pared with non-NSAID ulcers? The results of our study seem to indicate that this aspect of clinical trials would have to be addressed in future publications on ulcer treatment.

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Reply

SIR,—Bank *et al* report healing rates for NSAID associated gastric and duodenal ulcers while taking a histamine receptor antagonist (HRA) after stopping NSAID treatment strictly comparable to those published recently on behalf of a United Kingdom multicentre study group. It seems probable from their comparative studies that an H₂RA heals NSAID associated ulcers even more readily than non-NSAID associated ulcers providing the NSAID is stopped. A similar comparison cannot be made from our study because all patients were taking NSAIDs at the time of referral. Bank *et al* ask whether NSAID associated ulcers heal successfully with placebo treatment if the NSAID is stopped. Neither their or our study answers this question. With respect to gastric ulcer, however, Loludice *et al*¹ found that with antacid alone only 25% of patients healed within six weeks despite having stopped NSAIDs compared with 66% with antacids plus cimetidine.

Bianchi Porro and Pace² also showed that severe gastric lesions after NSAID withdrawal healed within four weeks in 50% of patients on placebo compared with 83% on ranitidine. By contrast, of those who continued with NSAIDs and took placebo, only 25% had healed lesions. Comparable information about the behaviour of NSAID associated duodenal ulcer seems not to be available.

The better performance of HRA maintenance treatment in NSAID associated duodenal ulcer compared with non-NSAID associated ulcer reported by Bank *et al* agrees with the findings of Penston and Wormsley.³ Nevertheless, responsiveness to maintenance treatment seems not to be accompanied by a low natural relapse rate because seven of 14 patients in Penston and Wormsley's study had recurrent ulceration despite discontinuing NSAIDs when maintenance was omitted.

It is clear that future studies should take into account these apparent differences between the natural history of NSAID associated and 'idiopathic' ulcers, but retrospective analysis of past work is likely to be of limited value as most ulcer healing and maintenance studies have specifically excluded patients on NSAID treatment.

Peptic ulcer remains a multifactorial disease but despite these studies show that in the great majority of cases, regardless of aetiology, control is achievable with HRA treatment.

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Case of watermelon stomach successfully treated by heat probe electrocoagulation

SIR,—We read with interest the report by Tsai *et al* (*Gut* 1991; 32: 93-4) of a patient whose gastric antral vascular ectasia was treated by laser photocoagulation. We have a similar case of a 77 year old woman to whom we applied heat probe electrocoagulation (Olympus Heat Probe Unit) with an equally satisfactory result.

The patient had a long history of iron deficiency anaemia, thought to be due to severe antral gastritis, which despite continuous oral and intravenous administration of iron was not under control. Several transfusions (at a rate of 1.4 units of blood per month) had been required since the beginning of 1990. In July when she collapsed with a haemoglobin concentration of 54 g/l, a diagnosis of 'watermelon stomach' was made endoscopically and confirmed histologically. There was no evidence of liver disease or portal hypertension. Two sessions of heat probe treatment were carried out applying 100 deliveries of 10 joules each. Subsequently there has been no need for further transfusion and the patient's haemoglobin remains above 100 g/l. However, there has been no change in the endoscopic picture.

Our patient had a history of coronary heart disease which is suggested¹ as a predisposing factor (as are liver cirrhosis and portal hypertension) to the formation of mucosal vascular malformations. Bipolar² and heat probe³ electrocoagulation have been reported to be as effective as the more expensive laser photocoagulation for treatment of gastric antral vascular ectasia, and our experience confirms this.

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- 1 Rutgeerts P, Van Gompel F, Geboes K, Vantrapen G, Broeckaert L, Coremans G. Long term results of treatment of vascular malformations of the gastrointestinal tract by Neodymium Yag laser photocoagulation. *Gut* 1985; 25: 586-93.
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Reply

SIR,—I read the letter of Kamberoglou *et al* with interest. Their patient had many features similar to the case we reported, with similar pretreatment transfusion requirements and earlier misdiagnosis. Heat probe thermocoagulation has been used successfully in treatment of bleeding duodenal ulcers¹ and also has the advantage of being cost effective compared with the Nd:YAG laser photo-

coagulation. I am, however, a little concerned over its use in the control of bleeding in the watermelon stomach. Collateral thermal damage to gastric mucosa is likely to be greater. It would be of little consequence if the vascular ectasia occupied only a small area of the antrum. However, the vascular lesions may be extensive.² The safety aspect of thermocoagulation of large areas of the stomach with a heat probe has not been addressed. The authors also admit that there was no visible resolution of the lesions endoscopically. In the laser treated patient, however, the endoscopic appearances improved, suggesting regression of the vascular abnormality which may have some bearing on rates of recurrence of bleeding in treated patients.

While heat probe thermocoagulation represents a cheap and attractive treatment for the smaller lesions of watermelon stomach, I think that treatment of the more extensive lesions is likely to be better with laser photocoagulation.

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NOTES

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Applications are invited by the Education Committee of the British Society of Gastroenterology, who will recommend to Council the recipient of the 1992 award. Applications should include:

- (1) A manuscript (2 A4 pages only) describing the work conducted.
- (2) A bibliography of relevant personal publications.
- (3) An outline of the proposed content of the lecture, including title.

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