numerous calculi and showing fibrous thickening of their walls. The ducts were lined by normal and mildly to severely dysplastic biliary epithelium. Severe dysplasia was characterised by cellular crowding, stratified pleomorphic nuclei with prominent nucleoli, and a papillary surface (Figure). No invasive carcinoma was identified.

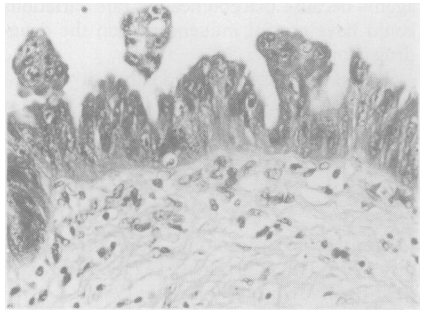

Figure: Severe dysplasia of epithelium in dilated bile duct.

Epithelial dysplasia is frequently seen adjacent to cholangiocarcinoma in the intra[2] and extrahepatic bile ducts[3] and carcinoma of the gall bladder which has a similar epithelial lining.[4] Extensive severe epithelial dysplasia involving the gall bladder, cystic duct, and common bile duct, associated with adenocarcinoma of the common hepatic duct, was recently reported in a patient with primary sclerosing cholangitis and chronic ulcerative colitis,[5] diseases which, like Caroli's disease,[6] are associated with an increased risk of cholangiocarcinoma. These findings, and that of epithelial dysplasia unassociated with carcinoma in Caroli's disease, provide evidence of the premalignant nature of biliary epithelial dysplasia. Because such dysplasia is usually detected only in surgical specimens, we agree that early resection of localised forms of Caroli's disease may be necessary to prevent late complication by cholangiocarcinoma.[1]

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IgA class reticulin antibodies of human subtype in gluten sensitive enteropathy

SIR,—We read with interest the paper of Dr Hallström in the September issue (*Gut* 1989; **30**: 1225–32) entitled 'Comparison of IgA-class reticulin and endomysium antibodies in coeliac disease and dermatitis herpetiformis'.

In the discussion the author refers to our article 'IgA class antibody against human jejunum in sera of children with dermatitis herpetiformis' (*J Invest Dermatol* 1986; **87**: 703–6), as follows: 'R_1-type of reticulin antibodies reacting with human liver and spleen has also been described previously and already Seah *et al*[1] and Eterman *et al*[2] showed that such antibodies can react with human jejunum, a finding recently confirmed also by Kárpáti *et al*.[4]' Here we described for the first time IgA type antibodies binding to human jejunum and that they may be related to reticulin antibodies. An IgG type reticulin antibody reacting with human small bowel was seen by Eterman *et al*[2] '. . . the IgG type of reticulin antibodies were reported of low frequencies (18–46%) and low specificity (75–85%) in coeliac disease. In contrast, IgA class reticulin antibodies seem to be more sensitive and specific'. (From the introduction of Dr Hallström's paper.)

Jejunal antibodies have distinctive characteristic signs compared with other IgA type reticulin antibodies: they bind to the small bowel, which is the damaged organ in gluten sensitive enteropathy and they bind at the site of gluten absorption which is the precursor of the disease. In addition, the binding site of IgA type jejunal antibody corresponds to or is very similar to the extracellular IgA deposition detected in the diseased jejunum of patients with gluten sensitive enteropathy. Because of the damaged structure of coeliac jejunum, this similarity can be ascertained by investigating the diseased small bowel of patients with almost normal villous structure: (a) in jejunal biopsy samples taken several hours to one to two days after gluten challenge in coeliac patients who have recovered on gluten free diet[3]; (b) we found IgA deposits in the small bowel of dermatitis herpetiformis patients with almost normal jejunal structure.[4]

In the present work Dr Hallström found both the endomysium, and IgA type reticulin antibodies to be very important in the diagnosis of gluten sensitive enteropathy, and by absorption studies the endomysium antibody (substrat:monkey oesophagus) was related to the human subtype of reticulin antibodies and was distinguished from that of rat subtype. We think that if antihuman antibodies are important in considering the pathogenesis of coeliac disease, they must be related to the IgA type antibodies reacting with human jejunum.

We conclude that one of the reticulin antibodies category mentioned does not correspond to the pathological concept of the IgA type jejunal antibodies supplied in our study.

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BOOK REVIEWS

Common problems in gastrointestinal surgery. Vol 1. By Josef E Fischer. (Pp 451; illustrated; £36.) London: Wolfe Medical, 1989.

Common problems in gastrointestinal surgery is one of a series produced by Year Book Medical Publishers on a variety of surgical subjects. The contribution in question is edited by Joseph Fischer, chairman of surgery at the University of Cincinatti. The approach is refreshing and novel. Each chapter is introduced by a specific clinical problem: four to eight line case history, one or more consultant is then asked to comment. Most contributors are pithy and to the point. Their comment usually consists of a brief overview of the literature, some reference to pathophysiology followed by the contributors own view on management. The book is largely, I suspect, designed to assist the private practitioner in North America to provide optimum clinical management based upon the views of experienced clinicians. The layout, diagrams and artwork are pleasing. Only key references are provided. The contributors: 66 in all are household names in GI circles, a few have been retired from practice for a variable time but most are regarded as contemporary experts in their disciplines. Only three are not from the USA (two from the UK and one from Canada). The reader must therefore expect a strong USA perspective.

Surprisingly the section on oesophageal and thoracic problems does not include any contribution on oesophageal carcinoma which some will find surprising with the development of endoscopic endoluminal ultrasonography, the growing recognition of early oesophageal cancer and the impact of low morbidity bypass, intubation and laser therapy on palliative therapy. I find it curious to come across two breast problems in the thoracic section.

The gastroduodenal section includes a single contribution on GI bleeding. The emphasis, as is prevalent throughout the book, is on surgical treatment without even reference to endoscopic assessment or the role of endoscopic therapy. The medical:surgical divide is a real one in North America and the concept of joint management is not one that flavours this book.

The hepatobiliary section is varied and interesting, but it is difficult to do justice to all that has occurred over the last decade in liver transplantation by reference to a single case report.

The endocrine section makes interesting reading, but the gastrointestinal component of many case reports is enigmatic.

There is some unfortunate duplication in the colorectal section particularly with reference to diverticular disease and regional enteritis. The important clinical problem of major colonic haemorrhage takes no account of rapid bowel preparation and therapeutic endoscopy or the impact of intraoperative panendoscopy on surgical strategy.

This is a bold and attractive approach to a surgical update. In gastroenterology it must include joint management with gastroenterologists. The experiment has been a good one