


Uncovering enteritis

The most common cause of ulceration of the small intestine in people of European stock is Crohn's disease, but the differential diagnosis includes tuberculosis, actinomycosis, typhoid, bacillary dysentery, polyarteritis nodosum, ischaemia, neoplasms, and the Zollinger-Ellison syndrome. With these conditions excluded, there remains a syndrome of multiple ulcers of the small intestine, which is variously known as ulcerative jejunitis,1 chronic ulcerative jejunoileitis,2 or, preferably, idiopathic chronic ulcerative enteritis.3 The rarity of the disorder is shown by the relative lack of reported cases. In 1980, Mills et al4 reviewed the 27 cases which had been reported since the first patient described in 1949 and added a further five cases. Recently eight more cases have been reported from Leeds.5

The subject is confused, mainly because idiopathic chronic ulcerative enteritis is almost certainly heterogeneous. All patients have intestinal ulceration and malabsorption but they may then be divided into four groups: those with proven coeliac disease, those with villous atrophy unaffected by a gluten free diet, those with a normal small intestinal mucosa, and those with a malignant histiocytosis.6

The first group is the smallest. Mills et al5 considered only three of the 32 patients they reviewed to have coeliac disease—defined as showing a clinical and histological response to gluten withdrawal.7 The eight patients recently described from Leeds included two more with coeliac disease, one of whom had a malignant histiocytosis, though there was circumstantial evidence of coeliac disease in the other patients in this series. Only in the patient described by Bayless et al7 was the coeliac disease diagnosed long before the development of small intestinal ulceration: this patient remained symptom free on a gluten free diet for six years before he developed anorexia, loss of weight, and abdominal pain, which heralded the presence of small bowel ulceration.8 In the other cases of proved coeliac disease radiological evidence of ulceration or stricture was already present at diagnosis.5 7 8 Two patients in the Leeds series, however, almost certainly had coeliac
Recurrent cancer of the large bowel

Cancer of the large bowel causes some 17 000 deaths each year in England and Wales and is the second most common cause of death from malignant disease. Many patients who die from cancer of the bowel have previously undergone what was hoped to have been a "curative" resection, only to return with lethal recurrent or metastatic disease; some patients in whom surgical cure has been successful will later develop a second, metachronous cancer elsewhere in the large bowel.

Is the picture one of complete gloom, or can painstaking follow up identify these lesions at a stage where further surgical resection is possible and rewarding? Once colorectal cancers could be removed successfully it soon became clear that the remaining large gut might be the site of development of a second tumour.1 In 1951, Rankin and Conger described seven patients whose second tumours had been resected successfully.2 By 1958 Moertel and his colleagues could report 261 multiple colorectal cancers among 6012 cases at the Mayo Clinic (4%), of which 157 were simultaneous, 95 metachronous, and nine both.3 Interestingly, 21 of these 261 patients had, in addition, another tumour elsewhere as well as their two or more colorectal growths.

A review from St Mark's Hospital, London, of 4884 survivors from operations for cancer of the large bowel showed that 83 patients (2%) had operations for metachronous cancers.4 Eighteen patients had their second cancer diagnosed in the first two years after initial operation, and some of these might have been synchronous tumours missed at the first operation; but among the remainder the average interval between the first and second operations was just over 11 years. The St Mark's report points out the difference in prognosis in patients who developed a second cancer of the large bowel while attending the follow up clinic regularly compared with those who had defaulted or had been discharged. The 41 tumours in the "follow up" group were diagnosed apparently earlier than in most series, and no fewer than 70% were at Dukes stage A or B. By contrast, eight of the 17 patients who were not attending the clinic had inoperable growths at the time of diagnosis. The policy at St Mark's was that patients should be examined by a double contrast barium enema every two years combined with sigmoidoscopy every six months—but that was at a time before the routine use of the

D P JEWELL

Consultant Gastroenterologist,
Radcliffe Infirmary,
Oxford OX2 4HE

---