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Varicocoele caused by a pancreatic pseudocyst

Sir,

We were interested to read the case report by Drs Dixon, Armstrong, and Fremin of a varicocoele caused by a pancreatic pseudocyst (*Gut* 1983; **24:** 438–40), but we believe the pancreatogram reproduced in Fig. 1 may have been misinterpreted. While accepting the difficulty of interpreting reproduced radiographs, we believe the appearances shown, and the description in the text of a blind ending to the main pancreatic duct are more suggestive of main pancreatic duct obstruction, a radiological feature which may be seen in the presence of a pseudocyst, rather than the fine terminal arborisation of the duct system more typical of an unfused ventral pancreas.[2] Although this in no way detracts from the interest of the report we would hesitate to ascribe this patient's recurrent acute pancreatitis to congenital duct malfusion, particularly in the presence of gall stones.

Depts of Medicine and Radiology, Ninewells Hospital, Dundee

IAN HAMILTON AND J S SOUTAR

References

1 Hamilton I, Bradley P, Lintott DJ, McMahon MJ, Axon ATR. Endoscopic retrograde cholangiopancreatography in the investigation and management of patients after acute pancreatitis. *Br J Surg* 1982; **69:** 504–6.
2 Ansel HJ. Normal pancreatic duct. In: Stewart ET, Vennes JA, Grenen JE, eds. *Atlas of endoscopic retrograde cholangiopancreatography*. St Louis: C V Mosby, 1977: 46 and 70–2.

Reply

Sir,

Thank you for allowing us to comment on the letter of Drs Hamilton and Soutar.

We recognise that the radiological features of the pancreatogram in our case reports may be caused by a pseudocyst. The latter, however, appears unlikely as an ultrasound performed the day after the pancreatogram showed no evidence of a pseudocyst.

We agree with the authors that radiology of the ventral pancreas usually reveals fine terminal arborisation of ducts. Pathological change in the ventral pancreas (as may have occurred in the case described), on the other hand, can lead to dilatation of the main duct and absence of the branching pattern.[1]

J M DIXON,
C P ARMSTRONG, AND
O EREMIN

Reference

1 Belba JP, Bell K. Fusion anomies of the pancreatic ductal system: differentiation from pathologic states. *Radiology* 1977; **122:** 637–42.

Books

A colour atlas of upper gastrointestinal surgery By Charles Grant Clark. (Pp. 168; illustrated; £50.) London: Wolfe Medical Publications. 1983.

The best way to learn operative surgery is undoubtedly to assist a master surgeon and then be assisted by him. The place of books has always been controversial because, on one hand, drawings, which highlight key steps, appear unreal; whereas, on the other hand, photographs of actual operations are often difficult to orientate and interpret. This latest addition to the literature is lavishly illustrated with 544 colour photographs at a cost of £50 but also displays the severe limitations of this format, particularly in the section on truncal vagotomy, where the pictures add little to the text. It might have been better if there had been more annotations of the photographs or accompanying line drawings to clarify the anatomy. The attempt to avoid the glare of a white background has resulted in considerable areas of yellow patches in many photographs. Perhaps dark green or blue would have been better.

By contrast, the text is good, clear, and concise, and is of most value when it highlights mistakes that can occur. An introduction to each section discusses the indications for the different operations which is particularly important in peptic ulcer surgery. All surgeons have their own personal preferences and any book on operative surgery is a personal view. For example, many surgeons do not like twin clamps for a gastroenteromy but the techniques shown in this book are standard and safe and appropriate for surgeons in training.

In summary, unfortunately the use of colour photographs has not been a great success, but this is not belittle the skill of the photographer nor the skill of the surgeon – it is inherent in the method.

A G JOHNSON