has been shown unequivocally in the treatment of bleeding peptic ulcer.¹

One of the important reasons given for lack of efficacy of conventional medical regimens in the control of bleeding from peptic ulcer is their inability to adequately control intragastric acidity by failing to maintain sustained intragastric achlorhydria,² which has been shown experimentally to be essential for stabilisation of clot.⁴ Peterson and Richardson¹⁰ have shown that sustained achlorhydria can be achieved only with hourly intravenous bolus injections of cimetidine (100 mg) with continuous nasogastric infusion of an antacid at the rate of 0.5 ml/min and not with conventional doses of H₂ receptor antagonists with or without antacids. In a preliminary prospective randomised study in patients with bleeding peptic ulcer using the above regimen we have recently shown that not only could achlorhydria be maintained but also a higher rate of control of bleeding than that obtained with the standard regimen could be achieved.¹¹ Furthermore, using such a regimen for all subsequent patients with bleeding peptic ulcer we achieved an overall control of bleeding in 75.4% of patients compared with 56.7% in the historical controls.¹²

We believe that there is increasing evidence that a relation exists between intragastric acidity, clot formation and peptic ulcer bleeding.¹¹⁻¹³ Surprisingly, however, there has been no large study of patients with bleeding peptic ulcer treated with an intensive medical regimen¹, aimed at complete neutralisation of acid and pepsin with the intent of preventing clot dissolution and rebleeding. Since such a regimen is inexpensive, easily available, and safe, we think there is an impending need for evaluating its efficacy in a large number of patients presenting with bleeding peptic ulcer.

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But was the procedure really necessary?

SIR,—Lee and Berhenne report 46 patients rendered stone and fragment free with cholecystolithotripsy (*Gut* 1991; 32: 536-8). Seven patients developed recurrent calculi yet six remained asymptomatic. Of the 39 gall stone free patients, 26 were asymptomatic and six complained of persistent abdominal pain similar to that before treatment. Seven other patients rendered pain free still complained of various abdominal symptoms including bloating, cramps, indigestion, nausea, and dyspepsia.

After reading this article, I am suspicious that the symptoms suffered by many of these patients had nothing to do with the gall stones. The fact that some had apparently improved after cholecystolithotripsy does not establish that the procedure should have been done in the first place. Improvement could have been due to the powerful placebo response of the cholecystolithotripsy.

Before evaluating this study we need to know the indications for cholecystolithotripsy. Some of the patients had persistent abdominal pain similar to that before treatment. This raises the important question: Were the symptoms which permitted entry into this trial due to the gall stones? Persistent right upper quadrant abdominal pain commonly occurs in the absence of gall stones and may be due to a functional disorder of the upper gastrointestinal tract.¹ Furthermore, several studies have clearly shown that the prevalence of dyspepsia is similar in those who have and do not have gall stones.²⁻⁴

It seems unlikely that cholecystitis (is there such a thing as chronic cholecystitis?) was an indication for lithotripsy since such patients are quite ill and usually require surgery fairly urgently. Their gall bladders would be unlikely to contract. We are not told that any of the patients were jaundiced or had pancreatitis, so the only remaining indication for removal of the gall stones would be biliary colic. It is possible, of course, that all the patients reported on had typical biliary colic, but this is not stated in the article.

Health ministries, third party payers, and increasingly the public are questioning the introduction of expensive new technology without proper validation. In this study cholecystolithotripsy seems to have taken place on some patients without indications for gall stone removal. Claims for the improvement of symptoms other than biliary colic are not substantiated by a double blind trial and go against experience.²⁻⁴ If, indeed, there were valid indications for lithotripsy in the patients reported, then the authors should have made these indications explicit in the article. If not, one wonders if the patients would have been better off with no treatment at all.

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Reply

SIR,—Dr Thompson wants to know the indications for cholecystolithotripsy and questions if the symptoms in our patients were indeed due to gall stones. Our multidisciplinary team agrees with Dr Thompson that right upper quadrant pain occurs in the absence of gall stones. This is further substantiated by the fact that up to 50% of patients have persistence of symptoms after cholecystectomy. We gave nine references in our discussion concerning this point. Our results of lithotripsy therefore compare favourably with cholecystectomy.

We are not aware of any institution using gall stone lithotripsy where the protocol does not require the presence of gall stone colic for entry to the study. We would like to assure Dr Thompson that in our institution in the lithotripsy clinic gastroenterologists and surgeons refer patients for treatment only if gall stone pain is present and if these patients would otherwise have been considered for cholecystectomy. All 220 patients entered into our study were diagnosed as having gall stone pain. We therefore disagree with Dr Thompson that cholecystolithotripsy has taken place in our institution without indication. Our team has decided that patients with so called 'gall bladder dyspepsia' should not be accepted for lithotripsy. One of our previous publications (reference 13 in our article) is more explicit in the acceptance protocol, stating that 'evidence of pain due to the presence of gallstones' is required.

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BOOK REVIEWS

Gastrointestinal symptoms: clinical interpretation. Edited by J Edward Berk and Walter Haubrich. (Pp 271; illustrated; £28.00.) Wolfe Medical Publishing, London, 1991.

The modern medical curriculum lays increasing emphasis on 'communication skills.' When I first encountered this jargon, I thought it had something to do with computers, but was reassured to find that it simply means the ability to talk to people. Either as a consequence of this educational initiative, or of the 'holistic' philosophy behind it, medical students seem to be better at history taking. This should be good news for gastroenterology in which, more than in any other branch of internal medicine (if only because the physical signs of disease are so often vague or absent), the aphorism, 'listen to the patient—he will tell you the diagnosis' holds true. But it isn't, because the modern science of gastroenterotechnology attracts the gadget minded and the would be surgeon and repels