Plainly, the percentage failure rate is not the same for Maalox bd and cimetidine, though the difference may be statistically insignificant because the study lacks sufficient power.

What the physician wants to know are the chances of successful completion of treatment and I would suggest my analysis more fairly reflects this need. In this context Table 2 of the paper may be unfortunately phrased. The withdrawals because of inability to tolerate treatment presumably are included mainly in the subgroup 'no second endoscopy'. If these were indeed mainly people who stopped treatment because of adverse effects then the Table is misleading.

MICHAEL LANGMAN

Department of Medicine,
Queen Elizabeth Hospital,
Edgbaston,
Birmingham B15 2TH

Reply

Sir,—We appreciate the very fair comments made by Professor Langman and would agree with him but, with respect, only if we were claiming that Maalox is a complete substitute for cimetidine in duodenal ulcer maintenance therapy – that is, equal in efficacy, freedom from side effects, convenience and costs.

Two considerations should be remembered when assessing our results. First, does antacid maintenance treatment reduce the chance of ulcer recurrence? Second, if it does, is such treatment a practical form of management? The two are of course related but it makes it easier to consider them separately. On the first count, we feel the answer is 'yes'; but it is on the second count that the shortcomings of antacid treatment may show up.

Our work was essentially experimental to test the hypothesis that maintenance antacid therapy was capable of reducing duodenal ulcer relapse rate. This is why in the analysis apparently more weight was put on efficacy. Thus, anybody who violated the protocol in any way was excluded from efficacy analysis; they were later reintroduced using various hypothetical outcomes to see to what extent they influenced the results. Patients who were withdrawn for side effects but were otherwise evaluable were indeed included in efficacy analysis up to the point of withdrawal; if they were withdrawn without a further endoscopy, then they could not be evaluable when judged by ulcer relapse rates. If our results are judged solely by Professor Langman’s recalculation (line 8 of his Table), then certainly Maalox does not appear to be so effective. But to restrict analysis in this manner would result in missing the central finding, namely, that antacid maintenance therapy does indeed reduce relapse rates (line 4 of Professor Langman’s Table) which, after all, was the central point of the study. (In fact, three of the patients who withdrew from the Maalox BD group because of side effects were evaluable for efficacy, so the recalculations are 18 in line 7 and 32.7% in line 8).

We were of course aware from the outset that even if effective and free from side effects, chewing three tablets of Maalox twice daily was not as convenient as taking one cimetidine tablet at bedtime. But we felt, nonetheless, that treatment would perhaps be tolerated by the majority and therefore in this group we could reasonably test our hypothesis. In our view, given the data we reported, the prescribing physician can decide which treatment to use in a particular patient on the basis of their expectation that treatment will be well tolerated, also taking the cost of treatment into consideration.

We accept Professor Langman’s criticism but given the clarifications above, feel our principal conclusion stands, namely, that in this experimental study, Maalox three tablets twice daily is indeed as effective as cimetidine 400 mg nightly in reducing duodenal ulcer relapse rates.

K D BARDHAN
Correspondence.

Rotherham District General Hospital, Moorgate Road, Oakwood, Rotherham S60 2UD

Fibre and enteral nutrition

Sir,—We read with great interest Dr Silk’s review, but we were surprised at the omission of any detail on the effects of enteral nutrition on cholesterol metabolism. In our own experimental studies, rats fed for 10 weeks with Vivonex develop severe fatty infiltration of the liver, similar to Kwashiorkor, with initial deposition of fat in the perportal regions with progressive involvement around the central vein with significant quantitative increases in total liver lipid and cholesterol. No such changes were detectable in the livers of animals fed for 10 weeks with Vivonex which was supplemented with 5% wheat bran. The accumulation of lipids and cholesterol in the livers of rats fed Vivonex has been reported by others. We concluded that dietary bran thus appears to play a role in maintaining normal lipid metabolism and suggest that caution be exercised in those patients on long-term enteral feeding with careful monitoring of blood lipids.

M R LEWIN AND A P JAYARAJ

Department of Surgery, The Rayne Institute, University Street, London WC1E 6JJ

References


Reply

Sir,—I would like to thank Drs Lewin and Jayaraj for their helpful comments about my Progress Report Fibre and enteral nutrition. They are correct in that I did omit details about the fact that it is well known that feeding rats with Vivonex results in severe fatty infiltration of the liver. My literature search failed to reveal results of their experiment showing that the supplementation of Vivonex with 5% wheat bran prevents these changes from developing. I apologise for this. The reason is that their data are as far as I am aware are only published in Abstract form (Gut 1985; 26: A522–3).

D B A SILK

Department of Gastroenterology and Nutrition, Central Middlesex Hospital, London NW10

Books


This is the most impressive textbook yet on gastrointestinal endoscopy. It is certainly the longest at 1168 pages and the heaviest, tipping the scales at 3.28 kg. It is also pricey, costing £95. Is it the best? I think so.

It is written in the style of the classic Saunders American textbook of medicine with 48 chapters contributed by 75 contributors. The chapters are written in academic fashion and are well laced with references, some chapters having more than 150. In an effort to keep pace with advances since the chapters were written, the editor has added the occasional footnote with additional recent key references.

The account of fibreoptic instrument technology was made transparently clear by the quality of the line-drawn diagrams. The chapters teaching how to do it; upper GI endoscopy, choledochofibrescopy, colonoscopy, flexible sigmoidoscopy and laparoscopy are very clear. A special methods section ranged from a chapter showing the beauty of the arcane specialty of chromoscopy, through peroral cholangioscopy and pancreatoscopy (a master and sub-endoscope system somehow sounds less attractive than a mother and baby endoscope) to endoscopic ultrasonography, videodendoscopy, gastroscopy and high magnification endoscopy. It is backed by good didactic chapters on the extraordinary range of pathology now to be viewed at endoscopy throughout the bowel. The oesophageal chapters were excellent as were surprising chapters on postoperative endoscopy, emergency laparoscopy and the differential diagnosis of inflammatory and infectious colitis. The