Etiology of chronic diarrhea

To the Editor

I have read with interest, the paper entitled "Etiology of chronic diarrhea" by Dr. Sabeha Al-Bayatti,[1] and the criticizing letter of Dr. Hazim Bernouti upon the paper.[2] In spite of the fact that the author declined to reply to Dr. Hazim's comments, I may take the chance to reply and add some few comments upon the paper. I agree that having 28% of the cases of chronic diarrhea due to ulcerative colitis, sounds odd, especially in a country with a lot of infective diseases such as Iraq (many of which are flourishing globally as well [tuberculosis! not to mention TB enteritis]), but a percentage is known to be as well one of the most serious double-bladed tools in statistics (in which the paper is already very poor). Twenty-eight percent means 14 cases only, out of 50 cases, which are pooled from the outpatient department and hence are not representative of chronic diarrhea in the population at large. Likewise, most patients with amebiasis (acute) and giardiasis (chronic) are treated as out patients, while patients with ulcerative colitis may become obliged to be admitted. The author of the paper has missed this fact, as the paper is already poorly structured. Starting by the title, probably it should have been "Etiologies of chronic diarrhea in a sample of medical inpatients in Yarmouk Teaching Hospital in Baghdad, Iraq". As such, the author will not give an impression that she is talking about the population at large.

The author did not mention the bases on which the patients were sampled, and to how extent is this sample representative of the chronic diarrhea cases at large. And it must be stated that more than 90% of cases of acute diarrhea are caused by infectious agents,[3] and in contrast to acute diarrhea, most of the many causes of chronic diarrhea are non-infectious.[3]

Likewise, the paper has no objectives to talk about in a structured form, and there is a lot of mixture between results and discussion. There were no conclusions, nor mention of statistical analysis of the data presented in the paper. The author should not be dogmatic in defining diarrhea, as the definition of having stool weight more than 200gm/day is also true, provided the patient is on western diet.[3,4] Diarrhea could be defined for epidemiologic purposes, in terms of stool frequency, or stool weight depending on the locality in which the study is conducted. Regarding microscopic colitis, in association with clinical features suggestive of colitis, the sole histologic finding of collagenous or lymphocytic colitis, may be a temporary phenomena, resolving with prednisolone or salazopysin[4] and hence may not progress to chronicity. And hence a second biopsy is necessary after a drug free period to document persistence or disappearance of histologic findings of microscopic colitis. Also, the post acute colitis syndrome, which occurs after acute infective colitis episode, may last for several weeks to months after the acute attack. It gradually resolves, but it could be clinically mistaken for chronic diarrhea. It may utilize a lot of resources, but in vain.

Surveying the tables, it is not known why the age range 0-9 years was listed in Table 3, while no patients were examined in this range, and it is not clear as well, how could the non specific tests of hemoglobin percentage, white blood cells, erythrocyte sedimentation rate, be very helpful in the definitive diagnosis of chronic diarrhea etiology. The same also stands for ultra sonography. The categorization of the tests usefulness as +, ++, +++, should have been replaced by statistical analysis to show the sensitivity and specificity of each test towards the diagnosis of etiologies of chronic diarrhea. These statistical terms should replace the term (usefulness), which carries no solid base at all. The author did not mention, which part of the bowel was affected by Grohn's disease (in the single case) and there is a clear mix up between diabetic and thyrotoxic diarrhea (last paragraph of the discussion). The inability of the author to reach to the third part of the duodenum is criticized, as far she is using a one-meter length gastro-duodenoscope (an enteroscope is not necessary in this situation). Duodenal aspirate analysis, which is a simple test, could have helped in the diagnosis of giardiasis, and duodenal biopsy to diagnose intestinal lymphoma or sprue. Crosby capsule could have helped solving the problem of biopsying the jejunum (although third part duodenal biopsy is as representative as jejunal biopsy). She could have biopsied the terminal ileum through the colonoscope as well. Referencing was not following the Vancouver Style strictly, and the last 2 references (13-14) were not utilized by the text. Further, minute details are available on request.

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Reply from the Author

Author declined to reply.

References

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3. Ahlquist DA, Camilleri M. Diarrhea and constipation. In: Braunwald E et al. Harrison's Principles of Internal Medicine, 15th ed. New York (NY): McGraw Hill; 2001. p. 242
4. Beers MH, Berkow R, Bogu RM, Fletcher AJ. Diarrhea and constipation. The Merek Manual of diagnosis and therapy. 17th ed. Westpoint (PA): Merck Research Lab NJ; 1999. p. 275.