, the major 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,4 which changes will result in trabecular thinning and penetration in cancellous bone, reducing its mechanical strength and increasing fracture risk. Although bone density measurements were performed post-operatively in only 50 (61%) patients and fracture incidence may thus have been underestimated. The recent report from Lees’5 contains no data on fracture incidence and the clinical significance of the percentage reductions in bone mineral density is thus unclear. In common with the Lees group, we have found that the reduction in bone mineral density after liver transplantation is less than that reported in earlier studies,5 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
must confess that I had never before
thought of 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 from 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
timely 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 princi-
parically from North America but also Europe,
Australia and South Africa - it was a distin-
cution. What a splendid list. I began to fear that
it would be useful after all. After digesting several
chapters (I rarely read a book in sequence),
I realised that my initial unfavourable impres-
sions 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
cure of choice. Even now it is not difficult to
see why, although the introduction of ERCP
may be considered as "victory" (visions of my
teenage children and what they do to their hair).

I put the book to one side.

MR Cholangiopancreatography Tech-
niques. Results and Clinical Indications.
Edited by P. Favone, R Passariello. (Pp 150;
illustrated; DM 148.00.) Berlin: Springer

Magnetic resonance cholangiopancreati-
ography (MRCP) is a technically new diagnostic
investigation that is becoming quite rapidly
used in clinical practice. This book aims to
deal with the details of the techniques, results
and clinical indications. This is quite a challenge
given the speed with which new techniques are
developed. Nevertheless, the book is a
valuable contribution to the development of clinical
practice. The value of MRCP in relation to
cancer treatment is enhanced 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 refer-
ences. A debatable point is the emphasis on the
interpretation of these techniques that may be
useful although this does not detract from their
over-all conclusions. The uneven presentation
of the chapters is somewhat confusing and
may make the book less useful for certain groups
of readers. However, the book is a valuable
collection of current research and should be
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
3D breath-hold and dynamic functional stud-
i would have been useful. 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 pan-
creatic and biliary disease.

J P NEOPTOLEMOS

BOOK REVIEWS

Mary biliary cirrhosis. Hepatology 1991; 14:
296-300.

The role of preoperative ERCP and sphinct-
eterotomy in the laparoscopic era. "The unex-
pected bile duct stone", "Preoperative endo-
sopic sphincterotomy", "Management of
retained stones", "Early diagnosis of bile leak-
age", "Endoscopic management of postoper-
ative leaks" and "A cost-effective approach
to the treatment of common bile duct stones
with surgical versus endoscopic techniques"
also make this book a must for practising
gastroenterologists.

J P NEOPTOLEMOS

1 Eastell R, Dickson ER, Hodgson SF, Wienser RH, Porysko MK, Wahner HW, et al. Rates of vertebral bone loss before and after liver transplantation in women with pri-
mary biliary cirrhosis. Hepatology 1991; 14:
296-300.