LETTERS TO
THE EDITOR

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 had a similar recent account 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 a heavy meal due to 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 Marathons running. Although such cases are rare and the aetiology obscure, the presence of splanchic vasovasodilation 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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Replay

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. The time scale of the changes in diet has been misunderstood. We stated in our report that 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 sauce contain antibacterial trypsinase. 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 in the type C. 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 pathogenic 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 fracture incidence 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 increased 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,2 which changes will result in trabecular thinning and penetration in cancellous bone, reducing its mechanical strength and increasing fracture risk. Although bone mineral density measurements were performed post-operatively in only 50 (61%) patients and fracture incidence may thus have been underestimated. The recent report from Leed’s contains no data on fracture incidence and the clinical significance of these small changes in bone mineral density is thus unclear. In common with the Leed’s group, we have found that the reduction in bone mineral density after liver transplantation is less than that reported in other studies, 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 agree with myself on the large numbers of black and white radiographs of the bile tree taken by all kinds of techniques: laparoscopy and ERCP in particular. There were also quite a few colour photographic illustrations 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 principa-

lly from North America but also Europe, Australia and South Africa – it was a distin-

guished list. I began to feel this book might 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 answer to gallbladder and common bile duct stones. The same applies to MRCP. I am becoming quite rapidly that is occurring both in techniques and clinical evaluation of MRCP, and the information presented is a distillation of current published work combined for a good margin of value of the personal experience and views of the authors.

By and large, their aims are achieved in a series of short chapters that discuss the details of the various MRCP techniques in current use and the place of MRCP in most clinical situations. Only MR radiologists are likely to benefit from the physics and techniques chap-

ter, but the other chapters are more widely accessible. The evaluation of jaundice is the area most studied using MRCP and the potential to replace diagnostic ERCP in many situations is illustrated. This is reinforced in the chapter on choledocholithiasis which puts MRCP in the context of other diagnostic techniques, although I was surprised to see the discussion of CT contrast cholangiographic methods. Benign and malignant biliary steno-

ses are well covered and the particular diag-

nostic advantages of MRCP in “mapping” the biliary tree were illustrated. The book also receives less attention, reflecting the problems of spatial resolution and of correlating ana-

tomical changes with clinical features of pancre-

atitis, 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 technique that has been used. Although this does not detract from their over-

all conclusions. The not infrequent grammatici-

cal, 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 likelihood of future technical developments such as 3D breath-hold and dynamic functional stud-

ies 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 pancre-


cratic and biliary disease.

J P NEOPTOLEMOS

BOOK REVIEWS


Magnetic resonance cholangiopancreatogra-

phy (MRCP) is relatively new and diagnostic investigation that is becoming quite rapidly used in clinical practice. This book aims to convey details of the results, techniques and clinical indications. This is quite a challenge given the rapid progress that is occurring both in techniques and clinical evaluation of MRCP, and the information presented is a distillation of current published work combi-

ned with the personal experience and views of the authors.

By and large, their aims are achieved in a series of short chapters that discuss the details of the various MRCP techniques in current use and the place of MRCP in most clinical situations. Only MR radiologists are likely to benefit from the physics and techniques chapter, but the other chapters are more widely accessible. The evaluation of jaundice is the area most studied using MRCP and the potential to replace diagnostic ERCP in many situations is illustrated. This is reinforced in the chapter on choledocholithiasis which puts MRCP in the context of other diagnostic techniques, although I was surprised to see the discussion of CT contrast cholangiographic methods. Benign and malignant biliary steno-

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Strong points are the copious good quality illustrations and the numerous up to date references. A debatable point is the emphasis on the particular technique that has 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 likelihood of future technical developments such as 3D breath-hold and dynamic functional studies 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 pancreatic and biliary disease.

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1 Eastell R, Dickson ER, Hodgson SF, Wiener RH, Porysko MK, Wahner HW, et al. Rates of vertebral bone loss before and after liver transplantation in women with pri-