contrary, several studies[4 7 8] firmly discredit such relationships. Neither have they disproved the view that, in the presence of a flat mucosa,[9-11] a high mitotic index (>0·2%) is a helpful, prospective index of untreated coeliac disease. The material studied lacked the appropriate disease controls necessary to challenge that assertion.

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Nodular necrobiosis in association with ulcerative colitis

SIR,—In 1982 we reported in this journal a cutaneous manifestation of Crohn's disease which we called nodular necrobiosis.[1] We have now observed an identical lesion in ulcerative colitis.

The patient, a woman aged 53 years, presented with a six month history of diarrhoea and rectal bleeding. Investigation, including colonoscopy, confirmed a diagnosis of ulcerative colitis extending to the mid-descending colon. There were no extra intestinal manifestations of inflammatory bowel disease but after three months she developed a solitary painful lump on the left leg. This gradually became less tender but did not alter in size or colour. On examination there was a 5 cm, purple lesion on the left lower leg which bore a close resemblance to nodular necrobiosis. Biopsy confirmed this diagnosis. The lesion has persisted despite her colitis responding well to therapy with steroid enemas and sulphasalazine.

We therefore conclude that nodular necrobiosis can occur in both Crohn's disease and ulcerative colitis.

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European survey of fertility

SIR,—The authors of the study concerning fertility and pregnancy in women with Crohn's disease[1] should have confined their investigation to the 182 matched pairs who were actually married at the time of the study. Unmarried women in general unequivocally tend to avoid conception. We miss detailed gynaecological data on whether other reasons for infertility have been excluded. The intention to become pregnant, or not, should have been taken into account. Forty patients were advised by their doctor not to conceive; 42 others deliberately refrained from becoming pregnant because of Crohn's disease. Furthermore one should

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not assume that women with Crohn's disease always have the same cohabitation behaviour as healthy controls, because of possible abdominal pain during sexual intercourse, perianal complications, or impaired general state of health. Information on the fertility of the husbands would have been useful. It is known that infertility is found in more than 30% of the cases in the man.[2] Interestingly, women with Crohn's disease became pregnant slightly more frequently before diagnosis than did the healthy controls (60% *vs* 57%). It is well known that several years may pass between the first symptoms and the definite diagnosis of Crohn's disease.[3] Presumably, at least part of the 60% with Crohn's disease could have conceived during a period when they were affected with the disease.

Our objections are not intended to diminish the importance of this study, but we do think the author's conclusions are a bit overdrawn. The data presented are more relevant to non-conception, than to fertility of women with Crohn's disease.

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Endoscopic sclerotherapy using absolute alcohol

SIR,—In your February 1985 issue: Sarin *et al* (*Gut* 1985; **20:** 120–4) reported the use of absolute alcohol as a sclerosant for injecting oesophageal varices. They found it to be an effective, safe, economical and freely available sclerosant for developing countries. We, therefore, started injecting absolute alcohol (95%) to further study its efficacy and safety in human beings. Before this we had used polidocanol as a sclerosant in more than 300 patients with portal hypertension.

Endoscopic sclerotherapy was carried out using an Olympus GIF Q panendoscope and NM 1K injector. 0·5–1 ml absolute alcohol was injected intravariceally in each variceal column at gastroesophageal junction and 3–4 cm proximal to it with a total volume of 5–10 ml per session. Sclerotherapy was repeated at two weekly intervals until obliteration of varices, or development of complications.

So far 17 patients (cirrhosis 11, non-cirrhotic portal fibrosis six) have received this regimen. All of them received a total of 43 sittings with a mean of 2·5 per patient and mean volume of alcohol injected per session was 7·4 ml. Thirteen (76·4%) of the 17 patients developed complications (Table) and two died. One patient succumbed to massive bleeding and the other to a haemorrhagic pleural effusion secondary to oesophagopleural fistula. Efficacy of absolute alcohol for obliteration of varices could not be judged because of the complications. Thus in our view the use of absolute alcohol as a sclerosant should be avoided.

Table *Complications in patients after endoscopic sclerotherapy with absolute alcohol*

Complications	*Patients*	*%*
Deep necrotic oesophageal ulcers	13	76·4
Retrosternal pain	10	58·8
Dysphagia	7	41·1
Stricture	4	23·5
Bleeding ulcer	4	23·5
Mediastinitis	1	5·8
Oesophagopleural fistula	1	5·8

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Books

Food and the gut By J O Hunter and V Alun Jones (Pp. 309; illustrated; £19·50). London: Ballière Tindall, 1985.

The function of the alimentary tract is to receive, process and absorb food, excreting any undigested residue. Gastroenterology has been concerned with diseases of the digestive system and relatively little attention had been given to the effects of food on alimentary function. In the last decade, however, the specific effects of food constituents on order and disorder in the gut has been the focus of much basic and clinical research. This book is particularly timely in integrating this research for the attention of clinicians. It brings together a team of authorities in such diverse fields as the effects of feeding on the development of the gut, its effect on gut hormone activity, its influence on intestinal permeability, and on the balance and function of intestinal microflora.

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