The marine bacterium Vibrio parahaemolyticus, a known cause of gastroenteritis from seafoods, especially abroad, also occurs in British coastal waters—though only one incident traced to home-produced crabmeat has been reported. The vibrio is often present in imported crustaceae, especially shrimps and prawns from the Far East, and these have been responsible for some recent incidents. Though this organism may multiply rapidly, even at low temperatures, it is fully sensitive to heat: as with most microbial pathogens control lies in sound hygienic practice during and after processing. The consumption of any food raw inevitably carries some risks to health, and shellfish are no exception. Adequate heat treatment would, however, overcome most of them. Perhaps further education in cooking and eating these interesting foods is needed—who’s for oyster or mussel pie?


---

**Vitamin A and cancer prophylaxis**

There has been growing over many years a rich store of publications on the possible relevance of vitamin A and its analogues to the risk of development of cancer, and squamous carcinoma in particular. In the light of this mass of reports the sponsorship by the USA National Cancer Institute of clinical trials of the value of a vitamin A analogue as a cancer preventive should occasion no real surprise. Normally the external parts of the body and its entrances and exits (mouth, pharynx, anus, and vagina) are lined by squamous epithelium, whereas the gut, lower respiratory passages, gall bladder, and endocervix are lined by glandular epithelium. Sometimes normally glandular epithelium becomes squamous and whenever such “squamous metaplasia” occurs there are grounds for suspecting increased risk of cancer development. In the fetus, and to a lesser extent in mature animals, vitamin A deficiency predisposes to squamous metaplasia; adequate levels of vitamin A protect against its development; and (especially in immature animals) excessive levels of the vitamin encourage replacement of normally squamous epithelium by the glandular type—so-called mucous metaplasia.

Convincing evidence for these statements comes both from in-vitro and in-vivo studies. More direct evidence of the value of vitamin A in protection against cancer has come from experiments in which tissues in organ culture or in intact animals were exposed to carcinogenic polycyclic aromatic hydrocarbons (PAH) in such a way that they developed squamous cancers. Cone and Nettesheim showed that vitamin A protected rats against the early development of squamous neoplasms in response to a carcinogen, 3-methylcholanthrene, given by endotracheal instillation. Their findings were particularly important because these workers measured the amount of vitamin A stored in the liver to remained free of recurrence. Of the remainder, recurrence developed at the anastomotic site in 13 of the 15 patients. Nine patients required a further operation, and in five this meant excision of the rectum. So at the time of follow-up, though 14 of the 20 original patients still had their ileorectal anastomosis intact, nine had obvious recurrent disease, which at that time had been controlled medically.

These results do not enable the surgeon to be dogmatic about the correct advice to an individual patient needing colectomy for Crohn’s colitis. In each case the two- or three-fold increased risk of recurrent disease which seems to be associated with ileorectal anastomosis has to be balanced against the disadvantage of permanent ileostomy. Perhaps the most puzzling feature is why there should be an increased risk of recurrence after ileorectal anastomosis, as the rectum is virtually normal in many of these patients. Does the minimal residual disease in the rectal stump relight? Or does the preservation of the sphincter in some way affect the susceptibility of the small bowel to develop further recurrence?


---

**Crohn’s colitis and ileorectal anastomosis**

When medical treatment fails to control the symptoms of Crohn’s colitis excising the diseased bowel offers the only prospect of restoring the patient to health. The operation most commonly done is a proctocolectomy; this leaves the patient with a permanent ileostomy. Less commonly, when the distal bowel disease is minimal, the rectum may be spared and bowel continuity restored by an ileorectal anastomosis. Preservation of the normal sphincter mechanism is obviously an attractive alternative for the patient, but what, if any, are the hidden disadvantages?

In recent years several large series have described the late results of the surgical treatment of patients suffering from Crohn’s colitis. Altogether 225 patients underwent proctocolectomy with permanent ileostomy and 72 patients had a total colectomy and ileorectal anastomosis. Clearly the two groups were not strictly comparable: the bias was almost certainly in favour of the patient with ileorectal anastomosis group, as this operation is contraindicated in patients with severe rectal disease and perirectal suppuration. The overall recurrence rate for patients undergoing proctocolectomy was 25%, but for patients undergoing ileorectal anastomosis it was nearly three times as high—73%. The operative mortality rate was a little higher for proctocolectomy, but again this may have reflected differences in the severity of the disease in the two groups.

The most recently reported series has analysed the fate of 21 patients undergoing ileorectal anastomosis in great detail. Twenty patients were followed up for a mean of 8.3 years (one patient died three years after the first operation after further surgery for recurrent ileal disease). Only five of the 20 patients...