colonic motility. This is also true for the subgroup of IBS sufferers who we have identified as having hypomotile colons.

With regard to clinical details about the patients, we have little to add to that which appears in the text. All the patients had been first seen in the outpatient clinics and the diagnosis of diverticular disease or irritable bowel syndrome made by an independent clinician. None of those with diverticular disease had peridiverticulitis or abscess either clinically or radiologically. All had had abdominal pain and alteration in bowel habit which had prompted referral to a specialist department and on subsequent investigation all had been found to have diverticular disease involving the sigmoid colon. It is a matter of debate as to whether the presenting symptoms and the finding of diverticular disease on barium enema examination are causally related, but it does little to enhance our knowledge of the mechanism of symptoms simply to say they are due to the irritable bowel syndrome.

Until a pathophysiological marker is found, the diagnosis of irritable bowel syndrome will remain one of exclusion. Stratifying patients according to symptoms is attractive but not always possible as the pattern of symptoms may be variable, definition of the symptoms imprecise and their elucidation highly subjective. The extent to which investigations are pursued to prove there is no 'organic' disease present is determined by many factors but we believe that the 20 patients we studied would have fulfilled rigorous criteria for the diagnosis of IBS. Moreover, in the several years of follow up since the studies were completed, there has been no reason to revise the diagnosis in any of the patients. Symptoms were recorded at structured interview at the time they were admitted to hospital and prior to colonoscopy. The patient whose bowel habit was considered normal was a 44 year old male with a six year history of left sided abdominal pain which was eased by defecation, whose general health remained otherwise good, and in whom investigation had been negative.

When the recordings of sigmoid IPs were analysed, we found no correlation between any symptom or group of symptoms and the pressure recording that had been made. Perversely, symptoms occurring during the period of study were extremely rare – a phenomenon frequently remarked on by others investigating intestinal motility in IBS. Only two of our subjects had their usual pain during the period of recording and, interestingly, this was accompanied by a reduction in the frequency and amplitude of pressure waves in both.

Finally, we would share Dr Thompson's sentiments that improved measurement techniques should be accompanied by 'more sophisticated definition of the subjects studied'. Unfortunately, we fear that defining subjects by symptoms alone is ingenuous and unlikely to lead to any useful new strategies for the diagnosis or management of the IBS sufferer in the everyday clinical environment.

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Colorectal cancer in UC

SIR,—Gyde *et al*[1] in their paper on the colorectal cancer risk in ulcerative colitis argue that patients tend to develop colorectal cancer at about 50 years of age, irrespective of their age at onset of colitis. They therefore suggest that screening patients aged less than 30 or more than 60 is unnecessary. This suggestion was based on 35 patients with carcinoma derived from a population which excluded those with onset of colitis before the age of 15, thus including a bias against carcinoma in younger age groups.

Of 100 patients treated at this hospital for carcinoma complicating ulcerative colitis, 11 were under 30 years of age, and 23 were over 60 years of age. If surveillance were limited to patients between 30 and 60 years of age, this would mean that a third of carcinomas developing would be missed, and one third of these would be in patients in their 20s. This is unacceptable. Results from this hospital show that the cancer risk in extensive colitis is related to the time from onset of the disease and all patients who have had their disease for 10 years or more are at increased risk. Surveillance should be offered to all such patients if other factors such as infirmity or old age do not prevent them from attending the hospital.

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Reference

1 Gyde SN, Prior P, Allan RN, *et al.* Colorectal cancer in ulcerative colitis: a cohort study of primary referrals from three centres. *Gut* 1988; **29:** 206–17.

Reply

SIR,—The main thrust of our paper was to provide the best estimate at present available of the colorectal cancer risk in ulcerative colitis. We did not wish to further muddy the already murky waters of screening for colorectal cancer in colitis.

In discussing our results we examined whether the