- 1 Graham DY, de Boer WA, Tytgat GN. Choosing the best anti-*Helicobacter pylori* therapy: effect of antimicrobial resistance. *Am J Gastroenterol* 1996;**91**:1072-6.
- 2 Cutler AF, Havstad S, Ma CK, *et al.* Accuracy of invasive and noninvasive tests to diagnose *Helicobacter pylori*. *Gastroenterology* 1995;**109**:136-41.
- 3 Bell GD, Powell KU. *Helicobacter pylori* reinfection after apparent eradication: the Ipswich experience. *Scand J Gastroenterol* 1996;**216**:96-104.

Dermatitis herpetiformis and cigarette smoking

EDITOR,—Some time ago a study by Snook and colleagues (*Gut* 1996;**39**:60-2) found cigarette smoking to be less prevalent among those with coeliac disease. This prompted Lear and colleagues (*Gut* 1997;**40**:289) to evaluate smoking status in patients with dermatitis herpetiformis (DH), an autoimmune blistering skin disease that also presents with a gluten sensitive enteropathy. They found that 29 patients with DH were significantly less likely to be smokers than matched and unmatched controls.

As we also have a large population of patients with DH, we did a preliminary review of our existing database to evaluate smoking status in these patients. A review of over 200 patient charts with biopsy confirmed DH (granular IgA in papillary dermis) revealed smoking information on 105 patients. Fifteen of these patients were less than 20 years of age at disease onset and thus were eliminated from the study, leaving 90 evaluable patients. Of these patients eight (8.9%) were smokers, whereas 17.1% of the Utah population aged 20 years or older are smokers,¹ thus confirming the findings of Lear *et al* that patients with DH are less likely to be smokers than those in the general population.

The reasons for this finding are not fully clear. It is well known that cigarette smoking adversely affects the skin, although a few conditions have been reported where smoking may have a beneficial effect.² Likewise, when it comes to the gastrointestinal tract, smoking may have adverse effects in the case of Crohn's disease, yet beneficial effects in ulcerative colitis.³

How do we explain this apparent beneficial effect of smoking when it comes to DH? It is likely that the immunosuppressive effects of smoking play a role in this autoimmune disease, yet there are other autoimmune skin diseases, such as psoriasis, which are made worse and not better by smoking.⁴ One study found decreased serum IgA in smokers which may also play a role.⁵ Finally, the well known vasoconstrictive effects of nicotine could play a role at least in the cutaneous manifestations of DH.

As we found our DH patients more likely to be non-smokers, does this mean that if they take up the habit their DH will go away or even improve? We don't know, but it seems unlikely. We also doubt our institutional review board would ever approve a study to find out. This study was a preliminary review and does not prove that being a non-smoker is a risk factor for DH. It may be only one variable of the equation, and other likely much more important confounding factors such as genetics and other environmental factors play a greater role. Further more complete studies are needed to confirm our finding.

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- 1 Shopland DR, Hartman AM, Gibson JT, *et al.* Cigarette smoking among U.S. adults by state and region: estimates from the current population survey. *J Natl Cancer Inst* 1996;**88**:1748-58.
- 2 Smith JB, Fenske NA. Cutaneous manifestations and consequences of smoking. *J Am Acad Dermatol* 1996;**34**:717-32.
- 3 Thomas GA, Rhodes J, Green JT. Inflammatory bowel disease and smoking - a review. *Am J Gastroenterol* 1998;**93**:144-9.
- 4 Mills CM, Srivastava ED, Harvey IM, *et al.* Smoking habits in psoriasis: a case control study. *Br J Dermatol* 1992;**127**:212-17.
- 5 Ferson M, Edwards A, Lind A, *et al.* Low natural killer-cell activity and immunoglobulin levels associated with smoking in human subjects. *Int J Cancer* 1979;**23**:603-9.

Tomorrow's challenge in liver transplantation: diminishing the imbalance between donor organ availability and need

EDITOR,—It was with great interest that we read Periera and William's article (*Gut* 1998;**42**:883-5) reviewing the problem of the great imbalance between the limited number of donor livers versus the increasing need for transplantation in the UK and possible remedies to this tragic situation: strategies to increase the number of actual donations from the annual pool of potential donors. This great imbalance between allograft supply and demand is a challenging problem which confronts transplant centres everywhere. Furthermore, as medical science advances and clinical epidemiological analysis of post-transplant outcomes become clearer, we find that diseases that were previously either absolutely or relatively contraindicated for transplantation, such as chronic hepatitis B¹ and alcoholic cirrhosis,^{2,3} are now conditions potentially treatable by transplantation, further widening the differential between those in need of a transplant and number of available organs.

Clearly, as Periera and Williams point out, there is a need to increase the numerator side of the organ supply:demand ratio and use every available organ. It must be emphasised, however, that the need to reduce the denominator side of this ratio—that is, reduce the need for transplantation, is equally as great. Currently, alcoholic cirrhosis and chronic hepatitis C (HCV) infection are the two most common indications for transplantation for liver disease in British Columbia, comprising 15 and 22% of all transplants as of 1997. These proportions are comparable to other centres across Canada and the United States. When one also considers that many of those infected with HCV acquired the infection from intravenous drug misuse and that alcohol consumption is reported to be an exacerbating

factor in the progression of HCV towards cirrhosis,⁴ it is clear that primary prevention of behaviourally acquired liver disease could substantially reduce the donor supply/demand imbalance. The benefits of effective public health measures to reduce alcohol dependence, intravenous drug misuse, as well as immunisation of those at risk of hepatitis B, may not help those currently in need of a transplant but would be expected, over the next few decades, to impact favourably on pre-transplant waiting lists. The solution to today's donor shortage lies not only with those actively involved in transplantation or organ procurement but, ultimately, with all who are involved in health care.

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- 1 Yoshida EM. Hepatitis B infection and liver transplantation. *Can J Gastroenterol* 1997;**11**:462-68.
- 2 Gish RG, Lee AH, Keefe EB, *et al.* Liver transplantation for patients with alcoholism and end-stage liver disease. *Am J Gastroenterol* 1993;**88**:1337-42.
- 3 Orsorio RA, Ascher NL, Avery M, *et al.* Predicting recidivism after orthotopic liver transplantation for alcoholic liver disease. *Hepatology* 1994;**20**:105-10.
- 4 Poynard T, Bedossa P, Opolon P. Natural history of liver fibrosis progression in patients with chronic hepatitis C. *Lancet* 1997;**349**:825-32.

NOTE

Sir Francis Avery Jones BSG Research Award 1999

Applications are invited by the Education Committee of the British Society of Gastroenterology who will recommend to Council the recipient of the 1999 Award. Applications (TWENTY COPIES) should include:

- A manuscript (2 A4 pages ONLY) describing the work conducted
- A bibliography of relevant personal publications
- An outline of the proposed content of the lecture, including title
- A written statement confirming that all or a substantial part of the work has been personally conducted in the UK or Eire.

Entrants must be 40 years or less on 31 December 1998 but need not be a member of the BSG. The recipient will be required to deliver a 40 minute lecture at the Annual Meeting of the Society in March 1999. Applications (TWENTY COPIES) should be made to the Honorary Secretary, BSG, 3 St Andrews Place, London NW1 4LB, by 1 December 1998.