failure has been moulded by bureaucratic constraints, so that it is different in both scale and strategy from those in other relatively prosperous countries. It is also slow to respond to medical advances, which may need extra resources to make them equally available to all who could benefit, such as recombinant human erythropoietin for patients undergoing dialysis. Will the new methods of NHS funding to be introduced in 1991 change the pattern of the programme? Money that follows patients is said to make bureaucratic logjams simpler to resolve,²⁰ and it could provide an incentive for opening new renal units. The wishes of patients and the costs of transporting them to thrice weekly treatments both point to the desirability of increasing the numbers of renal units and specialists to fill geographical gaps in provision. McGeown and Feest *et al* have documented the real need for dialysis and transplantation. The reasons why the old style NHS has fallen short are known. Is it too much to hope that the white paper holds the key to open doors that have been held shut for too long?

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The pelvic ileal reservoir: apocalypse later?

Patients need monitoring for the long term effects of reservoir construction

The construction of a pelvic ileal reservoir with ileoanal anastomosis was first proposed as an alternative to permanent ileostomy and continent ileostomy in patients undergoing proctocolectomy for ulcerative colitis.¹ Ulcerative colitis remains the most common indication, but the operation has also become an effective alternative to total colectomy and ileorectal anastomosis for familial adenomatous polyposis and

has been used in patients with functional bowel disorders such as chronic megacolon and idiopathic constipation. The procedure is now considered a safe and satisfactory alternative to permanent ileostomy²: most suitable patients accept the offer of a pelvic reservoir rather than a permanent ileostomy.³

Even so, the creation of the reservoir is not without complications. The altered intraluminal environment in the reservoir has a profound effect on the ileal mucosa, producing chronic inflammation and varying degrees of villous atrophy.⁴ These inflammatory and architectural changes result in an appearance of colonic metaplasia.^{4,5} The evidence for colonic metaplasia is further substantiated by histochemical studies of mucin⁴ and by the acquisition of immunoreactivity for putative colon specific monoclonal antibodies.^{6,7} The inflammatory and metaplastic alterations occur in the reservoirs of patients with both ulcerative colitis and familial adenomatous polyposis and probably represent an adaptive response of the mucosa to the altered intraluminal environment. The ileal mucosa of experimental animal models shows similar metaplastic changes after reservoir construction.^{8,9}

One of the more severe long term complications of the reservoir is the active chronic inflammatory condition known as pouchitis. There is much confusion and controversy surrounding pouchitis, mainly because the term has not been tightly defined.^{10,11} Several heterogeneous mechanisms, including mucosal ischaemia,^{7,11,12} mucosal prolapse,⁴ and Crohn's disease¹¹ may cause inflammation in the reservoir, and all have been called pouchitis. This confusion accounts for the large divergence in prevalence rates in large series—7% to 42%.¹⁰ The definition of pouchitis should include clinical (painful increase in stool frequency, urgency, systemic symptoms), endoscopic (increased vascularity, bleeding, ulceration), and histopathological (acute inflammation, ulceration, chronic changes) criteria.^{11,12} These criteria define a condition that occurs in about 10-20% of patients with ileal reservoirs.^{11,13,14} Clinically, this syndrome is a relapsing and remitting chronic disease with a variable but often favourable response to antibiotics (particularly metronidazole) and to sulphasalazine or steroids, or both. Despite the undoubted response of many patients with pouchitis to metronidazole no consistent bacteriological changes have been observed in the reservoirs of these patients^{5,14,16}: the response to metronidazole may relate to its immunosuppressive properties. Stasis and bacteriological changes are probably a prerequisite for the morphological changes in the mucosa of the reservoir, and pouchitis may then supervene in susceptible individuals.

Although the cause of pouchitis is obscure, it seems to be closely linked to ulcerative colitis. Similar associations have been observed in the ileitis that complicates continent ileostomy reservoirs.^{11,17} In most large series pouchitis, when adequately defined, is more common in patients with ulcerative colitis than in those with familial adenomatous polyposis,^{10,11} and indeed may well be restricted to them.⁴ Acute inflammation in the reservoir mucosa, with and without pouchitis, is much more prevalent in patients with ulcerative colitis than in those with familial adenomatous polyposis,^{4,18} and similar distributions of immunoglobulin subtypes within intramucosal plasma cells have been shown in the reservoir of patients with pouchitis as in the colonic mucosa of patients with colitis.¹⁹ In both pelvic reservoirs and continent ileostomies pouchitis is associated with the development of conditions such as arthritis, iridocyclitis, and pyoderma gangrenosa, which are characteristic extracolonic manifestations of idiopathic inflammatory bowel disease.^{20,21} Patients with extensive colitis at proctocolectomy are more likely to develop pouchitis than those with more restricted disease,²² although there is no relation between backwash ileitis and pouchitis.²³

An attractive hypothesis for the pathogenesis of pouchitis is that the pelvic reservoir undergoes a process of colonic metaplasia, possibly as a result of changes in bacterial flora, and that this metaplasia recreates a colon-like environment that favours the recurrence of ulcerative colitis in the ileal reservoir. More worrying perhaps are the long term implications of colonic metaplasia in the reservoir mucosa. The mucosal epithelium of the reservoir shows increased proliferative activity in patients with and without pouchitis.⁶ The coexistence of colonic metaplasia and hyperproliferation may increase the neoplastic potential of the reservoir's epithelium. In both ulcerative colitis and familial adenomatous polyposis the colonic mucosa shows hyperproliferation,^{24 25} and, although to different degrees, both conditions are associated with epithelial dysplasia and malignancy.

The clinical, pathological, and experimental evidence should be put into context before any conclusions are drawn about the long term outlook for patients with pelvic ileal reservoirs. Current evidence suggests that the neoplastic potential of the pelvic reservoir is low. No convincing cases of epithelial dysplasia have been described in reservoirs constructed for ulcerative colitis. Very few reservoirs have been in place for over 10 years, however, and nearly all cases of epithelial dysplasia in the colon and rectum associated with ulcerative colitis arise after this time. Little evidence exists for increased neoplastic risk in continent abdominal ileostomies, some of which have been in place for 20 years.¹⁷ A recent report describes a carcinoma arising in a pelvic reservoir of a patient with colitis; in the authors' view the carcinoma arose not from metaplastic ileal mucosa but from remaining rectal mucosa within the pouch.²⁶ In patients with familial adenomatous polyposis adenomas have been observed in both pelvic reservoirs and continent abdominal ileostomies,^{4 27 28} but such adenomas could be considered to be part of the normal range of disease in familial adenomatous polyposis.

The optimist's view of the pelvic reservoir is that there is no increased neoplastic potential and that pouchitis is merely a hiccup in the establishment of the operation as the panacea for all diffuse colonic mucosal disease. The pessimist would suggest that all patients with an original diagnosis of ulcerative colitis will eventually develop pouchitis, that some will develop dysplasia and carcinoma, and that many patients with familial adenomatous polyposis will develop adenomatous dysplasia in the reservoir mucosa with high rates of malignancy. The truth, of course, lies somewhere in between. Until we have more objective evidence of the long term consequences of ileal reservoir construction surveillance by endoscopy and mucosal biopsy is warranted.

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National Cervical Screening Programme

Enforcement and coordination are required: guidance and interpretation are not enough

In the mid-1980s defects in the programme of screening for cervical cancer in Britain were highlighted in a series of research reports and in press, television, and radio programmes. Deaths were occurring that should have been prevented; women had to wait for months for the results of their tests, others were not recalled when they should have been, and many women were still not being screened at all.^{1 2}

These deficiencies led to a reappraisal of the NHS programme, and in 1988 the Department of Health issued a guidance circular intended to improve standards.³ Shortly afterwards the National Association of Health Authorities looked at the results being achieved and concluded that "there is every reason to believe that the NHS has risen to the challenge of translating policy into reality."⁴ The department should be congratulated for now (perhaps bravely) commissioning an independent audit (p 915) of the performance of district health authorities.⁵

Some of the findings certainly suggest that all is well. All districts now have computerised call-recall programmes, and 93% have fail safe mechanisms to follow up abnormal smears. An average smear reporting time of less than four weeks in three quarters of districts is a result likely to receive favourable publicity—although the new general practitioner contract, aiming at achieving 80% target coverage, has recently substantially increased this time.⁵ Three quarters of the districts were "fairly satisfied" with their programme; but, interestingly enough, this was not assessed by the prime performance indicator of effectiveness (not evaluated by Elkind *et al*) but simply reflected the hard work and commitment of those concerned.

The report should, however, cause some disquiet as well as some satisfaction. Substantial variability was found among districts. Some findings, such as restricted choice of smear taker and non-notification of results, are important causes of distress to women. Others warrant urgent explanation. Why,