Letters to the Editor

Collagenous colitis: response to treatment

Sir,

Rokkas et al.¹ report an interesting case of collagenous colitis showing a rapid clinical response to sulphasalazine therapy with apparent complete resolution of the collagen band. It is now becoming clear that a significant proportion of cases of collagenous colitis do respond to anti-inflammatory therapy of the type effective in idiopathic inflammatory bowel disease. Of six cases I have studied four have shown excellent clinical response to therapy; three to sulphasalazine and one to prednisone enemas. Jessurun et al.² have recently reported a series of 15 patients with collagenous colitis, eight of whom were studied before and after treatment with prednisone, sulphasalazine or a combination of the two. All eight patients improved considerably with treatment. The final suggestion of Rokkas et al.¹ that sulphasalazine should prove to be effective treatment in some patients can therefore be confirmed.

The finding of complete resolution of the collagen band is less commonly reported and there is reason for caution in the interpretation of this observation. In most cases studied by colonoscopy the collagen band has been present throughout the colon;² however, in patients where the band thickness has been mapped, collagen deposition has been shown to be patchy with a tendency towards distal sparing.²,³ For this reason, in patients who have not been fully studied by colonoscopy with multiple biopsies from throughout the colon, it is not possible to be certain that complete dissolution of the band has occurred.

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References


The spectrum of schizophrenia

Sir,

Weller’s recent leading article, ‘The spectrum of schizophrenia’,¹ is both a useful appraisal and timely reminder that schizophrenia may not be a discrete nosological entity but instead may merge imperceptibly into various abnormalities of personality. No reference was, however, made to the relationship between the schizophrenic and affective psychoses, and it may thus be inferred by some that the time-honoured distinction between the two remains clear-cut. This may not be so. Psychiatric classification is still based predominantly on symptom patterns, and multivariate statistical techniques have singularly failed to distinguish between the two on this basis.²–⁴ Testament to this ill-defined boundary lies in the frequency of the diagnosis of schizoaffective disorder,⁵ and its inclusion in both current ICD and DSM classifications. Genetic studies have also been unhelpful in differentiating between schizophrenic and affective psychoses. Most family studies have failed to show that cases diagnosed schizoaffective breed true, but rather that there is an increased incidence of either schizophrenia or affective disorder in first degree relatives.⁶–⁸ Furthermore, outside the concept of schizoaffective disorder, there is also evidence of an increase in schizophrenia in the offspring of parents with affective disorder.⁹ These studies have recently led Crow¹⁰ to propose that the schizophrenic and affective psychoses are not distinct illnesses, but rather that they lie at opposite ends of a continuum, and that this may have a genetic basis. That the frontier between these two illnesses is blurred clearly has both important ideological and practical implications, and Weller’s article should not be taken to imply that this is not so.

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References


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