educational theory promotes the value of case-based learning and problem-solving as opposed to digesting long tracts of text.

However, having read *Gastroenterology and liver disease*, edited by Richard Long and Brian Scott, I have changed my mind! This comprehensive book is organised into easy-to-use sections on areas of gastroenterology and liver disease, with individual chapters on key topics such as inflammatory bowel disease, nutrition and the management of gastrointestinal bleeding. Although it is designed for doctors starting their training in gastroenterology, it would also be particularly valuable for specialist nurses. It is clearly written by those who practise gastroenterology rather than preach about it, and contains a wealth of well-presented and pertinent information in both the text and the many tables. In addition to clear descriptions of all common GI diseases, it has a chapter on the organisation of gastroenterology services that is essential reading for those about to start a consultant post and also for current consultants who feel the need to reorganise their service! A particular highlight for me was the section on statistics and epidemiology for the gastroenterologist. The use of relevant examples manages to simplify the basis of the common study designs and statistical analyses used in the gastroenterological literature, which will be invaluable in deciphering the increasingly complicated trial and epidemiological literature.

Each self-contained chapter is packed with useful guidelines. Some, such as the guidelines on managing diabetics during endoscopy, appear to be designed locally, whereas others are based upon British Society of Gastroenterology guidelines, such as the polyp surveillance intervals. Its joy is that it is comprehensive, but not so overstuffed with information as to make it impractical to use on a day-to-day basis. By definition, it does not contain the latest data on novel therapies or a comprehensive description of all gastrointestinal conditions – I guess if you need more information, it's time to log on and read about it online!

So in summary, this is an excellent and well put together guide to the practice of gastroenterology and would make an excellent introduction to the subject for any interested professional.

James Lindsay

Atlas of video capsule endoscopy

Edited by Martin Keuchel, Friedrich Hagenmüller, David E. Fleischer. Heidelberg: Springer Medizin Verlag, 2006, £130.50 (hardback), pp 296. ISBN 3-540-23128-5

Let me make a confession. When I was first asked to review this book, I jumped at the opportunity because about 3 months ago I bought my own copy and have found it extremely valuable, but I have felt guilty about keeping it to myself. I know that if I let the trainees have access to it, it will very quickly disappear, for me never to see it again. Now I have two copies, so trainees can benefit.

The book title leads you to believe falsely that it is simply a series of pictures that allows you to pattern-match what you see on examinations of your patients with examples in the atlas. It is much more than that. Its 60 or so contributors deal with absolutely everything you could want to know about capsule endoscopy, from history to future developments. Indeed, the future developments chapter right at the end is particularly entertaining and was written by Paul Swain. Certainly, it will become dated but it is real ''Star Trek'' stuff at present. Applications, indications, technical and procedural routine, evaluation and reporting technique are all there; every known aspect of capsule endoscopy is dealt with, some in extremely ingenious ways. To complement the capsule endoscopy chapters of the book, there are supportive chapters dealing with other endoscopic and non-endoscopic imaging. These put capsule endoscopy in context and allow its role of therapeutic guidance to be discussed.

My only gripe is that the modern-day radiological techniques of CT and MR scanning are scarcely discussed – perhaps hardly surprising, as there is not a single radiologist amongst the contributors. Nonetheless, this is a pretty spectacular book from a technical and clinical endoscopic standpoint. The range of images of common, unusual and frankly rare conditions is virtually complete. There are very few conditions discussed in the text for which there is no capsule endoscopy image. The image in the section on coeliac disease of the capsule immersed in steatorrhoea in the colon is particularly inspiring. You want worms and parasites? They are here in profusion, as is everything else from angiodysplasia to tumours, coeliac disease to Crohn's disease. I think I'd probably go so far as to say that if you were considering setting up a capsule endoscopy service then you would be putting yourself at a very significant disadvantage if you didn't first go out and buy a copy of this book and read it thoroughly before starting.

Derrick F Martin

CORRECTION

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J Baillie, P-A Testoni. Are we meeting the standards set for ERCP? (*Gut* 2007;**56**:744–6). Both the editors and authors are grateful to the authors of the BSG audit of endoscopic retrograde cholangio-pancreatography (ERCP) study (EJ Williams, S Taylor, P Fairclough, *et al*. Are we meeting the standards set for endoscopy? Results of a large-scale prospective study of endoscopic retrograde cholangio-pancreatography practice (*Gut* 2007;**56**:821–9)) for pointing out that both their article and the accompanying commentary by Baillie and Testoni refer to two sets of data, which the commentary failed to clearly distinguish. The 2003 NCEPOD study (NCEPOD. Scoping our practice. The 2004 Report of the National Confidential Enquiry into Patient Outcome and Death. London: NCEPOD, 2004, http://www.ncepod.org.uk/2004.htm (accessed 28 Mar 2007)) was a small, retrospective study that looked at all endoscopy-related deaths within 30 days for in-patients only over a period of several months. The 2004 BSG survey was a much larger prospective, practice-based audit of all ERCPs in five selected regions of England, which relied on self-reporting. Despite the different methodologies, there was broad agreement in both studies regarding mortality rates. The BSG audit looked at cannulation and success rates in addition, and found that at least some elements of practice (eg selection, preparation, pre-investigation, monitoring, antibiotics and consent) were not as bad in reality as the picture that had been painted by the NCEPOD report, which focussed solely on patients who died. It was the judgment of the NCEPOD panel, looking at retrospective data on mortality, that two-thirds of deaths in the ASA 3–5 group occurred following procedures that were futile. The subsequent BSG survey found that while one-third of all the deaths were in the ASA 3–5 group, 90% of the the same group survived their procedures. Although 60% of patients in ASA category 5 died, these were only 13/4561 (0.28%) patients. Possibly 100% of these unfortunate individuals would have died without ERCP.

Table 1 of the paper by Williams *et al* summarises the findings and recommendations of the NCEPOD that the authors consider relevant to ERCP. It refers to all deaths occurring in hospital within 30 days of therapeutic gastrointestinal endoscopy between 1 April 2002 and 31 March 2003. This is the source of concern expressed regarding lack of resuscitation equipment on site (19%), deaths of patients who were confused (16%) but had nonetheless provided written consent for their procedures, lack of any written consent (21%), lack of clotting tests (80%), inadequate or absent monitoring during sedation, and so on. The BSG audit yielded a large amount of data, not all of which could be included in the final paper. However, there is clear evidence from the BSG data that the current practice of ERCP is better than the gloomy picture painted by the NCEPOD study. For example, during the prospective study, prothrombin time was documented to have been performed within one week of ERCP in 86% of patients, which represents very good compliance with practice guidelines.

The authors wish to apologise for this confusion between the two distinctly separate studies referred to within their commentary, which created a falsely gloomy picture of current British ERCP practice, which they trust this notice will correct.