with the findings (ratio 2.5:1) in an epidemiological study conducted earlier at our institution.

Avinash Supe, R D Bapat
Gastroenterology Surgical Services
K E M Hospital, Mumbai 400 012

Immunoproliferative small intestinal disease (IPSID): the Indian scenario

We concur with the view expressed by Puri et al.4 that IPSID is underdiagnosed in India probably due to a lack of awareness and non-availability of endoscopic and pathological expertise. We have seen 30 patients with IPSID during 1983-95. The median age at presentation was 35 years. All of them had diffuse involvement of the duodenum, jejenum, and in some patients ileum. Endoscopic examination showed the features described by Barakat.2 Endoscopic biopsy confirmed IPSID stage C in 26 patients; four patients required exploratory laparotomy for histologic diagnosis. Seven patients had the abnormal α-chain on serum immunoelectrophoresis.

We believe that the endoscopic appearances described are highly suggestive. Barakat2 described five types, namely granulopapular, nodulopaploid, ulcerative, infiltrative, and mixed. None of the 29 patients described by him had a normal endoscopic appearance, an experience similar to ours. We noticed granulopapular lesions in 4 patients, nodulopaploid in 7, ulcerative in 3, infiltrative in 5, and mixed pattern in 11 patients.

These findings are not specific, but combined with clinical features like a young patient with diarrhea, and long-segment involvement, make the diagnosis almost certain, and warrant repeated endoscopic biopsies or even laparotomy to establish the diagnosis. The absence of diarrhea and/or malabsorption, although rare, does not exclude the diagnosis of IPSID, as shown by two patients reported from our institute. Both these patients presented with symptoms of intestinal obstruction.

We would also like to point out that four patients reported from our institute3 have not been included by Puri et al. Furthermore, others5,6 have also reported cases of IPSID from India.

V Dhir, K M Mohandas
Division of Medical Gastroenterology
Tata Memorial Hospital, Mumbai 400 012

References

Reply from the authors

Although Dhir and Mohandas have a larger experience (previously unpublished) than ours, they state that "the endoscopic appearances described are highly suggestive" of IPSID, and then add that "these findings are not specific". The fact remains that it is not possible to differentiate infiltrative carcinoma and non IPSID lymphoma from IPSID on the basis of endoscopic appearance alone.

I am grateful to the authors for the addition of seven previously reported cases of IPSID from India which had been inadvertently omitted from our article.

A S Puri
Friends Medical Center
F-1 Kalindi Kunj Road
New Delhi 110 065

Primary esophageal tuberculosis

Sood et al. have overlooked the following point in their report on primary esophageal tuberculosis. This condition is exceedingly rare, probably because of the barrier effect of the intact squamous lining, peristalsis, and the surface coating by saliva and mucus. Secondary esophageal tuberculosis, on the other hand, can result from contiguous spread, swallowed infected sputum, and retrograde lymphatic and hematogenous spread.

It is often not possible to document a tuberculous focus elsewhere in the body, especially in the mediastinal lymph nodes and lung, during life. Claims of primary esophageal tuberculosis except after a careful autopsy should therefore be viewed with suspicion.

Sangeeta Desai, S Krishnamurthy
Department of Pathology
Tata Memorial Hospital, Mumbai 400 012

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