Omeprazole in H2 blocker non-responders

Sir,—The results of the study by Delchier et al1 on the similar effectiveness of omeprazole 20 mg mane and ranitidine 150 mg twice daily in H2 receptor blocker non-responders are very interesting, but also the comments by Bate'2 on this paper are important. We fully agree with Bate's opinion that a six week trial in the clinic, which should be judged sufficient to define resistance to H2 blockers, because ulcer healing rates further increase by continuing therapy with these drugs to eight weeks.3 It must also be emphasised that the adoption of unstandardised definitions of ulcer refractoriness continues to generate confusion in this field and prevents a useful comparability of findings pertaining to different studies.

Even though Delchier and colleagues adopted patient selection criteria which may have greatly influenced their final results, it is worth pointing out that the reduced efficacy of omeprazole in their trial is a relevant factor in determining the lack of significant difference between this drug and ranitidine in healing resistant ulcers. As the authors discussed in their paper, the well-known variability of individual response to single daily doses of omeprazole 20 mg4 may be the most reasonable explanation for the low efficacy of this dosage regimen in their study compared with the impressive one obtained in other trials, which tested single daily doses of omeprazole 40 mg.5 Some of our recent data seem to sustain their supposition. We used 24 hour continuous pH-meter6 to study two patients with endoscopically proven duodenal ulcers on the fifth day of treatment with omeprazole 20 mg mane. As reported in the Figure, the circular pattern of gastric acidity of both patients resulted poorly influenced by the drug. These findings show that the antisecretory effect of omeprazole 20 mg is very low in some subjects and the variability in acid suppression with this dosage can be even higher than previously reported.6 The reasons for this are at present unclear, but a derangement in the pharmacokinetic pathways of the drug might be involved.7 As regards patients' compliance, we could check daily drug intake because they were hospitalised.

On the basis of our data, it seems advisable to take into consideration the authors' suggestions that omeprazole 40 mg is probably the optimal dosage for treating H2 blocker non-responders and that 24 hour pH monitoring could be valid for verifying whether the clinically recommended dose of omeprazole 20 mg in duodenal ulcer disease,8 is really appropriate in individual patients.

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Epithelial dysplasia in Caroli’s disease

Sir,—We read with interest the report by Fozard et al9 of Caroli’s disease complicated by dysplasia of biliary epithelium in the absence of invasive carcinoma to bestrom. We recently witnessed similar changes in a 60 year old man presenting with recurrent episodes of epigastric and right upper quadrant abdominal pain associated with jaundice, pruritus, incontinence, and dark urine. Ultrasound showed numerous calculi within a grossly dilated intrahepatic ductal system but no proximal stricture or obstruction, changes consistent with Caroli’s disease. A formal left hepatic lobectomy was performed. In the resected liver, parenchyma was largely replaced by dilated bile ducts containing...