reported in the controlled trials. It is very difficult to
differentiate the diarrhoea of therapy and that of the
colitis without a concurrently studied placebo group.
Further research will be necessary to truly determine
the incidence of this proposed complication in the
general population of ulcerative colitis patients
-treated with olsalazine.

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Reply

SIR,—We would not disagree with any of the
comments in Dr Meyer’s letter. Our paper reported a
physiological study designed to investigate one of the
possible mechanisms for the diarrhoea reported in
some clinical studies using olsalazine. We did not
attempt to review the rather conflicting evidence on
the frequency of diarrhoea in patients taking this
drug, and note with interest Dr Meyer’s own experi-
ence. Our own experience is also that diarrhoea is not
a frequent side effect and in a further and controlled
study to be published shortly as an abstract we only
had one withdrawal because of watery diarrhoea
among 20 unselected outpatients with ulcerative
colitis given olsalazine; one of the 17 patients on
sulphasalazine also withdrew because of diarrhoea
exacerbation, in that case bloody. The patients on
olsalazine did, however, have more unformed stools
during treatment than those on sulphasalazine. This
is not necessarily undesirable, and could be positively
beneficial for the 27% of patients with ulcerative
colitis who develop hard stools during exacerbations.

We agree with Dr Meyer that there is considerable
discrepancy in the reported incidence of diarrhoea on
olsalazine, and its true frequency is still not clear. In
our experience it is infrequent in the typical out-
patient with distal ulcerative colitis, responds very
rapidly to withdrawal of the drug, and is easily
distinguished from the true exacerbation of colitis
which can occur with any preparation which relies for
its therapeutic effect on the liberation of 5-amino-
salicylic acid in the colon.

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Changes in gastric alkaline secretion by ulcer healing
Drugs

SIR,—Professor Konturek’s findings that pirenzepine
does not influence gastric bicarbonate production in
man has been questioned by Dr Stockbrugger (Gut
1987; 28: 1687) because the dose administered (20
μg/kg) is quite low compared with the normal
therapeutic dosage.

Several years ago we performed experiments in
10 healthy subjects in whom HCO₃ secretion was
measured by Feldman’s method. Either pirenzepine
10 mg or saline were given, in randomised order,
by bolus iv injection at 0 and 60 minutes during a
120 minute continuous infusion with pentagastrin (6
μg/kg/h). The results (unpublished) showed,
in agreement with Konturek’s recent paper, that
pirenzepine exerts no direct effects on gastric
alkaline secretion in man.

On the other hand, Konturek et al have also
reported in Gut that intra gastric instillation of
colloidal bismuth induces a significant increase in
alkaline secretion by the human stomach. This
remains in apparent disagreement with a recent