

# PostScript

## LETTER

### Recurrent diarrhoea and weight loss associated with cessation of smoking in undiagnosed coeliac disease

This report on recurrent diarrhoea and weight loss associated with cessation of smoking in a patient with undiagnosed coeliac disease (*Gut* 2001;49:588), highlighting as it does the importance of documentation of body weight regardless of symptomatology, resonates with the evolution of the weight chart and haematological profile in a patient of mine with an eventual diagnosis of coeliac disease who first presented at the age of 79 years (when he weighed 70 kg) with a history of diarrhoea alternating with constipation, in association with radiographic documentation of colonic diverticular disease, to which his symptoms were subsequently attributed. By the time he was re-referred 15.5 months later, his weight had fallen to 64.8 g, and he now complained of vomiting and diarrhoea. His haemoglobin (Hb), mean corpuscular volume (MCV), and mean corpuscular haemoglobin (MCH) gave values of 12.0 g/dl, 96.6 fl, and 31.7 pg, respectively, and haematitic assays gave the following results (with reference ranges): serum vitamin B12 60 ng/l (170-900), serum folate 1.4 µg/l (2-14), red cell folate 90 µg/l (125-600), and serum ferritin 28 µg/l. Coeliac disease was subsequently validated by duodenal biopsy, and his weight then increased from a nadir value of 59 kg to a peak of 71.7 kg, seven months after implementation of a gluten free diet. Concurrently, his Hb, MCV, and MCH increased from nadir values of 11 g/dl, 81 fl, and 25.8 pg, respectively, to peak values of 13.1 g/dl, 86.4 fl, and 28.4 pg, respectively, during the course of replacement therapy with vitamin B12 and iron supplements.

#### Comment

In old age, underrecognition of other, and sometimes more clinically significant, gastrointestinal diseases can easily occur when they coexist with a strongly age related disorder

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such as colonic diverticulosis due to misattribution of many categories of gastrointestinal symptomatology. Weight loss is one of the "alerting" signs, warning against misattribution to colonic diverticulosis.

#### O Jolobe

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#### Author's reply

I concur with Dr Jolobe's comments that it is important to document simple demographic information such as the weight of the patient. Especially in the elderly, symptoms of coeliac disease can be subtle although this patient eventually declared himself because of progressive weight loss, diarrhoea, and a low serum folate level. The point of our report was that smoking may further mask symptoms of coeliac disease making it even more difficult to make the diagnosis.

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## BOOK REVIEWS

### Interactive Continuing Education in Gastroenterology CD-ROM

J Rhodes, A Forbes, H Hsin Tsai, *et al.* London: BSG and Harcourt Health Communications, 2000, £135.00. ISBN 0 7234 3214 7

Among all the other changes in the Health Service there has been a revolution in the way that continuing medical education is provided. There is a much greater awareness of the principles of adult education and more willingness to apply these in medicine and to experiment with new ideas. One of the fundamental principles of adult education is that individuals have preferred methods of learning and therefore it is important to provide a variety of means to keep up to date. The interactive problem based CD-ROM format is now an established part of this repertoire and it is very pleasing to see that the British Society of Gastroenterology has sponsored such a CD with a promise of more in the future.

There are two features to consider with the CD-ROM format: the quality of the interface and the educational content. A high quality interface between the learner and the program enables the learner to focus on the task in hand and not spend time and energy making the program work. A high quality educational content enables rapid learning of relevant material that will help the learner to deliver better quality care. How does this CD perform against these criteria?

Without reading the instructions it was not difficult to load the program and get started with the first clinical problem. My DVD loaded the CD in less time (about 90 seconds) than the maximum possible (15 minutes). The CD is arranged around 12 clinical cases. There are lists of symptoms, other relevant historical data, physical signs, investigations, and possible treatments or management strategies. The learner has to choose from these lists a limited number of items in three stages: history and physical; investigations; and management. After the first stage he has to propose three possible diagnoses and after the second a final diagnosis. Points are scored according to how discriminating the choice of items is. A highly relevant enquiry scores the most points while a ridiculous suggestion can lead (sometimes) to a negative score. Further points are awarded for the most appropriate differential and final diagnoses.

The final part of the programme involves multiple choice questions (MCQs) relating to the case for which more points can be accrued or lost. The final score is expressed as a percentage and for more than 70% a CME certificate is awarded. Apparently this certificate is valid for official CME credits in Europe and Australia as well as in the UK. Although the CD seems expensive at £135, it provides a relatively cheap way to accrue CME credits (£11.25 each). Certainly this is much cheaper than attending a British Society of Gastroenterology conference, just not so much fun!

With the first few clinical problems attempted I struggled to reach a score of 50% and was ready to throw my computer in the pond. However, before I decided to hand in my notice and change specialties, I read the instructions and learned that the cases had been chosen to tax even the most experienced gastroenterologists. Learners (even old crusty ones like me) are only expected to achieve 70% after they have been through a case two or three times. There is a learning curve associated with using the CD and, with further experience, my mark reached 63%. I have a few more cases to go and I am determined to score 70% first time on at least one occasion.

The CD contains a remarkable amount of helpful information. There are help screens available that explain the significance of items in the lists such as the indications for and performance of tests. There is a gastroenterology textbook available that can be accessed at anytime with easy searching facility. Finally, it is possible to obtain help while answering or reviewing MCQ responses. Thus a huge amount of information relevant to the program or the problem is readily at hand, minimising the need to go searching for information elsewhere. This process is time efficient but, more importantly, it forces the learner to link the information he or she is



reading to an active real world problem. This increases the relevance of the information and therefore the chance of remembering it.

The cases chosen (at least the ones I have done) are rare and would not normally come high on a list of differential diagnoses. This bias of rare disease has the effect of not giving enough credit for proposals of more common diagnoses which, because they are more common, are more likely to have been correct. On one particularly frustrating occasion I had, after the first stage, the correct diagnosis in the differential of three but the computer only awarded me half the marks available. I was told that my differential diagnosis "included some of the most likely diagnoses" rather than "your differential diagnosis seems likely". Initially, I interpreted this to mean that I had not included the correct diagnosis. However, after 10 minutes of frantically searching through the list of potential diagnoses, I stuck to my guns and was rewarded with full marks for the final diagnosis. If the intention was to induce arousal to facilitate learning through anger then the editors deserve full marks and a special certificate. In fact, choosing appropriate diagnoses from the list supplied was unnecessarily difficult and a very frustrating aspect of the interface.

An even more annoying feature of the interface was the quality of the endoscopic and histological images that accompanied the investigation section or second stage. Making some diagnoses seemed to depend on interpretation of these images and all the ones I found were of insufficient quality to make any sense of at all. The endoscopic and histological reports are available with the images but accessing these incurs a penalty the size of which is not revealed before a decision is made.

In summary, this is a good first attempt at producing an increasingly popular educational product. There are some frustrating aspects of the interface, particularly the differential diagnosis list and the quality of the diagnostic images. However, with minimal effort it was possible to get going with one of the cases. From an educational viewpoint the CD is short on early reward and encouragement. Learners perform best if they are encouraged and told they are doing well right from the start. Some, particularly those who are not required to write a review, may give up on it too soon. Having said this, the CD is based on sound adult learning principles. The subject is relevant to the learner (albeit largely small print stuff). The learning is self directed and problem based and there is a great deal of background information that means the learner can usually find the answer to a question without leaving the programme. Finally, there is an iterative quality for those who can be bothered to return to the case to achieve the higher mark required for a certificate. If they do, no one can say that their CME point was not well earned.

R Valori

## Intestinal Failure

Edited by J Nightingale. London: Greenwich Medical Media Ltd, 2001, £85.00. ISBN 1 90015 193 6

Intestinal failure is the newest of the failures. It is so new that many doctors do not know of its existence. And yet it was first described 31 years ago. The timing of this book is therefore important. Many of the chapters are written

by clinicians and researchers who have developed the specialty, in many respects written by one generation for the next. The first book dedicated to cardiac failure was published in 1851 (Wardrop J. *On the Nature and Treatment of Diseases of the Heart: Containing also an Account of the Musculo-Cardiac, the Pulmo-Cardiac and the Veno-Pulmonary Functions*. London: Churchill, 1851), so why has it taken so long for this specialty to emerge? Because it is so complex—definitely not. The reason is given by JE Leonard-Jones in his opening chapter. This specialty has depended on parallel developments in other specialties: gastrointestinal surgery, physiology, pathology, as well as nutrition and its subspecialties.

The book itself is structured in a logical manner, opening with a new definition of intestinal failure and a proposed classification. This in itself is courageous, as if incorrect the book would lose credibility. However, it stands solid. Following a historical overview by JE Leonard-Jones, a respected voice in intestinal failure, and a description of the normal anatomy and physiology of the intestinal tract, intestinal failure is divided into acute and chronic. The consequences, treatment, outcome, and problems of treatment are addressed in separate sections. I was pleased to see that a broad spectrum was covered, with chapters on intestinal adaptation, developing an intestinal failure unit, small intestinal transplantation, surgical treatments, stoma care, and so on. Initially, I wondered whether it was necessary to devote entire chapters to gall stones and renal stones but these are well written and appropriately placed. The chapter on designing a parenteral and enteral regimen is excellent, giving both practical advice as well as presenting useful reference data.

My criticisms are relatively minor, with little mention of the psychological issues for patients with intestinal failure as well as recognising the contents of a couple of authors' chapters from their previous work.

It is worth mentioning that this is not a book by doctors for doctors. This is a multidisciplinary book (like a nutrition team) brought together by Jeremy Nightingale. Contributors include nurses, dietitians, pharmacists, surgeons, physicians, stoma care nurses and, importantly, patients. The involvement of patients in their own care is of prime importance in nutrition, and this is also seen in this book with a chapter on the patient's perspective by Carolyn Wheatley.

Finally, it is worth looking at the back of the first page (unnumbered). Easily missed is a health worker's oath. A touch which highlights the quality of the man that brought this book together. My only real criticism is that this should have been in a more prominent place. This is an important publication that should be on the shelves of all nutrition teams.

S Gabe

## Irritable Bowel Syndrome: Psychosocial Assessment and Treatment

E B Blanchard. Washington, DC: American Psychological Association, 2001, £33.95, pp 336. ISBN 1 55798 730 0

As both a psychologist and a sufferer from irritable bowel syndrome (IBS), I found this book to be a very helpful guide to several controversial issues as well as a thorough analysis

of the existing literature. I also found the book comforting, and saying "comforting" is saying a lot when talking about IBS. However, the amount of research and analysis he offers here not only confirms my experiences and validates my clinical insights and practices, it also should provide the means for other psychologists and mental health professionals to help the many of us out here. So much for the personal!

Understanding the wealth of material he offers requires some psychological sophistication but it is rewarding to any who choose to pursue it. The issues he raises and discusses in a clear and straightforward fashion are important for physicians (not just gastroenterological specialists) and patients. As he and others have made clear, psychological treatments such as hypnosis and cognitive behavioural therapy can offer a great deal to patients in addition to what has come to be expected in the treatment of anxiety and depression. This is not the type of psychology where you sit for hours talking about the past, and this is an important message for psychologists, physicians, health professionals, and educators to get across to the public.

There are however several aspects of psychological treatment that need to be considered by physicians wanting to refer for treatment and patients seeking help. It is very important that the psychological practitioner has a good knowledge of the disorder as there are potential dangers both in inappropriate treatment and in treatment that does not seem relevant to the patient. The practitioner should be sophisticated enough to screen out and deal with inappropriate candidates. The practitioner also should be aware of and be able to use appropriately tools such as Blanchard provides for symptom and dietary tracking, and monitoring, and also be able to provide appropriate referrals for dietary and lifestyle programmes.

Whichever particular treatment turns out to be best, and of course this depends on the skill of the practitioner and the needs of the particular patient, the important message of the book is that these treatments do work and there is considerable evidence that they do work, evidence that he evaluates here: hypnosis, cognitive behavioural treatment, and brief psychodynamic therapy are all effective in treating the disorder and all of these plus biofeedback and relaxation are helpful for treating specific symptoms.

In addition to the above, Blanchard provides an analysis of prediction of treatment response which gives insight into who will benefit in what way from this type of treatment and who will probably not. There is a good summary of what is currently known about the disorder and an analysis of the extent and significance of what appears to be altered pain sensitivity together with an analysis of whether stress precedes or follows the start of IBS.

He also provides detailed treatment manuals for hypnotherapy, cognitive therapy, and cognitive behavioural treatment as well as numerous useful forms for assessment and treatment and a description of a model for a psychoeducational support group. All in all, Dr Blanchard has done a valuable service for psychologists interested in providing treatment for IBS sufferers. He has also done a valuable service for primary care physicians and patients interested in pursuing this type of treatment. With the availability of this book, any patient or physician should expect competent and knowledgeable treatment from any mental health practitioner, and

expect that the treatment will be appropriately directed towards the problem.

While the book is too big and probably too complicated for the average patient, it does point to a need that perhaps someone will fill soon: a brief, simple, and rational explanation of the role psychological therapies can play in the treatment of IBS for patients.

T R Bell

## CORRECTIONS

In the December supplement (*Gut* 2001; 49(suppl IV):iv11–iv21) Dr Ysebaert's address should be Department of Surgery, University Hospital Antwerp (UZA), Wilrijkstraat 10, B-2650 Edegem, Belgium. The authors apologise for the error.

The description of the February cover figure was incorrect. The correct legend should have read "Intimin gamma complemented ICC170(pICC55) adhering to follicle associated epithelium". *Gut* would like to apologise for this error.

## NOTICES

### Broad Medical Research Program—Inflammatory Bowel Disease Grants

Funds for inflammatory bowel disease (IBD) research are available immediately from the Broad Medical Research Program of The Eli and Edythe L Broad Foundation for innovative projects regarding etiology, therapy, or prevention. Grants totalling approximately US\$100,000 per year are available for basic or clinical projects. Larger requests may be considered. Initial letter of interest (no

submission deadline), simple application, rapid (60 day) peer review, and funding. Criteria for funding includes new ideas or directions, scientific excellence, and originality. Early exploratory projects, scientists not currently working in IBD, and/or interdisciplinary efforts are encouraged. Further information: Marciana Poland, Research Administrator, Broad Medical Research Program, 10900 Wilshire Blvd., 12th Floor, Los Angeles, CA 90024-6532, USA. Tel: +1 310 954 5091; email: info@broadmedical.org; website: www.broadmedical.org

### European Association for the Study of the Liver: 37th Annual Meeting

The EASL Annual Meeting will be held on 18–21 April 2002 in Madrid, Spain. Further information: EASL Liaison Bureau, c/o Kenes International, 17, rue du Cendrier, PO Box 1726, CH-1211 Geneva, Switzerland. Tel: +41 22 908 04 88; fax: +41 22 732 28 50; email: info@easl.ch; website: www.easl.ch

### Falk Symposium No 128: Exogenous Factors in Colonic Carcinogenesis

This will be held on 2–3 May 2002 in Würzburg, Germany. Further information: Falk Foundation e.V.-Congress Division, Leinenweberstr. 5, PO Box 6529, D-79041 Freiburg, Germany. Tel: +49 761 15 14 0; fax: +49 761 15 14 359; email: symposia@falkfoundation.de

### Endoscopic Oncology: Gastrointestinal Endoscopy and Cancer Management

This ASGE Annual Postgraduate Course will be held on 22–23 May 2002 in San Francisco, USA. Further information: American Society for Gastrointestinal Endoscopy. Tel: +1 978

526 8330; fax: +1 978 526 7521; email: asge@shore.net

### 11th International Symposium on Hepatic Encephalopathy and Nitrogen Metabolism

This meeting will be held on 30 May to 1 June 2002 in Amsterdam, The Netherlands. Further information: Secretariat, Nicolaes Tulp Institute, Academic Medical Center, PO Box 23123, 1100 DS Amsterdam, The Netherlands. Tel: +31 20 566 8585; fax: +31 20 696 3228; email: tulpinst@amc.uva.nl. **Deadline for receipt of abstracts: 1 February 2002.**

### Gastroenterology and Endotherapy European Workshop: XXth Anniversary

This course will be held on 17–19 June 2002 in Brussels, Belgium. Further information: Nancy Beauprez, Gastroenterology Department, Erasme Hospital, Route de Lennik 808, B-1070 Brussels, Belgium. Tel: +32 (0)20 555 49 00; fax: +32 (0)20 555 4901; email: beauprez@ulb.ac.be

### 5th International Workshop on Pathogenesis and Host Response in *Helicobacter* Infections

This will be held on 4–7 July 2002 in Helsingør, Denmark. Further information: Dr Tina Ken Hansen, Department of Cardiology-Endocrinology E, Frederiksberg Hospital, Ndr. Fasanvej, DK-2000 Frederiksberg, Denmark. Fax: +45 3545 7708; email: helpatim@biobase.dk

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