Personal Therapeutics

Duodenal ulcers

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Since long before the time of Lord Moynihan, duodenal ulcer management has been empirical; medical "treatment" regimens of varying complexity may have brought some comfort to patients, and, while surgery could produce cure, the selection of patients was arbitrary and the results variable. Successive drugs have appeared promising in theory, and sometimes in trials, but few have made much impact on overall outcome. The latest drug, cimetidine (Tagamet) (and there are undoubtedly other H_2 histamine antagonists to come), has a powerful physiological effect, and there were hopes that it might introduce a therapeutic revolution. Though 18 months' experience is too short to make a final judgment, so far the drug has produced changes in detail rather than on a large scale.

Aims in management

It is easy to be muddled about one's aims in treating patients with duodenal ulcer. Potential targets are:

- (1) treatment of the three complications (haemorrhage, perforation, and stenosis);
- (2) prevention of complications;
- (3) relief of symptoms;
- (4) prevention of symptoms.

Confusion arises if it is thought that treatment appropriate for one target is necessarily effective for another, or that all four have to be tackled in every patient.

TREATMENT OF COMPLICATIONS

Surgical treatment of stenosis and perforation is successful and relatively safe, given a patient who is not hopelessly unfit. I see no virtue in alternative approaches. Haemorrhage, on the other hand, is still often mismanaged; the essence lies in blood transfusion, which must be *early* and *adequate*. I am convinced of the advantages of early upper gastrointestinal endoscopy, which shows the cause of bleeding in 90% of cases, and may give direct evidence of continuing haemorrhage. Cimetidine has shown no sign of arresting haemorrhage or preventing a recurrence in trials so far, and I do not use it. (Moreover, I see no point in giving cimetidine to a patient whose ulcer has stopped bleeding, and who has no other symptoms from it).

Generally, surgery is best for continuing bleeding or a recurrence, though I hold back quite often in the elderly or unfit who will obviously have a difficult time postoperatively; bleeding

often stops, but I look forward to the day when endoscopic laser photocoagulation of bleeding points becomes available.

PREVENTION OF COMPLICATIONS

Curing a duodenal ulcer (with surgery or, possibly, with long-term cimetidine) will prevent complications. These are so uncommon and unpredictable, however, that I would recommend such prophylactic treatment only in seafarers, deep-sea divers, and others who would be at serious hazard if one occurred. Reasonably enough, men are not allowed to sail off-shore if known to have a duodenal ulcer, and even if their symptoms are few I recommend proximal gastric vagotomy.

RELIEF OF SYMPTOMS

Medicine has traditionally been used to relieve symptoms. When a flare-up of pain (and maybe vomiting) occurs, medical measures are directed to diminishing their severity and duration. Until 18 months ago I advised a dose of antacid (such as magnesium trisilicate mixture, *BNF*, or aluminium hydroxide gel, *BNF*, according to the state of the bowels) *every hour* for three to four days at the first hint of pain, reducing to two or three-hourly doses on succeeding days. (An equivalent antacid in tablet form is easier to carry around.) Sometimes a few days in bed helped a severe bout of pain.

Cimetidine has altered this approach, but not completely. Bad pain will almost always respond to cimetidine 200 mg thrice daily *with* meals and 400 mg at bedtime. Once started, it may be best to continue for six weeks to heal the ulcer. What then? There is no sound statistical evidence of "rebound," but some patients may get severe pain soon after stopping the drug. If they do I usually give them another month on full dosage, and then a further month on 400 mg at night only.

Not all exacerbations need cimetidine, however. Many patients respond well to the simple antacid regimen indicated above, and it is economical and safe to let them try it first. After all, a painful ulcer exacerbation is uncomfortable but it's not medically dangerous.

PREVENTION OF SYMPTOMS

Every patient's duodenal ulcer has its own, largely unpredictable, cyclical nature. An exacerbation cannot be anticipated, and the only preventive measures used to be contained in the conventional cautionary advice about pure and virtuous living: regular meals, moderation in drinking, and no smoking. If flare-ups are mild and infrequent then there is no problem. A full bottle of antacid always ready in the bathroom cabinet will settle most trouble, an occasional course of cimetidine the rest.

Several trials have shown that, taken continuously in various

doses, cimetidine has a good chance of preventing relapse. Yet I am using it long term in only a few patients who are unfit for surgery. This conservatism is born of caution combined with economy. The financial cost of continuous cimetidine, even just 400 mg at night, is high (£102.20 a year currently); and, while it has no consistent, recognised ill-effects on health, we cannot tell what may emerge as time goes on.

If troublesome episodes of pain are occurring several times a year, especially if they are disturbing a patient's life or work, then I advise surgical treatment (some form of vagotomy). Ninety per cent will do well. The 10% who don't are a problem, and may need more surgery, but there are not many of them, and most finish up fairly satisfied.

Drugs I do not use

MIMS lists nearly 90 preparations that could be used to treat patients with duodenal ulceration. Some doctors, and some patients, seem to like one or more of these that I have not mentioned. Nevertheless, the evidence that they are superior is small. Anticholinergics (often wrongly termed "antispasmodics")

have only marginal benefits, even in near-poisonous dosage, and in the tiny amounts contained in most standard preparations they can have no value. The various liquorice preparations and also De-nol have been shown, at different times, to be superior to standard antacid regimens, but the margin is not overwhelming, and I find no place for a preparation mid-way in effectiveness between antacids and cimetidine.

Conclusion

The duodenal ulcer scene is changing quite quickly and so, therefore, are every doctor's views. What I have written is like a single-frame of a cine film of my personal practice. One friend of mine has not referred a patient for ulcer surgery for 18 months as he believes in long-term cimetidine. Other colleagues find success with De-nol, carbenoxolone sodium (Duogastrone), etc. On the horizon are other sorts of drugs—pepsin-inhibitors, mucus-changers, and bile-binders. It is exciting and promising; but, remember, developing these drugs is expensive, so that once they are marketed the sales drive is necessarily forcible. Caution has very rarely hurt a patient.

MATERIA NON MEDICA

Waterskiing in Corfu

Waterskiing, to the uninitiated, is hilariously difficult. The four of us on holiday in Corfu were determined to master it. We duly reported one morning to the waterski school.

Theodore, our instructor, was a supercool cowboy with skin the colour of an old wallet and muscles to match. First he demonstrated his skill to the assorted sunbathers on the beach. His denim cap at a jaunty angle, he zoomed round the bay, jumping up and down, backwards, with one ski in the air. It looked as easy as falling off a log.

You start waterskiing crouched in the water. The problem is to stand up gradually as the boat accelerates away without falling over. Graham was first. His efforts to stand resembled Bambi on the ice. In no time at all the ungainly creature had crashed back into the water in a flurry of arms and legs. Laughter rippled round the beach. Cameras were unloaded from bags for the second attempt.

This time, he slewed sideways on take-off and was dragged unceremoniously through the water on his head. In fact for most of his 20-minute lesson, the poor unfortunate was either teetering precariously on his haunches or sprawling in the drink. My first attempts were equally inauspicious. "Why you bend your arms?" screamed our instructor as I surfaced groggily from the depths. There was no answer to that. Having learnt from my friend's mistakes, I managed to get up after four bungled efforts.

Barbara, to our chagrin, proved a natural, and after only one fall (flat on her face) was sailing round the bay in fine style. Janet, on the other hand, initially had little more success than Graham. Theodore lost his cool and began haranguing her about the effects these failures would be having on his reputation as a teacher. Provoked by this outburst, she arose like Venus from the waves.

Finally, determined not to be outdone, Graham came back for a second lesson. The crowd held its breath as he crouched in the water, ready for take off. Marvellously, he stood up like an expert and sped away. There was a heartfelt ovation from the beach.

"A great morning's entertainment," quipped one spectator, wiping the tears from his eyes. We could not have agreed with him more.—J H JESSOP (anatomy demonstrator, London).

Basic English

Philip Howard's welcome in *The Times* (26 June) to Longman's *Dictionary of Contemporary English* marked the demise of Basic English, of which C K Ogden was the "onlie begetter." His basic vocabulary had 850 words and the Longman dictionary has 2000, with a system of coding for syntax and with British and American pronunciations side by side—over 100 000 of them. Perhaps Basic English would have survived if Ogden had accepted phonetics and not rejected the residue of Bernard Shaw's estate. GBS wrote in 1944 that "Basic English can hardly become a universal language without

a phonetic script." Shaw's words were to be spoken and instantly comprehended ("by Jove, she's got it") while Ogden's words were to be read and pondered.

Ogden was an attractive and eccentric Cambridge polymath whose life and personality have been recently recalled in *A Collective Memoir* edited by his friend Professor Sargent Florence and J R L Anderson. Readers of the 1920s will remember a famous book called *The Meaning of Meaning*, which Ogden wrote with I A Richards, and even the very young may not have forgotten that Winston Churchill caused the Atlantic Charter to be printed in both Standard and Basic English. It is sad that a good word invented by Ogden—orthology—"the art of using words rightly," is not to be found in the *Concise Oxford Dictionary* or in the new Longman's dictionary.

Lawrence Durrell (*The Times*, 26 September), who before the war taught Basic English in Athens for the British Council, is determined to bring life to its dead bones. During the winter he is to publish a Basic English grammar and teacher, but he has made no promise to rewrite a chapter of *The Alexandria Quartet* within a limit of 850 words.—DOUGLAS HUBBLE (Newbury, Berkshire).

Uniqueness of Mann

Prolonged survival after removal of a bronchial carcinoma is rare enough, but intense creativity must be almost unique. In the middle of writing one of his best books, *Doctor Faustus*, Thomas Mann's health deteriorated and he was persuaded to consult his brother Heinrich's doctor. He was almost 71. Symptoms persisted and he was admitted to Billings Hospital, Chicago, in April 1946, where, in the words of Nigel Hamilton, author of *The Brothers Mann*, "the noted pneumonologist Dr William Elias Adams" carried out a bronchoscopy which showed a carcinoma. This was successfully removed, and two days after his discharge from hospital Mann was back at work on his book. "Just as the operation had proceeded classically and uneventfully in the clinical sense, so the convalescence progressed steadily and without complications. A man of 30, the doctors assured me, could not have responded better," he wrote later.

In the next few years he finished *Doctor Faustus* and *The Genesis of a Novel* and visited Germany for the first time since his exile, to receive the Goethe prize and to give a number of lectures. He travelled extensively in Europe and Scandinavia in 1950, and the following year decided to settle in Switzerland because of the wounding accusations made by the Committee on Un-American Activities. Meanwhile he had finished *The Holy Sinner*, had taken up the delightful *Confessions of Felix Krull* after a lapse of forty years, and was subsequently to write *The Black Swan*. He was still travelling to give lectures and receive honours. In 1955 he was preparing for the celebration of the 150th anniversary of Schiller's death when he developed a thrombosis in the leg, which rapidly became gangrenous. He died two months after his 80th birthday.—ALEX PATON (physician, Birmingham).