nine of these were said to have been deliberate. Four of these assaults involved bottles.

These results suggest that tempered glasses may be preferable to annealed glasses. Even so, several safety problems were also reported in relation to tempered glasses. There is probably no such thing as a safe glass. Public bars are a commonplace forum for intoxication, aggression, and related injuries and assaults. Indeed, the design and operation of such premises may influence levels of aggression and intoxication.⁴ Evidence on the merits of tempered glasses is not definitive. More research is required to produce a clear picture of the role of glasses, bottles, and other artefacts in bar injuries. It is particularly important to ascertain whether the introduction of tempered glasses into bars leads to a fall in injuries or simply to the adoption of other forms of weapon.

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- 1 Shepherd J. Preventing injuries from bar glasses. *BMJ* 1994;308:932-3. (9 April.)
- 2 Scottish Council on Crime. *Crime and the prevention of crime*. Edinburgh: Scottish Home and Health Department, 1975.
- 3 Mayhew P, Aye Maung N, Mirrless-Black C. *The 1992 British crime survey*. London: Home Office, 1992.
- 4 Single E, Storm T, eds. *Public drinking and public policy*. Toronto: Addiction Research Foundation, 1984.

Long term acid suppressing treatment

Survey shows variation in practice

EDITOR,—Stephen D Ryder and colleagues noted the lack of data on the long term use of acid suppressing drugs in general practice.¹ A recent survey of prescribing in five Ipswich general practices (36 000 patients) over a year addressed this issue. In all, 284 (0.78% of the population) patients had been receiving acid suppressing drugs for six months or more; 590 patients (1.64%) had received at least one prescription.

The most common reason for long term treatment was oesophageal disease (94 patients). Duodenal ulcers and "dyspepsia" (patients lacking a definitive diagnosis) accounted for 66 patients each. Gastric ulcer was uncommon, as in Harlow, occurring in 22 patients.

Although the percentages of the total population in Harlow and Ipswich maintained on these drugs are similar (0.82% and 0.78%), there are interesting differences when the reasons for treatment are examined. There was a greater tendency to use long term acid suppression for oesophageal symptoms in Ipswich (33%) than in Harlow (24%). Duodenal ulcer disease was proved in 23% of cases in Ipswich compared with 37% of cases in Harlow, where it was the most common reason for this treatment. The combined percentages of undiagnosed abdominal pains (dyspepsia) and duodenal ulcer disease in each group were close, 46% in Ipswich and 52% in Harlow.

The introduction of treatment protocols for the management of dyspeptic patients can reduce the size of this group. However, provision must be made for any consequent increased demands on endoscopy and radiology services. Partly for this reason we focused on assessing the impact of triple therapy (omeprazole 40 mg daily plus amoxicillin 500 mg three times a day and metronidazole 400 mg three times a day for two weeks) on those

patients known to have had duodenal or gastric ulceration. Rates for eradication of *Helicobacter pylori* of approximately 90% have been obtained with this regimen.²

In 26 of these patients who agreed to take triple therapy the ¹⁴C-urea breath test was used to confirm initial presence and final eradication of *H. pylori* after six weeks. Nineteen patients had been positive for *H. pylori*; 18 of these had *H. pylori* eradicated and their prescription stopped. This is a highly cost effective way to reduce drug use.

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- 1 Ryder SD, O'Reilly S, Miller R, Ross J, Jacyna MJ, Levi AJ. Long term acid suppressing treatment in general practice. *BMJ* 1994;308:827-30. (26 March.)
- 2 Bell GD, Powell KU, Burridge SM, Bowden AN, Ramech B, Bolton G. *Helicobacter pylori* eradication: efficacy and side effects profile of a combination of omeprazole, amoxicillin and metronidazole compared with four alternative regimes. *Q J Med* 1993;86:743-50.

Frequency of long term treatment underestimated

EDITOR,—I question the selection criteria that Stephen D Ryder and colleagues used in their study of long term acid suppressing treatment in general practice.¹ Why look only at patients who had received continuous treatment for six months? Why not look at all those receiving repeat prescriptions? I believe that the criteria bias the results towards duodenal ulcer disease and away from oesophageal disease and abdominal pain; also they grossly underestimate the total number of patients receiving long term treatment.

From an audit of 323 patients receiving repeat prescriptions for ulcer healing drugs (practice list 15 004) colleagues and I found that 285 had been receiving treatment for three months or more, 296 had had a prescription in the preceding four months, and 275 had been receiving treatment for more than one year. I suggest that this is an easier and more accurate measure of the extent of long term acid suppressing treatment. The indications for treatment were duodenal or gastric ulcer (98 patients), oesophageal disease (108), abdominal pain (90), non-steroidal anti-inflammatory drugs (27), so that oesophageal disease was marginally the commonest indication for treatment. Diagnosis was not always easy as many people had more than one problem—for example, duodenal ulcer and oesophageal reflux.

We found that 2% of our practice were receiving long term treatment; this is double the figure in Ryder and colleagues' paper and agrees with the study quoted from general practice. Altogether 189 patients were taking ranitidine, 88 cimetidine, 44 omeprazole; prescriptions for omeprazole are increasing rapidly, and we noted that once treatment was started the patients tended to demand repeat prescriptions.

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Low frequency hums

EDITOR,—C G Rice's editorial on annoyance due to low frequency hums prompts us to comment on two points: firstly, the assertion that, apart from the provision of a course of "rehabilitation," little can be done to alleviate tinnitus, and, secondly, the myth that tinnitus is "fortunately not life threatening."¹

Methods of treatment apart from counselling (medical, lay, and psychological) include relaxation training, biofeedback, cognitive therapy, hypnotherapy, manipulation of diet, hypnosis, ultrasound, tinnitus masking devices (environmental or wearable), and the provision and fitting of a suitable hearing aid. Treatment with tranquilisers, antidepressants, and sedatives may be used to reduce the effects of tinnitus or to reduce the tinnitus itself.²

In otorhinolaryngological practice a considerable degree of morbidity and occasionally death are known to be associated with tinnitus. Recently Lewis *et al* elucidated the psychiatric morbidity afflicting 28 people with tinnitus who had committed suicide; from March 1990 to April 1991 four people with tinnitus attending the Welsh Hearing Institute committed suicide.³

It is not good enough to perpetuate myths by telling people with tinnitus that little can be done to alleviate the symptom and that they have to live with it.

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- 1 Rice CG. Annoyance due to low frequency hums. *BMJ* 1994;308:355-6. (5 February.)
- 2 Coles RRA. Tinnitus and its management. In: Stephens D, ed. *Scott Brown's otolaryngology*. 5th ed. Vol 2. London: Butterworth, 1987:368-409.
- 3 Lewis JE, Stephens SDG, McKenna L. Tinnitus and suicide. *Clin Otolaryngol* 1994;19:50-4.

Charcot's links with Britain

Remember Charcot's contribution to rheumatology

EDITOR,—As a Frenchman, I was delighted to read the article by Raymond Hierons commemorating the 100th anniversary of the death of Jean-Martin Charcot.¹ Yet, as a rheumatologist, I was surprised that a large piece of Charcot's work was not mentioned. His medical thesis was devoted to rheumatoid arthritis, and in his famous book *Leçons Cliniques sur les Maladies des Vieillards* he is credited with the first description of both rheumatoid pericarditis and hand deformations. The latter is still quoted in recent rheumatology textbooks.

As Charcot's links with Britain are the focus of Hieron's article, it is interesting to recall that the classic textbook by Garrod on gout was translated into French under Charcot's supervision.² In this book Charcot added many notes and illustrations that are also frequently quoted.

His bitter feud with Léon Daudet has at least two causes. The more important is probably their ideologically and politically opposed views. Charcot was a republican, a materialist, and not religious whereas Daudet was a right wing royalist.

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- 1 Hierons R. Charcot and his visits to Britain. *BMJ* 1993;307:1589-91. (18-25 December.)
- 2 Garrod AB. *La goutte: se nature, son traitement et le rhumatisme goutteux* [translated by A Ollivier, annotated by J-M Charcot]. Paris: Adrien Delahaye, 1867.