Liver biopsy under ultrasound control

EDITOR,—I read the recent occasional viewpoint by Shah et al (Gut 1999;45:628–629) with much interest. The authors describe their regional practice of mandatory real time ultrasound guidance for percutaneous liver biopsy in all cases of suspected diffuse liver disease. However, the published literature does not convincingly support the universal adoption of such a policy.

The only prospective randomised study cited in support of their protocol, by Lindor and colleagues, is open to a number of methodological criticisms. In particular, in an unspecified proportion of the patients randomised to ultrasound guidance, the procedure was not actually performed under direct guidance and was instead immediately preceded by a “biopsy room” ultrasound scan. The net result of this may have been to select patients already screened by a “biopsy room” ultrasound scan. The major impact was a reduction in hospitalisation due to pain. There was no statistically significant difference in the rates of bleeding or hypotension. The reduction in pain, in a non-blinded study, could have been due to several factors such as the patients’ perceptions of a “safer” guided scan or the potential for the physicians to more readily hospitalise patients with abdominal pain in the “blind” group.

There is considerable published data available regarding the safety of percutaneous liver biopsy without real time ultrasound guidance.1,2 Indeed, the British Society of Gastroenterology’s recent guidelines do not advocate changing from the practice of pre-procedural ultrasound scanning (which will be part of the routine investigation of most patients with suspected hepatic disorders anyway) to biopsies performed exclusively by radiologists under imaging control3 and it is difficult to see how adopting such a policy nationally could be justified.

Finally, I would urge that too much gravity falls so readily from the pen that it is easy to forget that two distinct processes are involved: firstly, providing appropriate information and then obtaining consent from the patient. In attempting to combine these two steps, Shepherd and colleagues (Gut 2000;46:37–39) remove some of the patients’ essential safeguards. As Neale (Gut 1999;48(suppl 1):V11) points out in his gentle and thoughtful comment, “written information . . . is undoubtedly useful but it does not replace the over-riding need for doctors to speak with their patients . . .”.

Neither the paper nor the commentary cite the GMC advice4 although they are quoted extensively in the British Society of Gastroenterology guideline on informed consent for endoscopy procedures.5 Particularly relevant is this: “obtaining informed consent cannot be an isolated event. It involves a continuing dialogue between you and your patients . . . you should give . . . the patient time to ask questions”.

However carefully prepared, a booklet cannot be appropriate for every patient and every circumstance. Pressing patients to “sign consent” in advance of meeting any endoscopy staff is to deprive them of the opportunity to ask questions or seek reassurance. “If you are the doctor . . . undertaking an investigation it is your responsibility to discuss it with the patient . . . although the job may be delegated to an appropriate person.

Giving information by post is desirable; requesting signed consent by that route is not.

J R BENNETT
Kingfisher House, Vincare Lane
Long Compton, CV76 3LL, UK
Email: jrbennett@diad.pipex.com

Letters to the Editor

Reply

EDITOR,—The technique used in the Lindor paper was somewhat of a hybrid between the “X marks the spot” (site usually marked in the blind biopsy group (p=0.04), pain being the reason for admission in seven patients and pain plus hypotension in four. Bleeding occurred in nine patients in the ultrasound group versus 18 in the blind biopsy group (p=0.07). Simply stating that this last finding, which had a twofold difference between the groups was not significant and by implication not important, ignores what might be a very relevant trend, which did not reach the “magical” p<0.05 level due to insufficient numbers (that is, a type II error). As stated in our paper, a similar situation is probably relevant in the failure of studies to show significant differences in mortality due to the large numbers required. Clinical procedures are now the subject of appropriate monitoring. When clinicians fall below standard and imperil the safety of the patient, questions of competence are raised. The current concern about the safety of cardiac surgery has raised public awareness of the need for adequate training in all clinical procedures. The GMC and other professional bodies have looked at all aspects of day to day clinical practice and the moves towards structured training of junior doctors is part of these developments. Clearly there is a need to train gastroenterologists in endoscopic techniques—the need is no less for the practice of liver biopsy. “See one, do one, teach one” is an aphorism that will not stand up in the 21st century.

Dr Aspinal’s final paragraph, although amusing, trivialises the serious issue with which training in ultrasonography is currently causing in relationship to European accreditation in gastroenterology. Many European countries consider that a failure to be adequately trained in this technique should prevent the person from being accepted as a trained gastroenterologist. Although Dr Aspinal may not wish to venture outside the UK to practice medicine, many other clinicians do. Finally, one of the specialist registrars at our hospital did learn to ride a unicycle, it did not help his career progression but he was a very popular character.

S SHAH
J F MAYBERRY
A C WICKS
Y REIS
R J PLAYFORD
Leicester General Hospital
(approved training centre for European Accreditation in Gastroenterology)
Leicester, UK
Email: r.playford@jc.ic.ac.uk

Informed consent

EDITOR,—The phrase “informed consent” falls so readily from the pen that it is easy to forget that two distinct processes are involved: firstly, providing appropriate information and then obtaining consent from the patient. In attempting to combine these two steps, Shepherd and colleagues (Gut 2000;46:37–39) remove some of the patients’ essential safeguards. As Neale (Gut 1999;48(suppl 1):V1–11) points out in his gentle and thoughtful comment, “written information . . . is undoubtedly useful but it does not replace the over-riding need for doctors to speak with their patients . . .”.

Neither the paper nor the commentary cite the GMC advice although they are quoted extensively in the British Society of Gastroenterology guideline on informed consent for endoscopy procedures. Particularly relevant is this: “obtaining informed consent cannot be an isolated event. It involves a continuing dialogue between you and your patients . . . you should give . . . the patient time to ask questions”.

However carefully prepared, a booklet cannot be appropriate for every patient and every circumstance. Pressing patients to “sign consent” in advance of meeting any endoscopy staff is to deprive them of the opportunity to ask questions or seek reassurance. “If you are the doctor . . . undertaking an investigation it is your responsibility to discuss it with the patient . . . although the job may be delegated to an appropriate person.

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J R BENNETT
Kingfisher House, Vincare Lane
Long Compton, CV76 3LL, UK
Email: jrbennett@diad.pipex.com

Letters to the Editor

6 What training do gastroenterologists want in ultrasonography? The performance of ultrasound guided biopsy “method recommended by us. Nevertheless, the relevant statistical analyses from their study were as follows: two patients required hospitalisation in the ultrasound group compared with nine in the blind biopsy group (p=0.04), pain being the reason for admission in seven patients and pain plus hypotension in four. Bleeding occurred in nine patients in the ultrasound group versus 18 in the blind biopsy group (p=0.07).

R J ASPINAL
Digestive Disorders Foundation Fellowship, ICRF Molecular Oncology Unit, Imperial College School Of Medicine, Hammersmith Hospital, London W12 0NN, UK
Editor,—Shepherd and colleagues (Gut 2000;46:37–39) offer a timely and thoughtful contribution to the increasingly loud debate in trusts about informed consent. As well as endoscopy, their example is relevant to other services offering invasive open access procedures, especially radiology. Their booklet addresses three problems: (i) that information about the proposed procedures should be given in circumstances in which patients could not be perceived to be under duress to give consent; (ii) that the information is given, albeit indirectly, by one who is trained to perform the procedure; and (iii) that an explanation is given regarding risks as well as benefits, as is often not the case at present.

Neale’s commentary (Gut 2000;46:5–6) is, as one would expect, in many ways equally perceptive but he fails to take account of an essential aspect of open access services. As he makes clear, such a process of informing consent cannot address the problem of informing choice, a requirement that the information arrives through the post with an appointment for a particular procedure. However desirable it may be that such a choice should be an integral element of informed consent, the nature of an open access service dictates that the decision regarding the choice of the procedure must have been taken prior to the referral having been made. This raises two further issues: (1) how to enable appropriate judgment regarding the appropriateness of the procedure is offered. Neale’s example of ERCP, although not generally an open access procedure, serves to focus thinking about these unanswered questions but does not diminish the contribution of Shepherd and colleagues in enhancing the quality of information given to patients. The ratio of manpower to demand means that, for the foreseeable future, much as endoscopists may wish “to speak with their patients about options for further action” prior to offering procedures, attempting to do so in every case would impose unacceptable delays in their management.

S BRUCE
Endoscopy Unit, Hastings and Rother Trust, Conquest Hospital, The Ridge, St Leonards-on-Sea, East Sussex TN37 9RD, UK
Email: bruce.stuart@mail.har-tc.thames.nhs.uk

Reply
Editor,—Thank you for allowing me to see the correspondence regarding “informed consent”. Dr Bennett states that writing to inform a patient of what is involved in “open access” gastrointestinal endoscopy (including risks and benefits) is desirable but requests patients “to sign consent” at home. He cites GMC advice concerning informed consent cannot be an isolated event. It involves continuing dialogue between you and your patients... you should... the patient time to ask questions.” In contrast, Dr Bruce states that “inappropriate pressure to demand for gastrointestinal endoscopy” means that such as endoscopists may wish to speak with their patients about... (this) would impose unacceptable delays in management.” In writing a commentary on informed consent I did not attempt to resolve these differences. As was stated in the BSG guidelines on informed consent, “in busy clinical practice it is not possible to satisfy NHS guidelines metacognition... and the difficulty... Each unit must develop a code of practice suitable to its mode of operation... Law takes the view that the responsibility for obtaining informed consent lies with the endoscopist who is performing the procedure... “Where this is not practicable you may delegate (this responsibility)... to a person who is suitably qualified and has sufficient knowledge... and understands the risks...”

The difficulty with open access endoscopy lies in the shared responsibility. The GP has assessed the patient and usually remains responsible for the patient’s care. I assume that consultant gastroenterologists who offer open access endoscopy instruct participating GPs to ensure that patients understand alternatives, risks, and potential benefits, thereby delegating responsibility. And as Shepherd and colleagues (Gut 2000;46:37–39) make clear, patients are not “pressed” to sign the consent form at home; they have the option not to sign until they have discussed the procedure with the endoscopist. Moreover, if the BSG guidelines are followed “... a qualified nurse should check the level of understanding and provide further explanation if... an endoscopist should deal with any last minute questions...”

Meanwhile, the value of open access endoscopy remains a subject for debate. It has been suggested that as a one-stop dyspepsia clinic is a preferable means of practice. Such practice overcomes the problem of gastroenterologists “not speaking with patients about options.”

H A SHEPHERD
Winchester Gastrointestinal Unit, Royal Hampshire County Hospital, Romsey Road, Winchester, Hampshire SO22 5DG, UK

Increased prevalence of methylenetetrahydrofolate reductase C677T variant in patients with IBD

Editor,—We read with interest the paper by Mahmud et al (Gut 1999;45:389–394). The study showed an increased prevalence of methylenetetrahydrofolate reductase (MTHFR) C677T variant in patients with inflammatory bowel disease (IBD). The C677T polymorphism is a known genetic cause of mild hyperhomocysteinemia (hyper-Hcy) and may be associated with a variable degree of risk for thromboembolic disease in patients with IBD.

To confirm a higher prevalence of the C677T polymorphism, we investigated 99 patients with established IBD for this polymorphism compared with 1084 unselected newborns. DNA samples were genotyped for the MTHFR (C677T) mutation. Patients were categorised as homozygous for the thermal-labile variant (TT), heterozygous for the wild-type variant (CT), or homozygous for the wild-type (CC).

In the group of IBD patients, we observed 10 homozygous TT, 33 heterozygous CT, and 56 homozygous CC individuals. This distribution of genotypes is significantly different from that observed in the newborn group, in which 12 TT, 44 CT, and 48 CC individuals were found. From the 14 investigated patients presenting a homozygous TT genotype, we identified inflammatory bowel disease in three (IA, ID, and UC). The MTHFR (C677T) mutation may be associated with a variable degree of risk for thromboembolic disease in patients with IBD.
and those with ulcerative colitis (UC) were compared using the Mann-Whitney test.

A total of 16.2% (16/99) of IBD patients were homoygous for the C677T variant compared with 8.3% (90/1084) in the control group. This difference was statistically significant (P=0.003). When patients were stratified according to CD and UC, we found that homozygosity for the MTHFR C677T variant (TT) was present in 14.0% (7/50) of patients with CD and 18.4% (9/49) of those with UC. Both results were independently significantly higher than in the background population.

Onset of disease in carriers of the (TT) variant in CD and UC patients was 33.8 and 40.6, respectively, compared with 34.4 and 43.3 in non-carriers. This difference was not statistically significant. There was no correlation between disease activity indices of the IBD patients (Crohn’s disease activity index for CD and clininc activity index for UC) and carriers of the (TT) variants. Also, C reactive protein levels in IBD patients was independent of MTHFR gene prevalence. Genotyping of MTHFR gene was carried out on a subgroup of 50 patients with IBD (32 CD and 18 UC) to confirm the results. We also carried out genotyping of MTHFR gene in a control group (100 healthy individuals). The MTHFR gene is located on chromosome 1 (1p36.3). Additional loci on chromosomes 3, 7, and 16 are linked to IBD. The genetic basis of IBD is non-Mendelian in nature and very complex. Unrecognised factors may therefore be important in the pathogenesis of IBD. Further investigation of other factors is being carried out in our laboratory at present.

J NIELSEN
T B LARSEN
I FREDHOLM
IBSEN
Department of Clinical Chemistry,
Vejle County Hospital, 7100 Vejle,
University of Southern Denmark, Denmark

P MUNKHOLM
Department of Gastroenterology,
Hvidovre Hospital, 2860 Hvidovre,
University of Copenhagen, Copenhagen Denmark

H HEY
Department of Gastroenterology,
Vejle County Hospital, 7100 Vejle,
University of Southern Denmark, Denmark

Correspondence to: JN Nielsen. (Email: JNN@vs.vejle amt.dk)


Reply

EDITOR,—Thank you for the opportunity to comment on the letter of Dr Nielsen and colleagues. We are pleased that their data have confirmed our findings, as previously recorded (Gut 1999;48:389–94). We agree with their comment that the genetic basis of inflammatory bowel disease (IBD) is very complex. One point needs to be emphasised, namely that serum homocysteine levels were increased in our patients compared with controls, even when those patients who were homogygous for C677T polymorphism were excluded. This elevated level was present even when the effect of folate deficiency was excluded. This suggests that other polymorphisms as yet undiscovered may be present in one or other of the three enzymes responsible for removal of homocysteine in internal metabolism, namely methylenetetrahydrofolate reductase, methionine synthase, and cystathionine synthase. Accordingly, it is important to emphasise that all patients with IBD should receive regular therapy with 400 µg of folic acid daily.

D G WEIR
N MAHMUD
A MOLLOY
J SCOTT
Department of Clinical Medicine,
Trinity Centre for Health Sciences,
St James’s Hospital, James’s Street,
Dublin 8, Republic of Ireland
Email: doiwjr@tcd.ie

BOOK REVIEWS


Pediatric gastroenterology, and our knowledge about diseases of the small intestine in children, has grown rapidly over the last few years, owing to advances in the basic sciences, such as molecular genetics and, particularly, gut immunology. The purpose of this book is to provide the consultant paediatrician, as well as the trainee, with a review of the diseases of the small intestine in children. There are two major sections in the book: the first, more general, is focused on structure and mechanisms; the second, more specific, in which attention is given to the commoner and more important specific disease entities. This fourth edition of a book published in the past by John Walker Smith, and now coauthored by Simon Murch, reflects the long clinical experience of the first author. At the same time, it offers a thorough review of the most recent literature. The long clinical experience of the senior author, which is particularly evident in the chapter dedicated to oncological gastroenteritis, is now integrated by the strong clinical and research interest of Dr Murch in mucosal immunology. The value of the chapters dedicated to matrix (a topic to which Dr Murch has significantly contributed with his own research), and to the immune system of the small intestine in the first section of the book, and to colorectal disease and Crohn’s disease in the second one, is a proof of this special competence. Also very good is the chapter on laboratory assessment, although less convincing is the part of the same chapter that discusses the chief symptoms of the child with gastrointestinal problems (diarrhoea, vomiting). The appendix on special milks is especially useful. Overall, the editorial quality of the book is high.

In conclusion, this book is a very valuable reference not only for paediatric gastroenterologists, but also for general practitioners, medical students, and dieticians.

R TRONCONE


I enjoyed looking at this book. The editors’ intention is that “at a moment when a surgeon may open it and consult an authority on a particular topic related to IBD surgery”. They have assembled an international group of contributors and there are excellent sections on history, surgical pathology, pouches, and Crohn’s surgery. There are some surprising omissions, however. A chapter on revision surgery for pouches that have gone wrong would have been timely, and a thorough review of balloon dilatation and stents would have provided a look to the future. I think the sections on septic complications of pouches and Crohn’s disease should have been kept separate.

I was irritated by the lack of uniformity in the illustrations and drawings of procedures, and in places the text is very dense, for example, in the section on ileostomy.

A final point: there is only one chapter on medical management just when there is an explosion of new medical therapy. Joint physician/surgeon management is seen by many as the ideal, and surgical treatment cannot be viewed in isolation; the surgeon may open it and consult an authority on a particular topic related to IBD surgery. This is a comprehensive and well illustrated book that will be a welcome addition to the shelves of specialists in IBD surgery.

N MORTENSEN


This is a substantial book edited by Dr Michael Wolfe with six of his colleagues acting as section editors. Many of the hundred or so contributors are members of the Boston home team. The others are from the key centres in North America with a smattering of contributors from Canada, Europe, Israel, and South America. This is in effect a GI textbook, but stripped largely of pathogenesis, pathophysiology, diagnosis, and differential diagnosis. Five main sections consider treatment of oesophageal, gastroduodenal, pancreatic or biliary, hepatic, and intestinal diseases.

The two column black and white presentation is relieved by good summary tables, with small clear diagrams and figures within the two column format. No flashy colour or bullet points here, but good solid information.

Clear instructions to the contributors and careful editing has produced consistent and well balanced chapters. In some examples, the excellent contribution from Stephen Hanner deals briefly with an approach to history taking, physical examination, diagnostic studies, and laboratory investigation in patients with inflammatory bowel disease. This is followed by an overview of individual patient conditions.
The format is that now commonly adopted for digestive disease textbooks—that is, an initial section dealing with presenting clinical features followed by organ based accounts of specific diseases and syndromes. The final chapters are more broadly based, covering systemic approaches to the principles of drug therapy, and nutritional support. The emphasis is on presenting the current aetio-patho-
genetic concepts of hepatic, pancreatic, and gastrointestinal diseases and their management, whilst historical and epidemiological perspectives are dealt with more briefly.

The editorship is in the hands of five very eminent continental Europeans, and only 15 of the 103 authors are from the British Isles. Eurosceptics might be concerned that with a list of authors resembling a Chelsea tea-
sheet, the resulting product might be an uncomfortable read with limited relevance to British practice. Nothing could be further from the truth. The text flows easily, which is a great credit to those authors not writing in their first language. The chapters have a remarkable uniformity of structure, perhaps not surprisingly as this can be readily imposed by the editors, but also of quality, which is predictable in light of the dis-
tinguished authorship, and of style. The last of these can have been achieved only by dili-
gent editorial skills, and, I suspect, extensive rewriting. Although the authors are predomi-
nantly European, the spelling and approved drug names are from the opposite side of the Atlantic—a concession one assumes to the major potential market.

Mercifully, guidelines and patient care pathways are not favoured, whilst algorithms are sparingly dispersed. By contrast, the text is regularly punctuated with summarising tables and figures. These will be of particular interest to junior staff preparing their Power-
Point presentations. Hard pressed consult-
ants will be no less enthusiastic, as the book provides a resource for rapid but comprehen-
sive “revision” prior to a training session with the junior staff.

The chapters covering large bowel polyps and colorectal cancer will be of special value and interest to non-surgeons who have failed to keep abreast of the last decade’s develop-
ments in the classification and management of these tumours. Recommendations for endoscopic surveillance are discussed, though the authors admit that not all of these are fully supported by adequate evidence yet. Similarly, non-specialists requiring a review of liver transplantation and its place in the final year of the millennium, will be grateful to Ringe and his colleagues for their adroit contribu-
tion. The account of ulcerative colitis is a medicosurgical collaboration, which is a feature of many chapters. Medical therapeutic options are fully discussed, but one gain that might there may be a lower threshold for elective surgery in Ger-
man centres than in the United Kingdom. This, however, is a rare example of the possi-
ble divergence between British and continen-
tal practice. Neville and Axon offer a balanced account of non-ulcer dyspepsia, but, regrettably, the editors have not taken the opportunity of giving this confusing termi-
nology the red card. My men of the match are the Oxford trio for their chapter covering
Crohn’s disease. I doubt there is a better suc-
cinct account currently in print.

A minor criticism is the rarity of specula-
tion about future developments. It surely would have been timely to have made a few forays into the new millennium.

Although this book may not be in the champions’ league class, it is a thoroughly
premiership performance by a team that con-
stantly has its eye on the title.

MJ LANCASTER SMITH


The last dinosaur disappeared from Earth over 66 million years ago, wiped out in some cataclysm that changed the world and its cli-
mate for ever.

Mankind gradually evolved, competing in a hostile environment, winning because of brain and hands. Knowledge and writing gave power; mankind strode on, erect, dignified. The pinnacle of hand-eye coordination, thoughtful and wise, stepped forth the surgeon.

Evolution continued, specialising, improv-
ing, learning, until from the chrysalis emerged the ultimate epiphany, a colorectal surgeon. Hungry, needing to learn, to under-
stand the background, the proud evolution, the way of the tribe.

How to learn? Vast, illuminated, biblical scroll, or virtual, instant, ephemeral quantum world? Wonderful, mushy smell, comforting weight, swishing flick of page, light low, old knowledge enters old eyes, stimulates old satisf-
action, reveals new comprehension. But
taut skin, restless energy, young ambition seeks flickering screen, a virtual world. A conundrum.

I am old, and thinning; a user of comput-
ers, but no bedfellow. At the frontier, I use journals and the library; for reading, smaller books, concise, portable, incisive. However, for reference, to support an opinion, pursue a prejudice, grind an axe, to gainsay, then a large, lovingly written, luxuriously arranged book—a book and a half (indeed, two books); beautiful, admired, essential—just as such books as these.

But I feel a gulf. I sit on the written side of
that gulf, but close by I see a new generation, turning away, evolving further. Will they want such a book? There is no CD-ROM. Will they use other ways?

Although science changes rapidly, society and culture take much longer to adjust. Reading and book owning are as much


Kurt Isselbacher’s foreword to this volume indicates that it was not written for the medi-
cal specialist, but rather for the family practice. Neville and Axon o

R N ALLAN

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Letters, Book reviews