mortality rate less than 1%. Our series confirmed that ''explosive HCC spread'' may occur after RFTA, with no correlation with AFP, or differentiation or location of the tumour, and frequently even after total ablation.

Why do these patients develop this severe (and dramatic if observed in patients on waiting lists for orthotopic liver transplantation)[8] and unexpected complication and what is its prevalence? Whether or not we can identify patients at risk is open to discussion, which we believe should be exhaustive before abandoning PEI as obsolete in favour of RFTA as the treatment of choice for early disease not eligible for surgery. Let us wait for the end of the honeymoon period of this new procedure!

G E N E (Gruppo Epatocarcinoma Nord-Est, Hepatocarcinoma Group North East Italy), C Angonese, A Baldan, U Cillo, A D'Alessandro, M De Antoni, M De Giorgio, A Masotto, D Marino, M Massani, M Mazzucco, E Miola, D Neri, D Paccagnella, G Pivetta, L Tommasi, F Tremolada, A Tufano, G Zanus, F Farinati*
Department of Gastroenterology Science, Padua University, Padua, Italy

Correspondence to: Dr F Farinati, Department of Surgical and Gastroenterological Science, University Hospital of Padua, Via Giustiniani 2, Padua 35128, Italy; fabio.farinati@unipd.it

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Collagenous colitis in adult Sri Lankans: experience from the Indian subcontinent

The literature contains few data on the clinical features and demographics of collagenous colitic patients from the Indian subcontinent. Almost all published articles describe various clinicopathological facets of collagenous colitis in the West, which is now classified as a variant of microscopic colitis, where diagnosis is missed by failure to biopsy the normal or ''near normal'' looking mucosa at endoscopy for histological examination.

The case notes of 210 patients who underwent colonoscopy at Base Hospital-Panadura (Medical Unit), Sri Lanka (equivalent to a district general hospital in the UK, with a bed strength of 350), for various reasons, from 20 July 1999 to 20 January 2002, were retrospectively reviewed. Clinical features and results of other routine investigations of patients who were histologically diagnosed as having collagenous colitis were analysed. All those with chronic colonic symptoms had mucosal biopsies taken from all major segments of the colon, despite normal or ''near normal'' looking mucosa.

The results revealed that 29 patients had histological evidence of collagenous colitis with an approximate equal male and female distribution (15:14). The age distribution was 21–50 years (mean 45 (SD 7) years). Collagen thickening was focal in 17 patients, uniform in eight, and mixed in four. Symptoms included diarrhoea alone in four cases, diarrhoea with abdominal pain in 15, and abdominal pain alone in 10, all having intermittent symptoms for more than a year. No other major symptoms or signs were elicited. Histological changes were mainly seen in the distal colon. The colonic mucosa appeared normal in 21 and mildly erythematous (subjective) in eight patients at endoscopy. Routine haematological, biochemical, and stool tests, and abdomino-pelvic ultrasound examinations were normal. Van-Giesen stain was used to confirm the presence of collagen in biopsies following haematoxylin and eosin.

Collagenous colitis is increasingly recognised as a variant of chronic inflammatory bowel disease, which causes chronic watery diarrhoea, predominantly affecting women in the sixth or seventh decade.[1] In contrast, in our series, a female preponderance was not observed and mean age at presentation was much younger (approximately 35 years of age). Abdominal pain was a notable symptom in 86% (25/29) of cases while diarrhoea was found in only 66% (19/29). Early age at presentation may be due to early diagnosis, a background of a high degree of awareness of its existence, and the enthusiastic approach of biopsy of normal or ''near normal'' looking colonic mucosa at endoscopy in relatively young patients. Autoimmune mechanisms, cytokine pleomorphism, commensal bacteria, infective agents, various proinflammatory mediators, and nitrous oxide have all been implicated in the pathogenesis.[2] Whatever the mechanisms, these were not severe enough to cause significant abnormalities in our routine investigations or on clinical examination. It has been found that biopsy specimens from as proximal as the transverse colon should be obtained to rule out collagenous colitis with certainty.[3]

In our series, the majority of patients showed focal thickening, probably as a result of early diagnosis. Although unpublished, we have repeatedly highlighted the existence of collagenous colitis mimicking irritable bowel syndrome in adult Sri Lankans on many occasions,[4–7] and published data in the *Journal of Ceylon College of Physicians*.[8]

In conclusion, collagenous colitis seems to be more prevalent in adult Sri Lankans than suspected, and at an early age. The three histological types most likely represent various stages of disease progression, with changes being more pronounced in the distal colon. There was no sex preponderance and diarrhoea was not an integral feature in every subject. Collagenous colitis closely mimicked irritable bowel syndrome of relatively young Sri Lankans. An enthusiastic approach is essential for early diagnosis. More studies from the Indian subcontinent and South East Asian regions would be useful to compare with the results obtained in this study.

R L Satarasinghe
Sri Jayewardenepura General Hospital (Post Graduate Tertiary and Teaching), Kotte, Sri Lanka

H R R Fernando, D H Jayamaha
National Hospital of Colombo, Colombo, Sri Lanka

I Samarasinghe
Base Hospital Panadura, Panadura, Sri Lanka

A P De Silva
Sri Jayewardenepura General Hospital, Kotte, Sri Lanka

Correspondence to: Dr R L Satarasinghe, Sri Jayewardenepura General Hospital, Kotte, Sri Lanka, 011-2778610; pubsy@sltnet.lk

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