



Figure 2 Phospho- α -synuclein-positive submucosal neurites differentiate Parkinson's disease patients from controls. Double labelling with antibodies against neurofilament (NF) (A,B) and phosphorylated α -synuclein (C,D) revealed that some NF-immunoreactive (IR) neuritic structures were also phospho- α -synuclein-IR (merged image in E,F) in the majority of Parkinson's disease patients, but in none of the controls. Occasionally the inclusion-bearing neurites displayed dystrophic alterations (A,C,E). Scale bar: 30 μ m.

Ethics approval: The study protocol was approved by the local Committee on Ethics and Human Research on 27 February 2007.

TC and TL as well as PD and MN contributed equally to this work.

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CORRECTION

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R Spiller, Q Aziz, F Creed, *et al.* Guidelines on the irritable bowel syndrome: mechanisms and practical management (*Gut* 2007;**56**:1770–98). In paragraph 4.4.1 the sentence “This in turn acts on the adrenal medulla, resulting in cortisol secretion into the circulation” should read “This in turn acts on the adrenal cortex, resulting in cortisol secretion into the circulation”.

Editor's quiz: GI snapshot

ANSWER

From the question on page 1673

The patient had a large inflammatory abdominal aortic aneurysm. The abdominal CT scan shows a large infrarenal aortic aneurysm with a maximum diameter of 7.5 cm extending into the iliac vessels. There is an enhancing soft-tissue cuff surrounding the anterolateral margin of the aneurysm. The aneurysm appears to compress the third part of the duodenum (fig 1 below), which, however, was not detected at endoscopy. These CT findings were suggestive of an inflammatory aneurysm. Inflammatory abdominal aortic aneurysms represent 3–10% of all abdominal aortic aneurysms and occur predominantly in men.¹ They differ from atherosclerotic aneurysms in that patients often present with abdominal symptoms or anorexia, weight loss, and raised inflammatory markers. CT has a specificity of 99.7% for diagnosis of inflammatory

aneurysms,² usually showing periaortic fibrosis as a cuff of enhancing soft tissue surrounding the anterolateral margin of the aneurysm. If periaortic fibrosis is extensive, adjacent abdominal structures may be compressed and adherent, most commonly the third part of the duodenum.¹ Although rare, inflammatory abdominal aortic aneurysms should be kept in mind as a cause of abdominal pain and/or anorexia, weight loss, and raised inflammatory markers. The natural history of inflammatory abdominal aortic aneurysms remains unknown, with 3.3–14% patients presenting with acute or chronic rupture.¹ As regards to management, the literature supports an operative approach with a 30 day operative mortality rate of up to 9%.¹ Complete regression of fibrosis and inflammatory process occurs in up to one-half of patients at long-term follow-up post-operatively. Clinical symptoms (such as weight loss and gastrointestinal symptoms) reverse in 93% of the patients after an operation.³ Endovascular therapy is also a potential treatment