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BRITISH MEDICAL JOURNAL

SATURDAY 14 MARCH 1970

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No. 5697 British Medical Journal, 1970, Volume 1, 641-702 Weekly. Price 7s.
BRITISH MEDICAL ASSOCIATION, TAVISTOCK SQUARE, LONDON W.C.1 TEL : 01-387 4499

Correspondence

Correspondents are asked to be brief.

Mild Ulcerative Colitis

SIR,—The questions raised by Mr. A. K. Maitra in his letter (14 February, p. 431) on the management of mild ulcerative colitis are indeed difficult ones, and it is understandable that confusion may appear to exist. Since there are no final answers to some aspects in advising surgical as opposed to medical treatment, it is possible to interpret expert opinion in slightly different ways.

It does seem clearly established that patients with ulcerative colitis have a greater risk of the development of colonic or rectal carcinoma than others. However, it also seems clearly demonstrated that those with total involvement of the colon and/or severe relapses have a substantially greater risk of carcinoma than do those with mild distal non-ulcerative inflammatory changes. It would seem that all authors are agreed on this matter. The point made by Professor B. N. Brooke[1] was not that the greater proportion of patients developing cancer in the colon had mild colitis, but simply that this group should not be ignored when considering the possibility of the development of malignant change. The colonic cancer risk in those with mild distal colitis, though present, would seem to be much smaller than in those with the more extensive and/or more severe disease.

Since the usual operation for ulcerative colitis is total procto-colectomy with permanent ileostomy, there is naturally hesitation in advising this radical procedure unless the risk of development of carcinoma is substantially greater than the risks attendant on this operation. No absolutely accurate information on this particular point is available, although the studies of Watts and colleagues[2] suggest that for those with extensive colonic involvement a stage is reached about three years after onset of the disease when the risk of tumour becomes greater than that of total colectomy. The results of the investigations of Dr. Morson and his colleagues[3] into the possibility of selecting these patients with even mild colitis who might be more at risk of malignant change than the others, appears strongly convincing. All specimens removed for established carcinoma in ulcerative colitis patients had similar uniform histological appearances, and there was a high incidence of carcinoma and active mucosal changes in those who underwent colectomy as a result of the detection of the biopsy changes.

In summary, it would seem that the only absolute guarantee to any patient with any degree of ulcerative colitis is a total procto-colectomy. However, it seems genuinely doubtful whether the risks of such a radical procedure, small though they are, are significantly less than the risk of malignant disease in those who remain symptomfree for years at a time, and who have only mild distal colitis. The persistence of a very real fear of the development of malignant disease may in itself be every justification for coming down on the side of operation.—I am, etc.,

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REFERENCES

1 Brooke, B. N., *Journal of the Royal College of Surgeons of Edinburgh*, 1969, **14**, 274.
2 Watts, J. McK., de Dombal, F. T., Watkinson, G., and Goligher, J. C. *British Medical Journal*, 1966, **1**, 1447.
3 Morson, B. C., and Pang, L. S. C., *Gut*, 1967, **8**, 423.

Bundle Branch Block

SIR,—I read with interest your leading article "Bundle Branch Block" (21 February, p. 450). You state that in an otherwise healthy non-patient population the incidence of bundle branch block is low. Although you admit that the incidence is higher in the elderly, the high incidence in the following report may surprise you.

Electrocardiograms were done on 161 consecutive admissions to the geriatric unit at this hospital under the care of Dr. H. Droller from November 1969 to January 1970. They were divided into two groups. Group I (78 patients) included those with any of the following criteria: taking diuretics, digitalis, or hypotensive drugs before or after admission; symptoms or signs of heart failure; a history of angina or myocardial infarction. Group II consisted of those without any of these criteria (83 patients; 53 women, 30 men). The ages ranged from 65 to 94 years.

The reasons for admission to hospital of those in Group II were not directly related to disease of the cardiovascular system except in some patients who had recently had a cerebral ischaemic episode and others who had senile dementia. Many of these admissions were on social grounds. Thus this group perhaps approximates fairly closely with the general population aged over 65 years so far as cardiac status is concerned. Of this Group II, bundle branch block was found in 9 (17%) of the women (4 left and 5 right) and in 2 (7%) of the men (both right).

Furthermore, no important underlying organic basis for their conduction disturbance was found, contrary to your prediction. None were hypertensive, but two of the women were in atrial fibrillation (one with left bundle branch block, the other