INFLAMMATORY BOWEL DISEASE

Impact of the increasing use of immunosuppressants in Crohn’s disease on the need for intestinal surgery

J Cosnes, I Nion-Larmurier, L Beaugerie, P Afchain, E Tiret, J-P Gendre

Background/Aim: Immunosuppressants are now used much earlier in the course of Crohn’s disease; however their effect on the natural history of the disease, especially on the need for surgery, is not known. The aim of this study was to assess the evolution of the need for surgery in Crohn’s disease during the last 25 years.

Patients and Methods: The medical charts of 2573 patients were reviewed retrospectively. The use of immunosuppressants (azathioprine or methotrexate), the need for intestinal resection, and the occurrence of intestinal complications were assessed using Kaplan-Meier analysis in five consecutive cohorts of patients defined by the date of diagnosis of Crohn’s disease (1978–82; 1983–87; 1988–92; 1993–97; 1998–2002).

Results: In 565 patients seen in the authors’ unit within the first three months after diagnosis, characteristics of Crohn’s disease at diagnosis did not differ from one cohort to another. The five year cumulative probability to receive immunosuppressants increased from 0 in the 1978–82 cohort to 0.13, 0.25, 0.25, and 0.56 in the 1983–87, 1988–92, 1993–97, and 1998–2002 cohorts, respectively (p < 0.001). Concomitantly, the cumulative risk of intestinal resection remained unchanged (from 0.35 to 0.34 at five years; p = 0.81). The cumulative risk of developing a strictureing or a penetrating intestinal complication remained also unchanged. Similar results were obtained in the 2008 patients seen during the same period who were referred to us more than three months after diagnosis.

Conclusion: Although immunosuppressants have been used more frequently over the last 25 years, there was no significant decrease of the need for surgery, or of intestinal complications of Crohn’s disease.

The treatment strategy for Crohn’s disease (CD) is evolving.1 Steroids and 5-aminosalicylates are still commonly used; however, during recent years there have been some significant changes. Firstly, the remarkable efficacy and the overall good tolerance of immunosuppressants were recognised2,3 and when compared with the morbidity of untreated disease,3 led to their wider greater use. Some authors even proposed using immunosuppressants from the very beginning of the disease, with the objective to modify its natural history,4 and this strategy has been shown to improve disease course and to avoid steroids in children with moderate to severe disease.4 Secondly, anti-tumour necrosis factor therapy became available in the late 1990s. Infliximab was shown to be able to induce clinical remission in patients unresponsive to standard treatment,4 to clear anatomic damage, and, when used as maintenance treatment, to maintain clinical remission5,6 and fistula closure.7,8 However, the impact of an increasing use of immunosuppressants and novel therapies on the natural history of CD remains poorly evaluated. An important and unbiased criterion for assessing the overall severity of CD is the need for surgery: for decades there has been a consensus to limit surgery to complications and refractory intractable forms.

The aim of our study, performed in a large series of patients with CD, was to evaluate the effect upon the need for surgery of an increasing use of immunosuppressants over the last 25 years.

PATIENTS AND METHODS

Patients

Patients with CD who were seen consecutively in our unit between January 1978 and December 2002 were included retrospectively. In January 2003, our unit moved from Rothschild hospital to St-Antoine Hospital and recruitment for this study was interrupted. Diagnosis of CD was based on Lennard-Jones criteria.9,10 Two groups of patients were analysed. The first group consisted of 565 patients who were seen in our unit early in the course of their disease—within the first three months following diagnosis of CD. The time of diagnosis was defined as the date of first detection of unequivocal inflammatory abnormalities of the intestine, as assessed from radiological, endoscopic, or peroperative observations. Patients in the second group (n = 2008) were seen more than three months after diagnosis, being referred to us for various reasons. Within each group, patients were divided into five consecutive five year cohorts, according to the date of diagnosis: cohorts 1978–82, 1983–87, 1988–92, 1993–97, and 1998–2002.

Study design

The study analysed the evolution of surgical requirements over 25 years by comparing the need for excisional surgery in relation to the use of immunosuppressants among the five chronologic cohorts. Only excisional intestinal surgery was taken into account. Appendectomy, stricturoplasty, bypass, and elective surgical treatment of abscess were not consid- ered. The time to first intestinal resection was the main outcome criteria. In addition, patients were noted the time to first large intestinal resection—either alone or cumulative, defined by a post-surgical index equal or superior to 20.11—and the time to establishment of a definitive stoma. The post-surgical handicap index has been developed to predict the functional consequences of intestinal resection for CD. It is calculated from operative records, taking into account the location and extent of intestinal resection. An index score equal or superior to 20 has a high predictive value of

Abbreviations: CD, Crohn’s disease; HR, hazard ratio.
diarrhoea following intestinal resection. Intestinal complications of CD were defined according to the Vienna classification: intestinal strictures as the occurrence of constant luminal narrowing demonstrated by radiological, endoscopic, or surgical examination combined with prestenotic dilatation and/or obstructive signs or symptoms but without evidence of penetrating disease. Perforations were intra-abdominal fistulas, inflammatory masses, and/or abscesses. First morphological demonstration of narrowing or penetrating complication was used to date the occurrence of the complication.

**Treatment of Crohn’s disease**

Our treatment policy has been described elsewhere. Flare up episodes were treated with mesalamine (3–4 g daily) or prednisolone (1 mg/kg per day, progressively tapered after four weeks), according to their clinical severity. When steroid therapy failed, patients seen before 1999 were given a three week course of enteral or parenteral nutrition; those seen after June 1999 (when infliximab became available in France) received infliximab 5 mg/kg.

As maintenance treatment, we used aminosalicylates (sulphasalazine, olsalazine, or mesalamine, 2–3 g daily) for asymptomatic or moderately active forms of the disease, and immunosuppressive drugs for severe forms (patients who were steroid dependent or poorly responsive to steroids). Azathioprine 2 mg/kg per day was used as the first line immunosuppressive drug. In case of repeated flare-ups or chronic active disease in a patient receiving azathioprine, its dosage was increased to 2.5–3 mg/kg per day. Intramuscular methotrexate (20–25 mg weekly) was used in patients unresponsive or intolerant to azathioprine. Its dosage was tapered progressively to 10–15 mg, and re-augmented in case of clinical relapse.

Although the overall strategy remained mostly unchanged, over time there was a clear tendency to initiate immunosuppressants earlier in the disease course.

Surgery was reserved for stenotic and extraparietal complications, or intractable forms after a well conducted medical management.

**Statistical analysis**

Continuous data are expressed as median (interquartile range), and differences between cohorts were tested for significance by ANOVA. Discrete data are given as percentages. Continuous data are expressed as median (interquartile range), and comparisons were made with Pearson χ² test. Statistical analysis was performed using GB-STAT statistical software (Silver Spring, MD, USA).

**RESULTS**

The characteristics of CD at diagnosis in the five cohorts of group 1 are given in table 1. Patients were very similar at diagnosis from one cohort to another, with a predominance of females, a mean age about 30 years, a large proportion of smokers (half the patients), and a similar disease location.

Table 2 gives the cumulative characteristics of the disease at the end of 2003. No attempt was made to contact the patients at that time and 31% of them had been lost to follow up. Because patients from the oldest cohorts had a longer disease duration, they developed more stricturing or penetrating complications and were classified so according to Vienna classification. Similarly, the respective proportions of patients needing steroids or immunosuppressants, and operated on, should be interpreted in relation to different durations of follow up. Azathioprine was maintained for a prolonged period in most cases but had to be stopped within the first month because of adverse events in 16 patients (11%). It was switched to methotrexate in eight of those latter patients.

Changes in the use of immunosuppressants over 25 years in group 1 patients

Figure 1 shows the cumulative use of immunosuppressants in the five cohorts. Data of patients for whom immunosuppressants had to be stopped early are included. As expected, immunosuppressants have been used more and more early over the last 25 years, with a five year cumulative probability
of prescription of zero in the 1978–82 cohort to 0.56 (95% CI 0.31 to 0.78) in the 1998–2002 cohort.

Cumulative need for excisional surgery in the five group 1 cohorts
One hundred and ninety patients (34%) were operated on at least once. Excisional surgery was performed in 41 cases before first admission in our unit and thereafter in 149 cases. Figure 2 gives the cumulative need for first excisional surgery. The curves were superimposed, with no significant difference from one curve to another (log rank, p = 0.81).

Table 2 Cumulative characteristics of the five consecutive chronologic cohorts of patients seen in our unit within the three months following diagnosis (group 1)

<table>
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<tbody>
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<td>Patients (n)</td>
<td>34</td>
<td>46</td>
<td>102</td>
<td>176</td>
<td>207</td>
</tr>
<tr>
<td>Deceased</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Lost to follow up</td>
<td>14 (41)</td>
<td>20 (43)</td>
<td>42 (41)</td>
<td>70 (40)</td>
<td>24 (12)</td>
</tr>
<tr>
<td>Median disease duration, months (interquartile range)</td>
<td>188 (23–256)</td>
<td>181 (64–207)</td>
<td>123 (43–144)</td>
<td>59 (10–91)</td>
<td>14 (5–35)</td>
</tr>
<tr>
<td>Vienna classification</td>
<td></td>
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</tr>
<tr>
<td>Inflammatory</td>
<td>15 (44)</td>
<td>17 (37)</td>
<td>42 (41)</td>
<td>95 (54)</td>
<td>130 (63)</td>
</tr>
<tr>
<td>Stricture</td>
<td>9 (26)</td>
<td>4 (9)</td>
<td>17 (17)</td>
<td>22 (13)</td>
<td>11 (5)</td>
</tr>
<tr>
<td>Penetrating</td>
<td>10 (29)</td>
<td>25 (54)</td>
<td>43 (42)</td>
<td>59 (34)</td>
<td>66 (32)</td>
</tr>
<tr>
<td>Medical treatment</td>
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</tr>
<tr>
<td>No steroids, no IS</td>
<td>6 (18)</td>
<td>7 (15)</td>
<td>20 (20)</td>
<td>57 (32)</td>
<td>69 (29)</td>
</tr>
<tr>
<td>Steroids, no IS</td>
<td>22 (65)</td>
<td>29 (63)</td>
<td>51 (50)</td>
<td>80 (45)</td>
<td>81 (39)</td>
</tr>
<tr>
<td>IS</td>
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<td>10 (22)</td>
<td>31 (30)</td>
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<td>66 (32)</td>
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<td>1 (1)</td>
<td>4 (2)</td>
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<td>Infliximab</td>
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<td>1 (1)</td>
<td>7 (4)</td>
<td>13 (6)</td>
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<td>Cumulative number of intestinal resections</td>
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<td></td>
<td></td>
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<tr>
<td>0</td>
<td>18 (53)</td>
<td>23 (50)</td>
<td>53 (52)</td>
<td>120 (68)</td>
<td>161 (78)</td>
</tr>
<tr>
<td>1</td>
<td>11 (33)</td>
<td>17 (37)</td>
<td>42 (41)</td>
<td>50 (28)</td>
<td>45 (22)</td>
</tr>
<tr>
<td>2</td>
<td>6 (18)</td>
<td>5 (11)</td>
<td>5 (5)</td>
<td>6 (3)</td>
<td>3 (1)</td>
</tr>
<tr>
<td>$\geq$2</td>
<td>3 (9)</td>
<td>1 (2)</td>
<td>2 (2)</td>
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Numbers in parentheses are percentages.
IS, immunosuppressants.

Table 3 Indications for the first intestinal resection in the five consecutive chronologic cohorts of patients seen in our unit within the three months following diagnosis (group 1)

<table>
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<td>23</td>
<td>49</td>
<td>56</td>
<td>46</td>
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<td>Diagnosis</td>
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<td>Stricture</td>
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<td>3 (13)</td>
<td>11 (22)</td>
<td>8 (14)</td>
<td>7 (13)</td>
</tr>
<tr>
<td>Perforation</td>
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<td>15 (65)</td>
<td>21 (43)</td>
<td>23 (45)</td>
<td>31 (67)</td>
</tr>
<tr>
<td>Failure of medical treatment</td>
<td>6 (38)</td>
<td>5 (22)</td>
<td>16 (33)</td>
<td>19 (34)</td>
<td>6 (13)</td>
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<tr>
<td>Other*</td>
<td>0</td>
<td>0</td>
<td>2 (4)</td>
<td>1 (2)</td>
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<tr>
<td>Unknown</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
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</table>

Numbers in parentheses are percentages.
*Other included mesenteric infarction, haematochezia, and small bowel adenocarcinoma, respectively.

Figure 1 Kaplan-Meier estimates of the cumulative risk of receiving immunosuppressants in five chronologic cohorts of patients with Crohn's disease.

Large intestinal resection, defined by a post-surgical handicap index $\geq$20, were 0.29 (0.15–0.50), 0.20 (0.10–0.36), 0.24 (0.16–0.35), 0.13 (0.07–0.22), and 0.17 (0.04–0.49), respectively. The curves were not significantly different according to log rank test (p = 0.23). The five year cumulative probability of having a definitive stoma varied not significantly between 0 and 0.03 from one cohort to another (p = 0.33).

Indications for first intestinal resection in group 1 patients
Table 3 gives the indications for the first intestinal surgery in the five cohorts. The proportion of patients being operated on for medical failure, stricture, and perforation, respectively, did not change significantly between the five cohorts, although in the most recent cohort there was a clear reduction of operations for medical failure (13% v 22–38% in the other cohorts). Kaplan-Meier analysis of the cumulative probability of intestinal stricture and perforation did not show significant differences between cohorts. In the cohorts 1978–82, 1983–87, 1988–92, 1993–97, and 1998–2002, the five year cumulative probabilities of intestinal stricture were 0.23 (0.11–0.43), 0.14 (0.06–0.29), 0.19 (0.12–0.30), 0.17 (0.11–0.26), and 0.10 (0.02–0.42), respectively (log rank
at the beginning of the year.

the columns indicate the number of patients at risk for intestinal resection
1978–2003 in 2573 patients with Crohn’s disease. The numbers above
Excisional surgery was performed in 490 cases (56%) before
after diagnosis, 880 (44%) were operated on at least once.

between cohorts (0–17%).

had to be
referred patients had had surgery before admission in our
unit (p<0.001). Otherwise, results observed were similar to
those of group 1 regarding an increased use of immunosuppressants but a stable need for excisional surgery over the
years (table 4). The risk of having a definitive stoma
remained also stable. However, in that group, the risk of
having a large intestinal resection decreased significantly
with time.

Evolution of the need for surgery 1978–2003
In the total cohort of 2573 patients from groups 1 and 2, 1070
underwent 1426 intestinal resections from January 1978 to
December 2003 (22 928 patient years). Two hundred and
seventeen resections (15%) were performed within the first
three months following diagnosis. Except for the year 1978
(46 patients only), the percentage of patients who were
operated on during the first three months remained less than
5% (fig 3). After the first three months, the operative rate
(number of operations performed per year) fluctuated within
a narrow range (3.3–7.5%), without any significant change
over 26 years (fig 3).

Discussion
This study shows that although immunosuppressants were
initiated much earlier during the course of CD, the need for
intestinal resection remained stable over 25 years. The
percentage of patients requiring intestinal surgery each year
remained equal. The probability of having a definitive stoma
appeared also to be unaffected from 1978 to 2002. However,
large intestinal resections became more unusual.

This study has some limitations. Firstly, the retrospective
nature of the study may have led to bias in the interpretation
of the data—however, it was necessary to obtain an
observation period long enough to ascertain the long term
effect on surgery of changes in the medical strategy of CD. In
addition, intestinal resection can be considered as an
unbiased and solid criterion, even retrospectively, as it is
performed only when necessary. Besides, during a period of
20–25 years, many factors other than the treatment strategy
may have influenced the indications for surgery. However, all
patients seen from the beginning were followed up in the
same unit by the same small group of physicians, who used
homogeneous guidelines and took collegial decisions.

Compared with the first group of patients, a higher proportion
of referred patients had had surgery before admission in our
unit (p<0.001). Moreover, comparison of cohorts at inclusion showed that

Table 4 Five year cumulative rates (95% CI) of therapeutic intervention in the patients
referred to our unit more than three months after diagnosis of Crohn’s disease (group 2, n = 2008)

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<td>Patients (n)</td>
<td>218</td>
<td>342</td>
<td>486</td>
<td>563</td>
<td>399</td>
<td></td>
</tr>
<tr>
<td>IIS therapy</td>
<td></td>
<td></td>
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<tr>
<td>Cumulative probability (95% CI)</td>
<td>0.04 (0.02–0.08)</td>
<td>0.14 (0.10–0.18)</td>
<td>0.27 (0.23–0.32)</td>
<td>0.45 (0.40–0.50)</td>
<td>0.63 (0.49–0.76)</td>
<td>&lt;0.00001</td>
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<td>278</td>
<td>296</td>
<td>203</td>
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<tr>
<td>Intestinal resection</td>
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<tr>
<td>Cumulative probability (95% CI)</td>
<td>0.36 (0.29–0.48)</td>
<td>0.30 (0.25–0.35)</td>
<td>0.32 (0.28–0.37)</td>
<td>0.31 (0.27–0.36)</td>
<td>0.36 (0.22–0.53)</td>
<td>0.528</td>
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<td>Patients at risk (n)</td>
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<td>227</td>
<td>274</td>
<td>263</td>
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<tr>
<td>Large intestinal resection</td>
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<tr>
<td>Cumulative probability (95% CI)</td>
<td>0.29 (0.23–0.35)</td>
<td>0.22 (0.18–0.27)</td>
<td>0.19 (0.16–0.23)</td>
<td>0.15 (0.11–0.19)</td>
<td>0.12 (0.05–0.28)</td>
<td>&lt;0.00001</td>
</tr>
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<td>Patients at risk (n)</td>
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<td>250</td>
<td>321</td>
<td>310</td>
<td>27</td>
<td></td>
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<tr>
<td>Definitive stoma</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Cumulative probability (95% CI)</td>
<td>0.01 (0.00–0.03)</td>
<td>0.02 (0.01–0.04)</td>
<td>0.02 (0.01–0.04)</td>
<td>0.02 (0.01–0.04)</td>
<td>0.02 (0.01–0.13)</td>
<td>0.72</td>
</tr>
<tr>
<td>Patients at risk (n)</td>
<td>202</td>
<td>315</td>
<td>387</td>
<td>355</td>
<td>33</td>
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</table>
they were very similar regarding demographic characteristics and disease location. In particular there is no reason to believe that CD became more severe with time while other disease characteristics did not change. Secondly, it should be noted that a relatively large proportion of patients were lost to follow up. We made no attempt to contact the patients or physicians to update the data. We do not believe this may have minimised the need for surgery of the oldest cohorts because patients who are lost to follow up are usually those doing well and not requiring further surgery. The cumulative probability of surgery in our patients was very similar to those reported in two unbiased and complete series of the literature, the NCDCDS'17 and the Copenhagen County cohort study.46 Finally, our unit is a tertiary referral centre and referral bias is unavoidable. To limit this bias, we restricted the analysis to patients seen during the first three months of the disease course. This precaution was not sufficient to eliminate such a referral bias because an important proportion of these patients came to surgery during that period. However, when we excluded these latter patients, analyses gave similar results and, in particular, the discrepancy between an increased use of immunosuppressants and a stable need for surgery remained unchanged. These results were confirmed in a second large group of patients.

The occurrence of stricturing and perforating complications was the main reason for excisional surgery. The frequency of these complications did not change significantly from one cohort to another. This is a disappointing result because it could be expected that immunosuppressants could have an anatomic effect and prevent these complications. Indeed, D’Haens et al reported that in 74% of patients with colonic or ileocolonic disease who were clinically responders to immunosuppressants (within the first three months), while the mean time of occurrence of the disease course. This precaution was not sufficient to change the natural history of CD, nearly half the patients were operated on more than three months after diagnosis could have avoided surgery. Thus we can extrapolate that in our series immunosuppressants were given too late and too scarcely to have a significant impact on the need for surgery. Such an assertion is not in accordance with the anatomic effect observed by D’Haens et al,19 that immunosuppressants, even when given early, may have no preventive effect on the occurrence of stricturing and penetrating complications.

An interesting and more encouraging result of our study was the decrease of the probability of having a large intestinal resection over the last 25 years in the group of referred patients. A similar trend, although not significant, was observed in patients who were seen early after diagnosis and were, for the most part, operated on in our surgical unit. The reason for such a decrease, from 29% to 12% five years after diagnosis, may be linked to a greater use of immunosuppressants, but may also be a change in the surgical strategy favouring segmental and limited resections in the most recent years.

In summary, this study shows that immunosuppressants have been used increasingly over the years. However, this evolving therapeutic strategy was not associated with a decrease in the need for surgery or in a decrease of the occurrence of intestinal complications. This result does not question the efficacy of immunosuppressants for achieving and maintaining remission, sparing steroids,22 and improving quality of life, but it does questions the timing of starting immunosuppressants in patients with moderate to severe CD.

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REFERENCES

**LETTERS**

**Efficacy and strategy of pneumatic dilatation in achalasia**

We read with interest the article by Eckardt et al. regarding the long term results of pneumatic dilatation in achalasia (Gut 2004;53:629–33). Fifty four patients were followed up for a median of 14 years after a single pneumatic dilatation using the Browne-McHardy dilator. Five and 10 year remission rates were 40% and 36%, respectively, and repeated dilatations only mildly improved the clinical response. Most of the relapses occurred within one year of dilatation. Patients with post-dilatation lower oesophageal sphincter pressures of <10 mm Hg had a significantly better outcome. The authors suggest that failure to respond to the first dilatation should lead to consideration of alternative therapy.

We disagree with this conclusion and we would like to bring to your attention a recent prospective study on the long term effects of pneumatic dilatation in 11 patients with achalasia. A different approach was chosen—that is, treatment consisted of one or more pneumatic dilatations under conscious sedation in order to achieve stable clinical remission, defined as persisting one year after dilatation. To this end, close follow up was performed in the first year after dilatation (scheduled assessments at three and 12 months). Thereafter, clinical and manometric assessments were performed yearly for six years. The clinical score according to Eckardt et al. Five patients needed one (30 mm diameter Rigiflex dilator) and six needed two (30 and 35 mm diameter) dilatations. No complications occurred. All patients remained in clinical remission and their lower oesophageal sphincter pressure decreased to <10 mm Hg and remained unchanged over time.

There are similarities in the results of the two studies. One of the outcome of our 11 patients was comparable with that of the eight patients of Eckardt et al. with a lower oesophageal sphincter pressure of <10 mm Hg who had a remission rate of 75% after 12 years; and (2) the observation that the six patients in our series who needed a second dilatation all relapsed within one year of the first dilatation agrees with the data by Eckardt et al., showing that most relapses occur within 12 months. However, our dilatations were more successful and, importantly, a second dilatation led to a sustained remission in all patients. We do not know the reasons for this difference but we believe it may be at least partly related to our use of the non-compliant Rigiflex dilator, which is currently considered the best choice, although there are no adequately powered comparisons with the Browne-McHardy dilator in the literature. Similarly to our result, a recent paper has shown very good efficacy of a second dilatation with the Rigiflex dilator in patients who had relapsed. Another possible reason is the use of conscious sedation during the procedure which allowed us to complete all dilatations; Eckardt et al., who used topical anaesthesia only, had to prematurely terminate 17% of the procedures.

In conclusion, our published experience and our current clinical practice, involving treatment and follow up of 10–15 new achalasia patients each year, suggest that performance of one or two dilatations until stable clinical remission is a valuable strategy, and that pneumatic dilatation under conscious sedation with the Rigiflex dilator is an effective long term treatment in most patients with achalasia.

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Conflict of interest: None declared.

**References**


**Authors’ reply**

Penagini and Cantù should be congratulated for the remarkable results they were able to obtain in 11 patients with achalasia treated by pneumatic dilatation. To my knowledge, not a single study has so far produced similar results. A review of prospective studies in patients undergoing pneumatic dilatation with the Rigiflex dilator indicated that approximately 80% will have a good or excellent short term response. However, if such patients are observed for long periods, the results obtained do not differ significantly from those observed following treatment with the older balloons. In a recent study, in which 56 patients were treated with the Rigiflex dilator and observed for more than 10 years, the long term success rate was 55%. Thus it is my impression that differences in treatment results are not so much related to differences in technique and operator experience but rather to the number of patients investigated, duration of follow up, and finally the quality of the study design. It is hoped that carefully designed randomised studies, which are now in progress, will tell us whether we should continue to offer pneumatic dilatation to the great majority of patients with achalasia or whether we should advise them to undergo surgery instead.

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Conflict of interest: None declared.

**References**


**Probiotics in IBD: mucosal and systemic routes of administration may promote similar effects**

We read with considerable interest the paper by Sheil et al (Gut 2004;53:694–700) who reported the successful application of the subcutaneous route for probiotic attenuation of colitis.

We agree with the corresponding commentary of Ghosh et al (Gut 2004;53:620–2) regarding the need to study mechanisms underlying probiotic interactions. Recently, we further standardised a method to compare the anti-inflammatory potential of orally administered lactic acid bacteria (LAB) in a murine model of acute 2,4,6 trinitrobenzene sulphonic acid (TNBS) induced colitis.1 This model allowed us to discriminate “protective” strains, showing between 30% and 70% reduction of inflammatory score, from strains which did not significantly attenuate experimental colitis. We could select highly performing strains of Lactobacillus salivarius and Lactobacillus rhamnosus that consistently lowered colitis. In comparison to the intravenous administration of 5×1010 live micro-organisms, 24 hours prior to induction of colitis, surprisingly, protection by the LAB strains via this systemic route closely matched the efficiency of the oral route (fig 1).

When evaluating both routes simultaneously, the anti-inflammatory effect was of comparable magnitude. Moreover, the prophylactic impact of the intraperitoneal administration of Lactobacillus salivarius strain was established up to two hours before TNBS administration. It is noteworthy that two delayed injections could lead to protection but caused marked weight loss (25% (p<0.05) vs 15% and 11%, respectively, for control and oral route groups) with alleved fever.

Our findings clearly confirm those of Sheil et al (Gut 2004;53:694–700) showing strain specific in vivo probiotic effects of LAB on the target tissue, suggesting a relationship between the type of LAB (or LAB components) and peritoneal immunocompetent cells. Pereyra and colleagues2 reported transient dose dependant induction of γδ TCR+ T-double cells. Pereyra and colleagues2 reported transient dose dependant induction of γδ TCR+ T-double cells. Two delayed injections could lead to protection but caused marked weight loss (25% (p<0.05) vs 15% and 11%, respectively, for control and oral route groups) with alleved fever.

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injected live LAB was 5 ... with strain and viability status. Both pro- and hypothesised that toxicity may also differ ... balance between Th1 and Th2 immunity, and or killed probiotics may influence the delicate ... inflammation, tolerance, and allergy models. Even if this study confirms the importance of the systemic route for certain probiotic activity, we cannot neglect the possible influence of local and innate immunity, the general status of the gut flora, and the role of epithelial cells in the cross talk between both.

Acknowledgements

We are indebted to Danisco France for financial support.

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Conflict of interest: None declared.

References


Figure 1 Lactic acid bacteria (LAB) protection on macroscopic damages induced by 2,4,6-trinitrobenzene sulphonate (TNBS). Improvement of the oral or intraperitoneal route LAB administration on reduction of TNBS induced colitis in mice. Results are expressed as per cent reduction of mean macroscopic inflammation of mice treated with LAB, in relation to the mean score of non-treated mice. Colitis index was assessed 48 hours after TNBS administration. Each bar represents an independent experiment of control (n = 10) and LAB treated mice (n = 10). *p<0.05, **p<0.01, ***p<0.001, significantly different from the corresponding TNBS control group (Mann-Whitney U test). CFU, colony forming unit; d: day.

Mutations in anionic trypsinogen gene are not associated with tropical calcific pancreatitis

Pancreatitis is considered to be an autodigestive disease due to premature activation of trypsinogen inside the pancreas. Its genetic basis has recently been established with the identification of causal mutations in cationic trypsinogen gene (PRSSI1) in patients with hereditary and non-hereditary pancreatitis.1 Mutations in other genes such as SPINK1 (encoding pancreatic secretory trypsin inhibitor)2 and cystic fibrosis transmembrane conductance regulator (CFTR)3,4 genes have also been associated with the disease. Tropical calcific pancreatitis is a type of idiopathic pancreatitis, reported particularly in the tropics. Recently, we and others demonstrated absence of PRSSI1 mutations but significant prevalence of the N34S mutation in the SPINK1 gene in these patients.5,6 However, our study raised two important questions: firstly, the exact role of SPINK1 mutations in disease causation as cationic trypsinogen is normal with an intact autolysis site; and secondly, the cause of the disease in the remaining patients negative for both PRSSI1 and SPINK1 mutations.

Of the nine members of the human trypsinogen family, only PRSSI1, PRSSI2, and PRSSI3 are functional genes coding for cationic, anionic, and meso-trypsinogen isoforms, respectively. The cationic form accounts for about one third of the total trypsins in pancreatic juice. We investigated whether mutations in the anionic trypsinogen gene may contribute to the pathogenesis of tropical calcific pancreatitis. Mutations reported to date in the PRSSI1 gene, 17 are clustered in exons 2 and 3 only. The remaining three are in the promoter region but reported in isolated patients. Hence we initially screened exons 2 and 3 of the anionic trypsinogen gene in 68 well characterised Indian patients with tropical calcific pancreatitis.7 Subsequently, we also sequenced the promoter, complete coding region, and the flanking region in an attempt to look for any novel mutation.

Owing to the extremely high sequence homology between PRSSI1 and PRSSI2, a nested polymerase chain reaction (PCR) was used to ensure specificity. The primers were selected from the published study of Chen and colleagues8 and all of the exons of PRSSI2 were PCR amplified, purified, and sequenced on both alleles using both primers and the Big Dye terminator cycle sequencing approach. However, we did not find any of the reported or any novel mutations in the coding region or in the splice site junctions, except a synonymous polymorphism A90A (GCA>GCG) in exon 3 of the anionic trypsinogen gene. This variation was observed in both the heterozygous...
and homozygous states with a mutant allele frequency of 0.58 (9 AA, 20 GG, and 39 AG) and homozygous states with a mutant allele of genes such as CFTR may explain the disease in the remaining patients. It also confirms the importance of the N345 mutation in SPINK1 as the major genetic factor for this type of pancreatitis.

**References**


**Elevated plasma protein C levels correlate with the presence of fatty liver (NASH and NAFLD)**

The clinical implications of non-alcoholic fatty liver disease (NAFLD) are derived mostly from its common occurrence in the general population and the potential of the condition to progress to fibrosis and cirrhosis. Markers that help in making an early diagnosis and treatment are warranted.

Protein C is a vitamin K-dependent glycoprotein that functions as a circulating anticoagulant through proteolytic cleavage and inactivation of the coagulation factors Va and VIIIa. Whether or not protein C levels increase in patients with NAFDIs has not been assessed.

We measured protein C levels in 44 patients (28 men and 16 women; mean ages 45 (11) and 49 (12) years, respectively); 15 patients with fatty liver (FL), 15 with non-alcoholic steatohepatitis (NASH), and 14 with chronic viral hepatitis B+C (CH). All were diagnosed by histology and liver technology scan or ultrasound. Ten healthy subjects were used as controls. Obesity, hyperlipidaemia, and diabetes were present in 60, 73, and 25% of cases, respectively; 64% of patients had elevated liver enzyme tests (alanine aminotransferase 45 (21) IU/L in FL and 43 (18) IU/L in NASH). Mean protein C levels were significantly increased in patients with NAFDIs (n = 30) compared with those with chronic viral hepatitis (140 (36) % of 101 (24); p = 0.0009) and healthy individuals (140 (36) % of 120 (12); p = 0.04).

No significant difference in protein C levels was noted between simple fatty liver and NASH (149 (34) % and 130 (37) %, respectively; p = 0.97%). A significant correlation was found between protein C and extent of fatty infiltration (r = 0.63; p = 0.001) (fig 1), insulin resistance index (r = 0.3; p = 0.01), and triglyceride levels (r = 0.45, p < 0.001).

Protein C could discriminate correctly between NAFLDs and chronic viral hepatitis in 82% of cases. No significant association was found between protein C and aminotransferase levels.

In conclusion, protein C was elevated in patients with NAFLD. The underlying mechanism remains unknown. Agewall et al suggested an increase in hepatic synthesis of protein C due to increased hepatic insulin resistance. Increased levels have been reported in patients with diabetes, hypertriglyceridaemia, and nephrotic syndrome, with the use of anabolic steroids, oral contraceptives, and alcohol, and with increasing age. Diabetic and hypertriglyceridaemia are predisposing conditions to fatty liver and were present in 23% and 73% of cases, respectively. The remaining conditions were excluded by clinical and biochemical findings. Although more studies are needed, these preliminary findings suggest that elevated protein C levels together with elevated liver enzymes may be used as markers for NAFLD and may obviate the need for liver biopsy.

**References**


**Coexistent chronic idiopathic intestinal pseudo obstruction and inflammatory bowel disease**

Chronic idiopathic intestinal pseudo obstruction (CIIP) is a severe condition presenting with abdominal pain and dysmotility. Inflammatory or degenerative changes of the autonomic nervous system or of the muscles of the bowel have been observed in CIIP. As patients with inflammatory bowel disease (IBD) may show clinical and histological signs of autonomic neuropathy and dysmotility, the aim of this study was to examine whether there is an association between CIIP and IBD.

Six patients at our hospital presenting with signs and symptoms of intestinal dysmotility were diagnosed with CIIP based on increasing features, antroduodenojejunal manometry, and full thickness biopsies (table 1). Patient No 1 had an acute erosive colitis some years previously with bloody diarrhoea and an enhanced sedimentation rate, which was treated with steroids, and patient No 2 had relapsing proctitis treated with 5-amino salicylic acid (5-ASA). Patient No 3 was
totally and patient No 4 partially colecto-
mised because of slow transit constipation.
Patient No 6 was proctocolectomised due to
refractory colitis. The patients were further
investigated with magnetic resonance (MR)
enterography and video capsule enteroscopy
to establish whether there were any signs of
IBD. If these examinations showed any
pathology, push enteroscopy and ileocolon-
oscopy were also performed. All biopsies
collected over the years were re-evaluated.
MR enterography did not reveal any
pathological changes in any of the subjects.
In three patients (Nos 1, 3, and 4), video
capsule enteroscopy revealed Crohn-like
ulcerations/erosions in the stomach and
small intestine. Further examination of
patient No 1 by push enteroscopy confirmed
the erosions in the stomach and one third of
the proximal small intestine. In patient No 3,
capsule enteroscopy showed aphthous ulcers
typical of Crohn’s disease throughout the
distal jejunum and ileum (fig 1A).
Ileocolonoscopy showed the same picture in
the ileum and ileorectal anastomosis.
Histopathological examination of the
thickened biopsies from patient Nos 1 and 2
showed visceral degenerative neuropathy,
combined with villous atrophy of the intesti-
tinal cells of Cajal (ICC)s. In patient No 3 and 6,
lymphocytic ganglionitis was found in
both neural plexa of the resected colon and
ileum (fig 1B), with signs of neurone
degeneration, and 50% and 80% reduction
of ICCs in the perimyenteric ICC-plexus and
deep muscular plexus of the circular muscle
layer, respectively. Patient No 4 had a normal
biopsy, and patient No 5 was not biopsied.
Examination of mucosal biopsies from
patient No 1 revealed focal active inflamma-
tion in the duodenum and cecum, and
chronic inflammation in the rectum; patient
No 5 had multifocal mild antral cryptitis, and
both patients were diagnosed with suspected
Crohn’s disease. Colon biopsies from patient
No 6 revealed epithelioid cell granulomas and
multinucleated giant cells, as well as multi-
focal transmural lymphoid hyperplasia con-
sistent with Crohn’s disease.
In three patients (Nos 1, 3, and 4),
dysmotility preceded the mucosal changes.
In patient Nos 2 and 5, these two entities
occurred simultaneously, while in patient No
6, dysmotility developed after proctococe-
tomy. Ganglionitis in patient No 3 could
have been caused by Crohn’s disease before
other symptoms of the disease developed.
Treatment with 5-ASA has reduced her
abdominal pain. The normal histology of
the sigmoidum in patient No 4 does not
exclude the possibility of ganglionitis in other
parts of the bowel due to the known patchy
involvement of the gut in Crohn’s disease.
The present observations indicate that
apart from inflammation, even purely degen-
erative neuronal and ICCs changes seen in
CIP can occur in patients who also have IBD/
ANIBD-like condition. At present, it is not
known whether the observed abnormalities
are part of IBD or independent of each other.
This small patient sample prevents us from
drawing any definite conclusion regarding
this question. Further observations are
needed to establish whether or not this
connection is causal.

### Table 1 Summary of the findings in our patients

<table>
<thead>
<tr>
<th>Patient No:</th>
<th>Debut age/CIIP age (y)</th>
<th>Main symptoms</th>
<th>Clinical diagnosis</th>
<th>Endoscopic pathology</th>
<th>Histopathology</th>
<th>Antroduodenal manometry</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  23/F</td>
<td>16/22</td>
<td>Pain, bloody diarrhoea</td>
<td>Crohn’s disease, CIIP</td>
<td>Small and large bowel</td>
<td>Degenerative neuropathy</td>
<td>Suspected Crohn’s disease</td>
</tr>
<tr>
<td>2  26/F</td>
<td>15/25</td>
<td>Pain, vomiting</td>
<td>Proctitis, CIIP</td>
<td>Rectum</td>
<td>Degenerative neuropathy</td>
<td>Abnormal</td>
</tr>
<tr>
<td>3  35/F</td>
<td>Teenage/29</td>
<td>Constipation, dyspepsia</td>
<td>Crohn’s disease, CIIP</td>
<td>Small and large bowel</td>
<td>Ganglionitis</td>
<td>Normal</td>
</tr>
<tr>
<td>4  35/F</td>
<td>35/39</td>
<td>Constipation, pain</td>
<td>Suspected Crohn’s disease, CIIP</td>
<td>Small bowel</td>
<td>Normal</td>
<td>Abnormal</td>
</tr>
<tr>
<td>5  55/M</td>
<td>39/41</td>
<td>GORD, later pain and diarrhoea</td>
<td>Crohn’s disease, CIIP</td>
<td>Large bowel</td>
<td>Suspected Crohn’s disease</td>
<td>Ganglionitis, Crohn’s disease</td>
</tr>
<tr>
<td>6  67/M</td>
<td>61/64</td>
<td>Pain, weight loss</td>
<td>Crohn’s disease, CIIP</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CIIP, Chronic idiopathic intestinal pseudo-obstruction; GORD, gastro-oesophageal reflux disease.

### References
Cannabisinducedhyperemesis:notjustaprobleminAdelaideHills

We read the article by Allen and colleagues (Gut 2004;53:1566–70) with interest and would like to report a case of probable cannabisinducedhyperemesis seen in a districtgeneralhospitalintheUK.

A 21 year old chef was admitted to our hospital on seven occasions over a two year period (April 2001 to December 2002) with profuse vomiting. Apart from a history of migraine as a child, he was fit and well. He smoked cannabis. Physical examination was unremarkable. The observation that the patient wanted to take regular baths because he had found that bathing eased the sickness was documented in the nursing notes but its significance was not appreciated. Investigations during attacks disclosed neutrophilia but blood urea, electrolytes, liver biochemistry, and serum amylase were normal. Abdominal x-ray was also normal. Upper gastrointestinal endoscopy showed gradeI oesophagitisandgastritis. Gastricbiopsieswerehistologicallynormal. An abdominal ultrasound scan and small bowel barium follow through examination were normal. Additional normal or negative investigations included: autoantibodies and immunoglobulins, C reactive protein, and urinary porphyrin screen. Computed tomography scan of the brain was also normal.

During his last admission, the patient’s girlfriend showed us an article published in an Australian newsletter which she had obtained via the internet, in which Dr JH Allen had raised the possibility of a link between recurrent vomiting and cannabis abuse. With the aid of the internet we traced and contacted Dr Allen who shared his experience of this condition with us.

Reviewing the patient’s history, he freely admitted to smoking cannabis and experiencing the compulsaive desire to bathe during bouts of vomiting. Following his last admission in December 2002, our patient stopped smoking cannabis and has remained free of sickness. His clinical presentation was almost identical to the cases described by Allen et al, together with the response to cessation of smoking cannabis, supports the view that our patient was suffering from cannabisinducedhyperemesis and that this condition is international.

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Conflict of interest: None declared.

Inflammatoryboweldisease stimulates formation of carcinogenic N-nitroso compounds

Inpatientswithinflammatorybowel disease (IBD) the clinical incidence of colorectal cancer is observed.4Although severe inflammatory conditions per se represent a risk factor for neoplasia, we would like to draw attention to the possible role of increased activity of inducible nitric oxide synthase (iNOS), as found in IBD patients,5 in the endogenous formation of carcinogenic N-nitroso compounds (NOC). In healthy individuals, relatively small amounts of NOC are formed by the interaction between NOC precursors (NOCP), present in dietary items such as meat and fish, and nitrating agents derived from dietary nitrate. It has been proposed that endogenous formation of NOC may explain the link between meat consumption and colon cancer risk found in epidemiological studies.6 We hypothesised that as a result of chronic inflammatory conditions in the large intestine, increased colonic iNOS activity may produce an excess of NO, nitrogen oxides, and nitrite, which in turn react with NOC present in the colon to produce relatively high levels of NOC. Increased formation of NOC in IBD patients may thus contribute to the relatively high incidence of colorectal cancer associated with this disease.

A recent population based case control study showed that, in cases with a history of IBD, increased exposure to drinking water nitrate was associated with an increased risk of colon cancer whereas no such association was found in the overall population.7 This clearly indicates that the risk of colon cancer in IBD patients is not only determined by the disease itself but dietary factors known to influence the endogenous formation of NOC are also associated with an increased risk in these patients. Although both the increased formation of NOC found in mice with chemically induced colitis8 and increased levels of NO and nitrite found in the colonic lumen of patients with ulcerative colitis9 support this hypothesis, NOC levels have never been investigated in IBD patients.

Therefore, we collected faecal samples from 17 patients diagnosed with ulcerative colitis and 17 healthy controls, and determined levels of N-nitrosodimethylamine (NDMA), a predominant carcinogenic NOC, using gas chromatography-mass spectrometry, as previously described.1 The study was approved by the medical ethics committee of the Maasland Hospital, Sittard, the Netherlands, and all patients gave their consent. In 41% of patients, we found levels of NDMA above the detection limit of 1 ng/g faeces, compared with 35% of controls. Comparison of concentrations in NDMA positive samples showed that the average concentration in patients was significantly higher than that in the control group (table 1). When IBD patients were subdivided into hospitalised and nonhospitalised cases, the difference between the nonhospitalised group and controls was even more pronounced, whereas NDMA concentrations in hospitalised patients and controls were similar. In all hospitalised patients received only liquid nutrition (Nutrison; Nutricia, UK) without additional high NOC intake. However, we now report that faecal NDMA levels in IBD patients are considerably higher than those we reported previously in gastric juice (0.25 (0.3) ng/g), which indicates that NOC exposure may be even more relevant in colon carcinogenesis.

Based on these results, we conclude that the colon of IBD patients is exposed to relatively high concentrations of this carcinogenic compound, probably as a direct consequence of continuous NO production by the inflammatory process. As this exposure may strongly contribute to the increased colon cancer risk associated with IBD, dietary recommendations for IBD patients, avoiding high NOC intake, seem warranted.

References

3 Bingham SA, Pignatelli B, Pollock JR, et al. Does increased endogenous formation of N-nitroso compounds in the human colon explain the association between red meat and colon cancer? Carcinogenesis 1996;17:51–5
5 Mirvish SS, Haorah J, Zhou L, et al. N-Nitroso compounds in the gastrointestinal tract of rats and in the feces of mice with induced colitis or fed hot dogs or beef. Carcinogenesis 2003;24:595–603

Table 1 Faecal N-nitrosodimethylamine (NDMA) concentrations in patients with inflammatory bowel disease (IBD) and in healthy controls

<table>
<thead>
<tr>
<th></th>
<th>Controls (n = 17)</th>
<th>All IBD cases (n = 17)</th>
<th>Non-hospitalised cases (n = 10)</th>
<th>Hospitalised cases (n = 7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NDMA concentration</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NDMA (ng/g)†</td>
<td>1.4</td>
<td>10.9†</td>
<td>14.3†</td>
<td>2.4†</td>
</tr>
</tbody>
</table>

*Average concentration of NDMA positive samples.
†p<0.05, ††p<0.01: significantly higher compared with the control group (Mann-Whitney U test).
Hepatocellular carcinoma occurring after successful treatment of childhood cancer with high dose chemotherapy and radiation

Hepatocellular carcinoma (HCC) is one of the world’s most common malignancies and accounts for more than 90% of all primary liver cancers. A number of different risk factors have been identified for the development of HCC. Hepatitis B carrier state, environmental toxins, chronic hepatitis C virus infection, hereditary haemochromatosis, and liver cirrhosis of almost any cause are well known risk factors for HCC. In addition, environmental toxins such as aflatoxins and contaminated drinking water may contribute to the pathogenesis of HCC, especially in Asia and underdeveloped countries. Finally, a number of HCC cases have occurred after the use of thorotrast for diagnostic procedures, and survivors of the atomic bomb of Hiroshima were also at higher risk for HCC development, indicating that radiation might also induce the development of HCC. Herein we describe a rare case of HCC occurring in a patient 17 years after successful treatment of peripheral neuroectodermal tumour (PNET).

A 32 year old female presented with pain in the right upper quadrant of her abdomen. Seventeen years prior to presentation in our hospital this patient was treated for a PNET with a combination of high dose chemotherapy (vincristine, Adriablastin, ifosfamide, and actinomycin D) and surgical removal of the 10×5 cm tumour from her right chest followed by combined radiation (60 Gy) and chemotherapy. There were no signs of any recurrence of the tumour observed on her last check up 12 month earlier. Physical examination of the patient in our clinic showed typical signs of late radiation damage (erythema of the skin and an underdeveloped right breast) (fig 1). A firm 3–5 cm mass was palpable at the lower edge of the liver. Laboratory tests showed elevated a-lactalbumin (41881 μg/L) and ESR (211 mm/h). Hepatitis serology was negative and there was no evidence of any other liver disease. Magnetic resonance imaging revealed multiple intrahepatic masses up to 6.5 cm. A biopsy from the hepatic tumour was taken and confirmed the clinical diagnosis of HCC. The patient died three months after the diagnosis was made.

To the best of our knowledge, secondary HCC following high dose chemotherapy has never been described and therefore we searched the German Childhood Cancer Registry, which started to register all cases of malignancies in children (<15 years) in 1980. This database also collects data from secondary malignancies following chemotherapy. In this database we were able to detect a total of four more cases of secondary HCC, which are summarised in table 1. Interestingly one patient was hepatitis B surface antigen positive.

Radiotherapy has been shown to be associated with an increased risk of solid tumours 10–15 years after treatment and later. There is one report in the literature of a radiation induced hepatoma in a patient with a non-malignant hepatic haemangiomatosis, which occurred 20 years after radiation of the liver with 28.5 Gy. To date, the molecular mechanism of hepatocarcinogenesis is not completely understood. The main causative agents—hepatitis B virus, hepatitis C virus, and aflatoxin B1—have been identified, which together are responsible for approximately 80% of all HCC in humans. This series of cases clearly supports the notion that secondary HCC can follow not only radiation therapy of children but also high dose chemotherapy, and may prompt careful follow up examinations of the liver in patients with a possible risk for the development of HCC.

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doi: 10.1136/gut.2004.059352

Conflict of interest: None declared.

References

Table 1 Details of five cases of secondary hepatocellular carcinoma

<table>
<thead>
<tr>
<th>First malignancy</th>
<th>Age (y)</th>
<th>Treatment</th>
<th>Age when HCC was diagnosed (y)</th>
<th>Time from first to second malignancy (y)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALL</td>
<td>4</td>
<td>Ctx*</td>
<td>20</td>
<td>15</td>
</tr>
<tr>
<td>Osteosarcoma</td>
<td>4</td>
<td>Ctx, RTx</td>
<td>18</td>
<td>9</td>
</tr>
<tr>
<td>ALL</td>
<td>4</td>
<td>na</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>PNET</td>
<td>15</td>
<td>Ctx, RTx</td>
<td>33</td>
<td>18</td>
</tr>
<tr>
<td>Teratoma</td>
<td>2</td>
<td>na</td>
<td>19</td>
<td>16</td>
</tr>
</tbody>
</table>

ALL, acute lymphocytic leukaemia; PNET, peripheral neuroectodermal tumour; Ctx, chemotherapy; RTx, radiation therapy.

*This patient was hepatitis B surface antigen positive.


Biologics in inflammatory disease: infliximab associated risk of lymphoma development

In their excellent overview of currently available biologic compounds that are in use or under investigation for Crohn’s disease (CD), Sandborn and Faubion (Gut 2004;53:1366-73) reconfirm the unique standing of infliximab. They also note the ongoing discussion concerning the increased occurrence of lymphoproliferative disorders in patients who received infliximab.

Recently, we followed a 61 year old patient with a 31 year history of relapsing CD. Initial treatment was with steroids but after 10 years of infliximab therapy a large 40 cm lymph node in the right axilla was identified, which prompted thorough work-up. There were no signs of any active gastrointestinal inflammatory bowel disease, and age-related lymphoma was considered.

A thorough history revealed a possible diagnosis of systemic anaplastic large cell lymphoma (SALCL) on these results, the diagnosis was ALK negative anaplastic large cell lymphoma with null/T cell phenotype. Clinical stage was IAE. CHOP-chemotherapy resulted in complete clinical and histological remission, which was evidenced by computer tomography, positron emission tomography, and negative rectal histology. Polymerase chain reaction analysis of the rectal biopsies revealed no T cell receptor rearrangement.

Three months later, the patient presented with postobstructive pneumonia. Bronchiectasis biopsies showed a diffuse large B cell lymphoma. In contrast with the preceding rectal biopsies, bronchial tumour cells were positive for CD20, EBER, EBNA2, and LMP-1, indicating EBV infection of latency type III, were detected in tumour cells.
However, tumour cells were negative for CD30 and ALK protein. Molecular analysis demonstrated a monoclonal immunoglobulin heavy chain rearrangement in the absence of a T cell receptor rearrangement, confirming the diagnosis. The tumour was neither heavy chain nor light chain rearrangement, spontaneous partial remission was seen, persisting now for 10 years. When the patient presented for fourth line chemotherapy, demonstration of antichimeric antibodies seems to carry a theoretical risk of elevating the incidence of lymphoma above the background rate. Infliximab was approved by the US Federal Drug Administration five years ago, and until April 2004 approximately 500 000 patients have been treated. Based on medwatch data, an incidence of lymphoma in Crohn’s disease: the Mayo clinic experience in 500 000 patients. Gastroenterology 2004;126:19–31.


Genotypes 677TT and 677CT+1298AC of methylenetetrahydrofolate reductase are associated with the severity of ulcerative colitis in central China

Increased blood levels of homocysteine have been found to be associated with inflammatory bowel disease (IBD) in several studies. The main genetic determinant associated with elevated plasma levels of homocysteine (t-Hcys) is the MTHFR 677C→T gene polymorphism of methylenetetrahydrofolate reductase, a critical enzyme involved in the remethylation pathway of homocysteine. An association of the MTHFR 677T allele with IBD has been reported in Northern Europe but not in the US, Canada, or Asia. Double heterozygosity MTHFR 677CT+1298AC also produces reduced enzyme activity and increased t-Hcys, but its association with IBD has never been studied. Similarly, the association of IBD with transcobalamin (TCN1 776G→A), a genetic determinant that influences transcobalamin levels and t-Hcys, is not known. Transcobalamin is the protein that promotes intestinal transcytosis and cell delivery of vitamin B12, the cofactor of the methionine synthase dependent remethylation pathway.

In this study, we have evaluated the association of ulcerative colitis (UC) with MTHFR 677C→T, MTHFR 1298A→C, and TCN1 776G→A in a series of 72 patients from central China who gave informed consent. This series was compared with 111 age and sex matched controls. The research protocol was approved by the local appointed committee. Extraction of DNA and determination of polymorphisms were performed as described previously by us. A continuity corrected x^2 test and an ANOVA test were used, respectively, to assess differences in categorical and continuous variables between groups. Odds ratios of independent categorical variables

Table 1 Patients with infliximab therapy and development of lymphoma

<table>
<thead>
<tr>
<th>Case</th>
<th>Age (y), sex</th>
<th>Dose</th>
<th>No of infusions</th>
<th>Lymphoma</th>
<th>EBV</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>77, M, NR</td>
<td>NR</td>
<td>NR</td>
<td>Burkitt lymphoma</td>
<td>NR</td>
</tr>
<tr>
<td>2</td>
<td>19, M, NR</td>
<td>NR</td>
<td>NR</td>
<td>Hodgkin lymphoma</td>
<td>NR</td>
</tr>
<tr>
<td>3</td>
<td>43, F, NR</td>
<td>NR</td>
<td>NR</td>
<td>Hodgkin lymphoma</td>
<td>NR</td>
</tr>
<tr>
<td>4</td>
<td>59, M, NR</td>
<td>NR</td>
<td>NR</td>
<td>DLBL</td>
<td>Positive</td>
</tr>
<tr>
<td>5</td>
<td>70, M, NR</td>
<td>NR</td>
<td>NR</td>
<td>DLBL</td>
<td>Positive</td>
</tr>
<tr>
<td>6</td>
<td>29, M, D</td>
<td>5 mg/kg</td>
<td>3</td>
<td>Hodgkin lymphoma</td>
<td>NR</td>
</tr>
<tr>
<td>7</td>
<td>68, F, NR</td>
<td>NR</td>
<td>NR</td>
<td>B cell NHL</td>
<td>NR</td>
</tr>
<tr>
<td>8</td>
<td>62, M, NR</td>
<td>NR</td>
<td>NR</td>
<td>DLBL</td>
<td>Positive</td>
</tr>
<tr>
<td>9</td>
<td>73, M, NR</td>
<td>NR</td>
<td>multiple</td>
<td>Mantle cell lymphoma</td>
<td>NR</td>
</tr>
<tr>
<td>10</td>
<td>74, F, RA</td>
<td>10 mg/kg</td>
<td>8</td>
<td>B cell NHL</td>
<td>NR</td>
</tr>
<tr>
<td>11</td>
<td>48, M, RA</td>
<td>10 mg/kg</td>
<td>2</td>
<td>B cell NHL</td>
<td>NR</td>
</tr>
<tr>
<td>12</td>
<td>59, F, RA</td>
<td>3 mg/kg</td>
<td>5</td>
<td>Multiple myeloma</td>
<td>NR</td>
</tr>
<tr>
<td>13</td>
<td>61, M, RA</td>
<td>1 mg/kg</td>
<td>1</td>
<td>Hodgkin lymphoma</td>
<td>NR</td>
</tr>
<tr>
<td>14</td>
<td>36, M, CD, HIV</td>
<td>10 mg/kg</td>
<td>NR</td>
<td>B cell NHL</td>
<td>NR</td>
</tr>
<tr>
<td>15</td>
<td>62, M, CD</td>
<td>10 mg/kg</td>
<td>1</td>
<td>Intravascular B-NHL</td>
<td>NR</td>
</tr>
<tr>
<td>16</td>
<td>48, F, DM</td>
<td>5 mg/kg</td>
<td>3</td>
<td>DLBL</td>
<td>NR</td>
</tr>
<tr>
<td>17</td>
<td>47, M</td>
<td>6 mg/kg</td>
<td>3</td>
<td>CD30+ T-cell lymphoma</td>
<td>Negative</td>
</tr>
</tbody>
</table>

Psoriasis

18 | 70, M, CD | 5 mg/kg | 3 | Follicular lymphoma | NR |
19 | 51, M, CD | 5 mg/kg | 4 | Hodgkin lymphoma | NR |
20 | 25, M, CD | 5 mg/kg | 1 | NK cell lymphoma | NR |
21 | 79, M, CD | 5 mg/kg | 1 | B cell NHL | NR |
22 | 24, F, CD | 5 mg/kg | NR | B cell NHL | NR |
23 | NR, RA, NR | NR | NR | Mixed cell NHL | NR |
24 | NR, RA, NR | NR | NR | Mixed cell NHL | NR |
25 | NR, RA, NR | NR | NR | B cell NHL | NR |
26 | NR, RA, NR | NR | NR | B cell NHL | NR |
27 | NR, RA, NR | NR | NR | B cell NHL | NR |
28 | NR, RA, NR | NR | NR | DLBL       | NR |
29 | NR, RA, NR | NR | NR | Lymphocytic NHL | NR |
30 | NR, RA, NR | NR | NR | Low grade NHL | NR |
31 | NR, RA, NR | NR | NR | Mixed cell NHL | NR |
32 | NR, CD, NR | 5 mg/kg | 1 | NK cell lymphoma | NR |
33 | 61, M, CD | 10 mg/kg | 3 | Metachronous lymphoma (ALCL, DLBL) | Positive |
Table 1  Clinical characteristics and methylenetetrahydrofolate reductase (MTHFR) and transcobalamin (TCN) polymorphisms in 72 patients with ulcerative colitis (UC) and 111 controls from central China

<table>
<thead>
<tr>
<th></th>
<th>Ulcerative colitis</th>
<th>Controls</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>72</td>
<td>118</td>
<td></td>
</tr>
<tr>
<td>Sex (F/M)</td>
<td>35/37</td>
<td>58/60</td>
<td>0.9423</td>
</tr>
<tr>
<td>Age (y) [mean (SD)]</td>
<td>41 (15)</td>
<td>40 (13)</td>
<td>0.4809</td>
</tr>
<tr>
<td>Age of onset (y) [mean (SD)]</td>
<td>38 (14)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current smoker (n %)</td>
<td>1 (1.4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extent of UC (n %)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rectum</td>
<td>40 (55.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Left colitis</td>
<td>15 (20.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Right colonic</td>
<td>1 (1.4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total colon</td>
<td>17 (23.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment (n %)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5-ASA/SASP</td>
<td>53 (73.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Steroids</td>
<td>15 (20.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antibiotics</td>
<td>13 (18.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intestinal resections (n %)</td>
<td>5 (6.9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genetic polymorphisms (n %) [95% CI]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MTHFR 667TT allele</td>
<td>50 (34.7) [27.3–42.7]</td>
<td>91 (41.0) [34.7–47.5]</td>
<td>0.2286</td>
</tr>
<tr>
<td>MTHFR 677TT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MTHFR 677TT/CT allele</td>
<td>10 (13.9) [7.2–23.0]</td>
<td>21 (18.9) [12.4–26.8]</td>
<td>0.3707</td>
</tr>
<tr>
<td>MTHFR 677CT</td>
<td>18 (25.4) [18.8–30.7]</td>
<td>41 (18.5) [13.7–23.9]</td>
<td>0.2889</td>
</tr>
<tr>
<td>MTHFR 677TT/CT+1298AC</td>
<td>4 (6.2) [2.0–14.0]</td>
<td>17 (15.3) [9.5–22.7]</td>
<td>0.0755</td>
</tr>
<tr>
<td>TCN 776G allele</td>
<td>14 (21.2) [12.6–32.0]</td>
<td>38 (34.2) [25.9–43.3]</td>
<td>0.0659</td>
</tr>
<tr>
<td>TCN 776GG+GG</td>
<td>62 (63.3) [53.6–72.3]</td>
<td>138 (60.0) [53.6–66.2]</td>
<td>5.079</td>
</tr>
<tr>
<td>MTHFR 677TT/CT+1298AC</td>
<td>42 (85.7) [74.3–93.6]</td>
<td>89 (77.4) [69.3–84.3]</td>
<td>0.2236</td>
</tr>
<tr>
<td>Total colon</td>
<td>7 (43.7) [22.6–66.6]</td>
<td>7 (14.0) [6.3–25.2]</td>
<td>0.0162</td>
</tr>
</tbody>
</table>

In conclusion, our study showed that the genotypes of MTHFR, associated with a decrease in enzyme activity, seemed to be more significantly associated with extension of disease than with the primary risk, at least in central China.

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doi: 10.1136/gut.2004.045294cor1

References

CORRECTION
doi: 10.1136/gut.2004.045294cor1

The original article by Cosnes et al (Impact of the increasing use of immunosuppressants in Crohn’s disease on the need for intestinal resection) was incomplete. Figure 2 was missing from the proof. A corrected version of the pdf can be viewed at http://gut.bmjournals.com/cgi/data/54/2/237/DC1/1, and the missing figure can be seen here.