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 completely control intragastric acidity by failing to maintain sustained intragastric achlorhydria, which has been shown experimentally to be essential for stabilisation of clot.2

Peterson and Richardson3 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 mEq/min and not with conventional doses of H2 blockers, patients 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.3 Furthermore, using such a regimen for all subsequent patients with bleeding peptic ulcer we achieved an almost complete control of bleeding in 75% of patients compared with 56.7% in the historical controls.4

We believe that there is increasing evidence that a relation exists between intragastric acidity, clot formation, and peptic ulcer bleeding.10,11 Surprisingly, however, there has been no large study of patients with bleeding peptic ulcer treated with an intensive medical regimen, aimed at complete neutralisation of acid and prevention of 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.


Reply

Sn.,—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 cholecystectomy. None 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


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 and non-specific), ‘listen to the patient—he will tell you the diagnosis’ holds true. But it isn’t, because the modern science of gastroenterology attracts the gadget minded and the would be surgeon and reps