**Idiopathic retroperitoneal fibrosis**

Now known to be an allergic reaction to insoluble lipid leaking through arteries

Retroperitoneal fibrosis is a fibrotic process that often occurs in elderly patients, affecting the median, aorta, and the tissue planes around the aortic aneurysms. It has also been observed in patients with Dupuytren's contracture of the palmar fascia and Peyronie's disease of the penis. The diagnosis and treatment of idiopathic retroperitoneal fibrosis is difficult, and progress has been made recently in understanding the causes.

Almost three-quarters of cases of retroperitoneal fibrosis are idiopathic. They remain thought to be caused by drugs, especially methysergide and antihypertensive agents, retroperitoneal malignancy, inflammation around the abdominal aorta, or collagen diseases. There is now doubt whether antihypertensive drugs cause retroperitoneal fibrosis; it seems more likely that these drugs were implicated only because they were used to treat hypertension caused by unrecognized retroperitoneal fibrosis.

The pathological appearances of idiopathic retroperitoneal fibrosis are uniform sheets of dense fibrous tissue encasing the ureters, inferior vena cava, and aorta. This inflammatory tissue has the macroscopic appearance of enlarged lymph nodes. It usually occurs in elderly patients, although there are reports of the disease in children. Clinical diagnosis may be difficult because the features are non-specific—malaise, fever, sweating, and oedema of the legs due to venous obstruction. It is well defined and occurs frequently, with males affected more than females. Examination usually shows little, although it occurs in a large percentage of patients. It is not a good sign of retroperitoneal fibrosis. Computed tomography is the most helpful investigation because it shows the extent of fibrosis and any associated aortic thickening or dilatation. Magnetic resonance imaging has not been widely used in diagnosis but may prove useful. Percutaneous needle biopsy of the plaque may exclude malignancy, but an adequate specimen is not always obtained.

In patients with acute obstructive renal failure due to retroperitoneal fibrosis the obstruction must be relieved urgently by percutaneous nephrostomy, ureteric J stents, or retrograde ureteric catheterisation. Definitive treatment necessitates laparotomy to free the ureters from the fibrotic plaque (ureterolysis) and wrapping of the ureters in omentum (omentumoplasty) to prevent recurrence. If very ill patients and patients with non-functioning kidney it is better to operate on only one side.

If the omentum is deficient or absent Silastic sheeting may be used to separate the ureters from the fibrotic plaque. Occasionally the ureter is so badly damaged by fibrotic infiltration that autotransplantation of the kidney is required. Steroids and ureteric stenting are useful before a definitive operation and in those patients considered unfit for an operation. The response to steroids may be determined by serum renography or by the erythrocyte sedimentation rate. Follow-up is difficult but is best performed with computed tomography.

Some fibrotic plaques resolve spontaneously, but disease activity may persist for many years. It is important to contribute to morbidity and mortality postoperatively as hypertension and venous thromboembolic disease.

Considerable progress has been made during the past 15 years in understanding the causes of idiopathic retroperitoneal fibrosis. It was suggested as early as 1972 that the fibrosis may be a reaction to an antigen in aortic atheroma. Necropsy and computed tomographic studies have shown that idiopathic fibroplasia of the aorta, particularly in aortic aneurysms, is the cause of idiopathic retroperitoneal fibrosis. Studies with gallium scintigraphy have shown a high uptake of isotope in plaques of idiopathic retroperitoneal fibrosis, confirming that an inflammatory reaction is present.

This unusual disease is thus an allergic reaction to insoluble lipid that has leaked through a thinned arterial wall from atheromatous plaques. The preferred name for idiopathic retroperitoneal fibrosis should probably now be chronic periaortitis. This term also provides a pathologic explanation for mediastinal fibrosis (caused by atheroma in thinned coronary arteries) and periaortitism fibrosis. Some patients with chronic periaortitis have been found to have circulating...
antibodies to ceroid, and there is an exciting possibility that these antibodies may in future be used as markers of the activity of the disease.12

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15 Tresadern CG, Bandy JF, Singh M. Omental sleeve to prevent current retroperitoneal fibrosis around the ureter. Urol Int 1972;27:144-8.

Alcohol services: exhortations rather than commitment

Many problem drinkers cannot find specialist help

Alcohol is a source of pleasure, profit, employment, tax revenue on a large scale (£11 000 a minute), and a casualty toll that is growing steadily. An average health district is likely to contain 10-15000 people who are drinking more than is sensible, have problems from their drinking, or are dependent on alcohol. A 1978 government advisory committee recommended that “every person with a drinking problem should be able to find the help he or she needs” and emphasised the importance of primary care workers backed up by local counselling and specialist services. Yet a year later the Royal College of Psychiatrists reported that “despite all the dedicated effort, and the many successes, society has largely been pretending to mount a response to alcoholism.” In the same year so worrying were the conclusions of a government think tank report on the future of statutory services that it was suppressed, while a report on the voluntary sector’s response to alcohol problems found “serious deficiencies.”

Present services for problem drinkers are many and diverse and both statutory and voluntary. Specialist services include community alcohol ‘teams, advisory and counselling services, day centres, residential projects, alcohol treatment units, detoxification facilities, self help groups, and private clinics. Yet despite the government’s previous exhortations and criticisms a review by Alcohol Concern of services in England and Wales makes depressing reading. Three regional health authorities in the south do not have a specific policy of planning services. In the north, where there are policies, there are, for example, “substantial gaps in provisions and uncertain funding in Yorkshire,” while in the West Midlands “services are woefully inadequate and either non-existent or minimal.” In greater London only nine out of 32 boroughs have an adequate service. What is strikingly obvious from Alcohol Concern’s report is that the voluntary sector has displayed most initiative; it is the statutory sector and central government that have failed to act.

Many problem drinkers cannot find the help they need. For example, admission of women to psychiatric units for problems related to alcohol increased by 23% between 1979 and 1984, yet most residential services are for men only; furthermore, women who are married cannot claim board and lodging from the Department of Health and Social Security, barring all but the wealthy from residential care. Similarly between 0.5% and 10% of older people have alcohol problems—yet no alcohol agencies exist specifically for older or retired people. Meanwhile, among the young, 39% of drivers aged 20-24 who are killed in road accidents have blood alcohol concentrations over the legal limit yet the government’s educational campaign directed at the young has been described as of “questionable efficacy without adequate enforcement.” People from ethnic minorities are underrepresented among the staff of alcohol agencies and many people from ethnic minorities are probably being received into acute psychiatric care because of disturbed behaviour that may be related to alcohol. Finally, services in which a whole family could participate in the treatment seem to be non-existent.

The government wants to have its cake and eat it: some departments are interested in boosting the production of alcohol—for example, by giving grants to new plants producing alcohol—while the DHSS and Home Office bemoan the crime and sickness associated with alcohol. Doctors in general have little knowledge of alcohol and a high prevalence of alcohol problems, which may explain their ambivalence in acting despite evidence that simple advice about cutting down drinking from a doctor is effective in as many as two thirds of heavy drinkers. The voluntary sector, which provides most of the skills in services for problem drinkers,