the last sepsis relapse, all cultures were persistently negative and there was no disease recurrence. Thus, the recovery from infection and C. coli clearance could not be achieved, despite several courses of antibiotics, until an attempt to sterilize the gastrointestinal tract with bacitracin/neomycin was done.

The high frequency of Campylobacter found in symptomatic and asymptomatic patients with PAD might be the result of failure to eradicate bacteria, causing a condition of intestinal carriage. It has been showed that the failure of humoral immune response might permit the colonization of epithelium and lamina propria with a possible induction of tissue damage. In this scenario, the observed susceptibility to extracellular bacterial infections such as Helicobacter and Campylobacter indicates the essential role of humoral immunity. The inability to mount an antibody response might account for the genetic stability of the microorganism over time and for the high frequency of C. coli carriage in patients with antibody defects. A patient with XLA with cellulitis associated with C. coli bacteremia relapses after a disease-free interval of more than 5 years has been already described in 2004; in this patient, the pathogen isolated from the blood was considered responsible for the cellulitis, although C. coli was not directly obtained from the skin lesion.

What was unexpected in our patient with XLA was the shift from a silent infection to a life-threatening disease, a shift not caused by a change in the molecular pattern of the C. coli strain isolated from stools, skin lesion, and blood. The prolonged and relapsing nature of the life-threatening infection could not be attributed to microbial and/or host genetic factors. Thus, environmental factors should be taken in consideration. The recent description of a patient with XLA with a Campylobacter isolated from intestinal mucosal biopsies, who presented bacteremia in the absence of diarrhea and with negative stool cultures, prompted us to hypothesize in our patient a sudden break in an intestinal site; however, the colonoscopy did not show any mucosal alteration. Whatever is the underlying pathogenetic mechanism, the high prevalence of C. coli intestinal carriage in PAD suggests to introduce periodic stool cultures with high sensitive techniques and the treatment of positive symptomatic and asymptomatic patients with nonabsorbable antibiotics to prevent a rare, but possible, life-threatening infection.

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Efficacy of a Symbiotic Product During Clinical Relapse of Ulcerative Colitis

To the Editor:

The role of gut microbiota in promoting and maintaining inflammation in inflammatory bowel disease is well recognized.1 Probiotics2,3 and prebiotics4 have been employed in the treatment of ulcerative colitis with encouraging results although definitive evidence of their effectiveness in this clinical setting is still lacking.

We have tested the possible efficacy of a symbiotic preparation containing prebiotic inulin and various probiotic agents (Lactobacillus plantarum, Lactobacillus gasseri, Lactobacillus casei, Bifidobacterium infantis, Lacto- bacillus salivarius, Lactobacillus acidophilus, Streptococcus thermophilus, and Lactobacillus sporogenes) in 20 outpatients experiencing a mild-to-moderate clinical relapse of left-sided ulcerative colitis while on maintenance treatment with mesalamine 2400 mg daily.

The patients were unwilling to undergo a new course of corticosteroids because of previous side effects (decompensated diabetes, sodium retention, severe skin rash) and were seeking a different therapeutic approach.

The symbiotic preparation, at a dose of 5 g BID was added for 4 weeks to the ongoing mesalamine treatment.

Disease activity was assessed before and after treatment by means of Rachmilewitz activity index calculated on the basis of stool frequency, No funding or conflict of interest to be declared.
blood in the stools, fever, abdominal pain, erythrocyte sedimentation rate, and hemoglobin values. Only patients with an initial score of 9 or higher were considered. Remission was defined as a score lower than 5.

Forty-five percent of patients attained clinical remission. A further 15% showed clinical improvement (reduction in the score values).

Our preliminary results suggest the possible beneficial effect of a symbiotic agent when added to mesalamine in patients with a mild-to-moderate flare-up of ulcerative colitis, further confirming the pathogenetic role of enteric flora in this disorder.

Controlled studies on a larger number of patients are warranted to establish the real therapeutic value of this symbiotic agent in this clinical setting.

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To the Editor:

I commend Dr Peter Grubel for an interesting and original article about an evaluation of transabdominal ultrasonography (US) performed by a gastroenterologist in his office. In the retrospective review, the author analyzed 310 patients who underwent US by a gastroenterologist. The diagnostic accuracy of US was assessed in patients undergoing subsequent examinations by computed tomography, magnetic resonance imaging, or endoscopic retrograde cholangiopancreato-graphy. The aim of the study was to evaluate the utility of gastroenterologist-operated US in a community practice, in the light of the fact that gastroenterologists in the United States do not perform transabdominal US on their patients as a part of their daily routine. In contrast, imaging is frequently required to guide management of patients with abdominal disorders. The author concluded that gastroenterologist-operated US provided instant and accurate information relevant to the diagnosis and management of abdominal disorders.

I think that Dr Grubel’s conclusion is not surprising for many doctors who consider that US should be performed on a routine basis in clinical practice and that ultrasound should be considered “the stethoscope of the 21st century.” Several clinicians have described their experience in performing transabdominal US with good results. I am a gastroenterologist and I have been performing US in my routine practice for many years. I am sure that its usefulness for gastroenterologists/hepatologists is invaluable. My main concern should be addressed to the health authorities in countries where only radiologists are allowed to conduct US examinations.

It is very surprising that clinicians in those countries perform blind biopsy of the liver on a routine basis, but they cannot perform US examinations to visualize the pathway of the needle during biopsy in their routine practice. Certainly training is necessary, and I believe that US courses should be included in regular medical school programs. Moreover, training in US is relatively simple and is in any case mandatory for other clinicians (cardiologists and gynecologists) who are allowed to do US in their routine practice in the same countries.

I would like to encourage the discussion among experts regarding this topic and I strongly believe that preventing clinicians, such as gastroenterologists/hepatologists, from performing US is not based on scientific or clinical reasoning and it is not useful for clinical practice. Besides, what is so different between gastroenterologists/hepatologists and other clinicians (cardiologists and gynecologists)? Why are clinicians in cardiology and gynecology allowed to perform US as a part of their daily routine, and gastroenterologists/hepatologists are not? That privilege belongs to radiologists only. Why are gastroenterologists/hepatologists allowed to perform endoscopic US but not transabdominal US, although the methods are very similar in terms of interpretation? Unfortu-nately, preventing gastroenterologists/hepatologists from performing US can be encountered in countries which have a strong impact on guidelines in clinical practice worldwide, such as the USA and Great Britain.

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