LETTERS TO THE EDITOR

Painful rib syndrome

EDITOR,—The painful rib syndrome recently described by Scott and Scott is, in my opinion, a misnomer. Over the years I have seen numerous cases similar to the ones they report, and have found that the tender spots they allude to are not in the ribs but in the muscles. They are, in fact, myofascial trigger points. Pain develops because of trauma induced activation of nociceptors at these sites in what is now called the myofascial pain syndrome.[1] These trigger points may be found in any muscle in the body. In the abdomen they commonly occur in the rectus abdominis and external oblique muscles. They do not only develop, however, at or near to their insertion into the ribs, but also in their bellies and at lower attachment sites such as the iliac crest, inguinal ligament, and pubic bones.

The pain emanating from trigger points in this syndrome may be abolished by injecting a local anaesthetic into them.[2] Recently it has been shown that pain is also relieved by stimulating A-delta nerve fibres at these sites with dry needles; treatment that is physiologically more rational besides being simpler, safer, and equally effective.[3]

Gastroenterologists must learn to recognise 'trigger point pain' because it is common and can be treated. The concept of the painful rib syndrome restricts the diagnosis to pain in the lower thorax and upper abdomen, as well as implying that there is no effective treatment other than reassurance. Trigger point pain may occur anywhere in the abdomen with additional sites in the perineum and back. The pain can be recognised easily so unnecessary investigations and operations are avoided. It usually responds quickly to acupuncture; further courses can be given if relapse occurs.

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1 Simons D. Muscular pain syndromes. In: Fricton JR, Awad E, eds. *Advances in pain research and therapy*. New York: Raven Press, 1990: 1–41.
2 Fricton JR. Management of myofascial pain syndromes. Ibid 325–46.
3 Baldry PE. Acupuncture, trigger points and musculoskeletal pain. 2nd ed. Edinburgh: Churchill Livingstone, 1993.

EDITOR,—Scott and Scott review what they call the painful rib syndrome (*Gut* 1993; **34**: 1006–8), consisting of three features: pain in the lower chest or upper abdomen, a tender spot on the costal margins, and reproduction of the pain on pressing the tender spot. In the discussion, it is stated that the cause of this syndrome is not known.

It is perhaps helpful to look at history. The region at or below the cartilaginous parts of the ribs is also known as the hypochondrium from Greek hypo=below and chondros=cartilage. It was Galen from Pergamon (living AD 129–199) who first described a syndrome at this location consisting of pain in the region below the ribs, bloating, and anxiety. He coined the term hypochondriacum flatulentumque morbum.[1 2]

In Graeco-Roman times, hypochondria was considered a part of melancholia – what we today call depression. Today, the meaning of the word hypochondria has changed. In the eighteenth century, hypochondria still had the antique denotation.[2] As hypochondria was (or is?) particularly common in England, it has been described as the English malady.[3] I would like to suggest that Scott and Scott will find the aetiology of their syndrome when they obtain a medical history looking for signs of depression.

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1 Claudii Galeni. *Opera omnia*. Kühn G, ed. Lpz. 1821–33.
2 Fischer-Homberger E. *Hypochondrie*. Bern: Huber, 1970.
3 Cheyne G. *The English malady: or, a treatise of nervous diseases of all kinds, as spleen, vapours, lowness of spirits, hypochondriacal, and hysterical distempers*, etc. London/Dublin: 1733.

Reply

EDITOR,—It is encouraging that others readily recognise the syndrome we described. It is also interesting that Dr Dyer sees this as part of a wider syndrome and it behoves all clinicians to keep this in mind when confronted with patients who have pain that does not readily fit other well defined categories. At the least it may prevent unnecessary investigations, and it may even lead to effective treatment. Our study did not look into the aetiology and Dr Dyer's concept of myofascial trigger points is plausible. Although reassurance and explanation is probably sufficient for most patients, some remain troubled and for them acupuncture is possibly appropriate. We agree with Professor Feurle that depression possibly plays a part in this syndrome, but doubt that it is an important part. Clinical depression was not a prominent feature among our patients at the time of examination although 28% gave a history of either depression or anxiety.

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Colonoscopic surveillance in ulcerative colitis

EDITOR,—We read with interest the article by Lynch *et al* (*Gut* 1993; **34**: 1075–80), and agree that the problem of defining those patients at risk of developing colorectal cancer poses great logistical problems. Yearly surveillance colonoscopy did not detect most of the cancers in patients with colitis, but this was because nearly all patients in whom cancer eventually occurred fell outside their surveillance programme. Only three of nine patients who developed colon cancer had their disease initially assessed by colonoscopy, and a further two patients had total colitis diagnosed by barium enema. We would suggest that ideally all patients with an initial diagnosis of colitis should have the extent of their disease assessed colonoscopically, thereby better defining those patients deemed to be at higher risk of developing cancer.

It is obviously true that colonoscopy will not prevent cancer from developing in the colitic colon[1] because of the imperfect link between dysplasia and cancer, and because of the low proportion of the surface area of the colon biopsied during surveillance colonoscopy. We would therefore propose that surveillance colonoscopy should not be the only follow up that colitic patients receive. It is artificial to separate colonoscopic surveillance from proper clinical care of a patient with a condition that relapses and remits, and during which medical treatment may have to be changed. In the largest prospective study of follow up of patients with colitis, 13 of 17 cancer patients in the surveillance programme had a Dukes's A/B cancer, suggesting that this group of patients will have a better outlook than those patients presenting symptomatically.[2] The finding of dysplasia in 22 patients treated by colectomy would possibly have prevented at least seven cancers.[2] A recent study has also concluded that an aggressive policy of colorectal cancer prevention had a much higher incidence of early tumours compared with a non-prevention group, which translated into a survival advantage at five years that was statistically significant.[3]

We feel that Lynch *et al* have been too pessimistic in their article on the value of follow up of colitis patients. Colonoscopy performed every two years from the 10th year after diagnosis is clearly feasible, requiring 12 colonoscopies per 100 000 population.[4] All authors agree that the risk of developing colorectal cancer increases with duration and extent of disease.[5] In addition, young age of onset of colitis is also associated with increased risk,[6] although other studies suggest that older age of onset of colitis may be associated with a shorter interval to development of cancer.[7] We do agree, however, that the strategy for follow up of patients with colitis deemed to be at high risk of developing colorectal cancer needs further thought and study. In the meantime, surveillance of high risk patients from the 10th year after onset of colitis seems a sensible approach.

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1 Catnach SM, Rutter KRP, Bown RL. Colorectal carcinoma in patients with ulcerative colitis and recent colonscopy. *Gut* 1993; **34**: 1148–9.
2 Lennard-Jones JE, Melville DM, Morson BC, Ritchie JK, Williams CB. Precancer and cancer in extensive ulcerative colitis: findings among 401 patients over 22 years. *Gut* 1990; **31**: 800–6.
3 Giardiello FM, Gurbuz AK, Bayless TM, Yardley JH. Colorectal cancer (CRC) in ulcerative colitis (UC): effect of a cancer prevention strategy on survival. *Gastroenterology* 1993; **104** (suppl): A705.
4 Jones HW, Grogono J, Hoare AM. Surveillance in ulcerative colitis: burdens and benefit. *Gut* 1988; **29**: 325–31.
5 Sugita A, Sachar DB, Bodian C, Ribeiro MB, Aufses Jr AH, Greenstein AJ. Colorectal cancer in ulcerative colitis. Influence of anatomical extent and age at onset on colitis-cancer interval. *Gut* 1991; **32**: 167–9.
6 Ekbom A, Halmick C, Zack M, Adami H-O. Ulcerative colitis and colorectal cancer. *N Engl J Med* 1990; **323**: 1228–33.
7 Gyde SN, Prior P, Allan RN, Stevens A, Jewell DP, Truelove SG, *et al*. A cohort study of primary referrals from three centres. *Gut* 1988; **29**: 206–17.

Reply

EDITOR,—Thank you for the opportunity of replying to Messrs Rayter and Leicester's letter. We agree with much they say. In our paper we advocated longterm clinical follow