reasons which the authors state. I do hope that their results will not reverse this trend. It has been suggested that perhaps patients in the younger age group do not respond so well to this type of management but this has not been our experience or those of others using the same type of dilator.[2] Csendes and colleagues state that the procedure is painful but this is not something our patients have complained of when the procedure is carried out under diazepam sedation which they do not use. The main danger of pneumatic dilatation, which the authors rightly emphasise, is perforation of the oesophagus. This complication can nearly always be managed conservatively but it must be emphasised that in this gastrointestinal procedure as in many others medicosurgical collaboration is important.

Lastly, the authors emphasise the problem of individuality of the different dilatation methods and the consequent difficulty of comparing these. This observation may be correct but I do not think it should be considered an impossible task. There are enough Units carrying out the procedure for such a project to at least be considered.

A W DELLIPIANI

North Tees General Hospital,
Hardwick,
Stockton-on-Tees,
Cleveland TS19 8PE

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Reply

SIR,—We are grateful to Dr Dellipiani for his interesting comments.

The inflationary pressures that we use vary from 12 to 15 pounds per square inches (250 to 300 mmHg metric) which we believe are high pressures.

We have not used diazepam sedation because the pain that is usually seen with pneumatic dilatation, could be masked. We always perform radiological control of dilatation, however, and could therefore use diazepam.

Cooperative randomised studies are needed, but it will not be an easy task.

ATTILA CSENDES

Hospital Clinico
'Jose Joaquin Aguirre',
Santiago, Chile

Mediators of vasopressin induced natriuresis in cirrhosis – possible role of atrial natriuretic factor

SIR,—Lenz *et al* (*Gut* 1989; **30:** 90–6) recently reported increased natriuresis and diuresis in patients with cirrhosis and ascites after vasopressin infusion. The authors suggested suppression of sympathetic nervous system activity as an important mediator of the beneficial effects of vasopressin. Neither this nor other mechanisms discussed, however, could satisfactorily explain the observed improvement of renal function.

For further elucidation of the interesting results reported by Lenz *et al*, investigation of the atrial natriuretic factor (ANF) might be helpful. The role of this first well defined natriuretic hormone in volume retention of cirrhosis is being controversely discussed,[1] with some authors reporting a relative deficiency of ANF plasma concentrations or impairment of ANF release in patients with cirrhosis and ascites.[2] In rats, infusion of vasopressin has been shown to increase ANF plasma concentrations[3] and ANF-induced natriuresis was found potentiated by vasopressin administration.[4] Observations of an inhibition of vasopressin release by ANF[5,6] lend further support to the contention that both hormonal systems are closely related. Thus, determination of ANF plasma concentrations might reveal ANF as a mediator of the vasopressin induced natriuresis in patients with cirrhosis and ascites.

ALEXANDER L GERBES

Department of Medicine II,
Klinikum Grosshadern,
University of Munich,
Munich, Federal Republic of Germany

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pressin concentration in human subjects. *Clin Endocrinol* 1986; **25:** 181–7.

Reply

SIR,—We appreciate the helpful and very positive comments made by Dr Gerbes. Indeed there is evidence from animal models, that both ANF and vasopressin influence the action or level of activity of the other and interact at the level of the kidney.[1] Although vasopressin itself, in pharmacological doses, is a potent diuretic that most likely exerts this effect by directly inhibiting sodium reabsorption at a point in the nephron distal to the proximal tube.[2] Furthermore it has been shown, that vasopressin analogues may stimulate ANF secretion in cirrhotic patients[4] and infusion ANF has a natriuretic effect at least in some cirrhotic patients.[3] Therefore ornipressin induced stimulation of ANF secretion and enhancement of ANF action at the level of the kidney could be an important factor of natriuresis in our patients.

K LENZ

I Med Univ Klinik, Lazaretlg. 14,
A1090 Wien,
Austria

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News

Lady Sobell Gastrointestinal Unit

The official opening on 5th June 1989 by H R H Princess Alexandra of the new Lady Sobell Gastrointestinal Unit at Wexham Park Hospital, Slough marked the successful culmination of a major fund raising campaign, which raised £1·5 million in three years, to build, equip and endow a single storey, 320 m^2 building comprising an endoscopy suite of two rooms, one with a full *x*-ray unit, recovery and waiting areas, seminar room, two research laboratories, four offices and appropriate ancillary accommodation. The new unit, headed by Dr P I Reed, will allow development of a fully integrated gastrointestinal service to serve a large health district and expand research activities.

Sir Francis Avery Jones BSG Research Award 1990

A three page summary of personal research work is invited by the Education Committee of the British Society of Gastroenterology who will recommend to Council the recipient of the 1990 Award. A bibliography may also be submitted if desired. The Award consists of a medal and £100 prize. Entrants must be 40 years or less on 31 December 1990 but need not be a member of the BSG. All (or a substantial part) of the work must have been performed in the UK or Eire. The recipient will be required to deliver a 40 minute lecture at the Plenary Session of the Spring meeting of the Society at the University of Warwick in 1990. Applications (15 COPIES) should be made to: The Honorary Secretary, BSG, 3 St Andrew's Place, Regent's Park, London, NW1 4LB, BY 1 DECEMBER 1989.

Future BSG Meetings

1989: Autumn—Dublin (27–29 September); 1990: Spring—Warwick (28–30 March); Autumn—Southampton (26–28 September); 1991: Spring—UMIST (Manchester) (10–12 April); Autumn—London (25–27 September); 1992: Spring—Sheffield (25–27 March); Autumn—Warwick (9–11 September); 1993: Spring—Scottish Exhibition Centre (24–26 March); Autumn—Warwick (15–17 September); 1994: Spring—UMIST (23–25 March); Autumn—York (21–23 September–provisional)