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OMEPRAZOLE IN THE TREATMENT OF DUODENAL ULCER AND PREVENTION OF RELAPSE: A.B.Thompson, K. Laukaitis, K. Budajeva, E. Belling, G. Brummer, S. Eriksson, J.P. Arumugam, E. Galan, A. Ashworth, H. Gudjonsson, R. Bailey, G. Bianchi Porro, L. Frison, N. Havu (on behalf of an International Multicentre Study Group). Department of Medicine, Division of Gastroenterology, University of Alberta, Edmonton, Canada.

To determine the optimal dose of omeprazole in duodenal ulcer disease 1004 patients (from 76 centres in 16 countries) with endoscopically proven ulcers (GU) were allocated at random to double-blind treatment with 20 or 40 mg of omeprazole daily for 2, 4 or 8 weeks until healing was confirmed endoscopically. Patients still suffering from ulcer 8 weeks treatment were treated with omeprazole 40 mg daily for another 4-8 weeks. Following healing, 928 patients were allocated at random to double-blind maintenance treatment with omeprazole 10 mg daily (n=308), omeprazole 20 mg daily (n=308) or ranitidine 150 mg at bedtime (n=312) for up to 12 months. The patients had assessments of symptoms at all visits and repeat endoscopy to confirm healing at 3.5, 6, and 12 months, and in-between if indicated. A laboratory safety panel was performed at all visits and at the healing phase and at 6 and 12 months.

Cumulative healing rates (Per Protocol Cohort) in the omeprazole 20 mg and 40 mg groups were 66.5% and 71.6% at 2 weeks, 53.3% and 57.1% at 4 weeks and 96.7% and 99.6% at 8 weeks, respectively. A Mantel-Haenszel survival test over the 8-week period gave p=0.003 in favour of omeprazole 40 mg but the difference may be considered to be of minor clinical importance. Of the 14 unhealed patients at 8 weeks (1.5% of total), all healed within a further 4-8 weeks on omeprazole 40 mg daily. During the 12-month maintenance period the results were as follows:

<table>
<thead>
<tr>
<th>Remission</th>
<th>Difference vs ranitidine</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>80.6%</td>
<td>22.6%</td>
<td>&lt;0.01</td>
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Omeprazole 20 mg 87% 24% (17% to 31%) 0.0001
Omeprazole 40 mg 90% 9% (8% to 16%) 0.15
Ranitidine 150 mg 63% -

All Patients-Treated Cohort. *Unadjusted lifetime analysis; **log-rank test.

The Per Protocol analysis gave almost similar results. A Cox regression analysis of possible prognostic factors revealed that longer time to healing (p=0.001), smoking (p=0.001), a long ulcer history (p=0.001) and young age (p=0.001) had a negative influence on the odds for staying in remission. All treatment regimens were safe and well tolerated.

In conclusion, omeprazole 20 mg daily is an appropriate dose for most patients with duodenal ulcer and almost all patients healed their ulcers within 8 weeks. During continued treatment with omeprazole 40 mg daily all patients healed. During 12 months' maintenance treatment, more patients were maintained in remission with omeprazole (30 or 20 mg daily) than with ranitidine.

H. PYLORI ERADICATION REDUCES THE POSSIBILITY OF REBLEEDING IN PEPIC ULCEr DISEASE. T. Rokkas, A. Mavrogoges, E. Rallis, N. Gianikakos. Gastroenterology Unit and Histopathology Dept, Dep. 401 Army General Hospital, Athens, Greece.

There is a close relationship between H. pylori and peptic ulcer disease and furthermore H. pylori eradication is associated with low recurrence rates. However, it is unknown whether eradication has any impact on ulcer complications such as bleeding. The aim of the present study therefore was to address this subject. Thirty one patients hospitalised for duodenal ulcer (DU) bleeding, treated conservatively and -with a previous history of bleeding, comprised the group studied. All patients had emergency endoscopy and all proved to be H. pylori positive. On discharge day patients were given Omeprazole 20mg daily for 4 weeks, for ulcer healing which was achieved in all patients (100%). After this, patients were randomised to receive either Omeprazole 20mg TID alone (group O + n=15) or the combination of Omeprazole 20mg TID + Amoxycillin 500mg QID (group O+A, n=16) for two weeks. Endoscopy was then performed four weeks after stopping treatment to check for H. pylori eradication and then when rebleeding occurred. Results: There were no differences between groups O and O+A concerning age, sex, smoking habits and NSAID use. The median follow up period was 10 months (range 4-13) in group O and 8.8 (6-14) in group O+A. Eradication was achieved in 21/5 (13.3%) patients in group O and in 13/16 (81.2%) patients in group O+A (p=0.001). Four patients (26.7%) in group O+A and none of the patients in group O were patients where eradication had failed. In contrast none of group O+A had rebleeding (p<0.001). Conclusion: ID patients with bleeding, H. pylori eradication is associated with significant elimination of further bleeding episodes. Therefore H. pylori eradication should be considered in all such patients.
MULTICENTRE UK DYSPHAGIA STUDY
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Aims: This study, of approximately 10,000 patients presenting to over 1,000 general practitioners (GPs) throughout the UK, aims to define the epidemiology of dysphagia and determine whether symptom subgrouping provides a useful way of patient management in primary care.

Methods: Adults presenting to their GP with moderate or severe dysphagia, defined as at least 2 weeks epigastric pain/burning, but no alarm signs (eg weight loss, blood in stools) or other serious illens, no documented ulcer or oesophagitis, were not chronic smokers and who were not taking anti-secretory or prokinetic drugs were treated for 4 weeks with the prokinetic agent cisapride (10mg tds). GPs scored symptoms at the first visit, after 4 weeks cisapride treatment, and 4 weeks thereafter. Patients were subsequently categorized according to symptoms as: ulcer-like dysphagia (U) (localized/ nocturnal/ periodic pain/Interim (epigastric pain plus (R), specific (N) (diuse 46% displayed 80% of DYSPEPSIA is sustained improvement most 1, 6.5 (0-32, 10,000 DYSPEPSIA and approach classified In clinical upper GI-endoscopy.

Results: This study was funded by Jansen Pharmaceutical Ltd, UK.

PRESCRIBING OF NON-STEROIDAL, ANTI-INFLAMMATORY DRUGS BY INDIVIDUAL PRACTICES AND UPPER GASTROINTESTINAL BLEEDING IN THEIR PATIENTS
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INTRODUCTION Non-steroidal, anti-inflammatory drug (NSAID) use is associated with bleeding peptic ulcer but the extent to which differences in prescribing by individual doctors contribute to this has not been quantified. We have, therefore, investigated whether there is a correlation between the level of non-NSAID prescribing by individual doctors and the rate at which their patients present with ulcer complications.

METHODS Five hundred Nottingham patients aged 60 or over presenting with ulcer bleeding between 1983 and 1990 were interviewed prospectively and their general practitioners identified. NSAID prescribing rates (all ages) were obtained for the year 1991/2 using data derived from the UK indicative prescribing scheme. Patients from practices not within the scheme or where major changes of personnel occurred between 1985 and 1992 were excluded leaving 357 patients (131 taking NSAIDs) from 102 practices covering a population of 542,938 for evaluation. A total of 228,728 NSAID items was prescribed (420 per 1000 people per annum). The range of NSAID prescription for individual practices was 173-833 per 1000 people per annum. Ulcer bleeding (over 60's) occurred at a rate of 0.51 (range 0.294) ulcer bleeds per 1000 people (all ages) per year. Ulcer bleeding correlated significantly with prescription of NSAIDs (r = 0.45 p < 0.0001). This correlation was strong (r = 0.45, p < 0.0001) when ulcer bleeding in patients on NSAIDs was considered separately. There was no correlation (r = 0.14) with NSAID-related bleeding was causal.

CONCLUSION It is likely that prospective concurrent age matched data would yield yet stronger correlation but the results of this study suggest that NSAID related ulcer bleeding could be reduced substantially if high prescribing practices reduced prescribing to the levels of their lower prescribing colleagues.

NON-ULCER DYSPHAGIA VERSUS ORGANIC DISEASE: EVALUATION OF VALIDITY OF DISCRIMINANT SYMPTOMATOLOGY AND CLASSIFICATION IN DYSPHAGIA SUBTYPES
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The objective of our Omega-project was to determine the incidence of organic lesions in dyspeptics-by symptomatology-by means of a prespecified history questionnaire and a standardized diagnostic procedure and eventually elaborate criteria for a more rational diagnostic and therapeutic approach at the primary care level.

Method: All patients who consulted the general practitioner for dyspeptic symptomatology of minimum one month duration were eligible for the multicenter trial. All had a routine general examination, inclusive haematology and blood-chemistry. Those presenting more than one symptom of discriminant validity for detection of organic disease such as night pain, severe pain, disturbed daily activity, severe heartburn, involuntary weight loss, and or age above 45 were submitted to an upper GI-endoscopy. Patients without organic disease were subsequently classified in clinical dyspepsia subtypes and received a probatory therapy with cisapride (15-40 mg/d) during one month. The study included a follow-up examination, one and two months after discontinuation of the therapy. All patients were submitted to endoscopy if they failed to respond to the treatment or in case of a relapse occurred within the follow-up period.

Results: By mid February 1993, the complete set of data of 376 patients (about 50% of those included in the trial) was available for analysis. 27% were endoscoped at admission and an additional 7% at the end of the study or in the follow-up period respectively. According to the prevailing symptomatology, patients classified as dysmotility-like dysphagia, 19% as reflux-like dysphagia and 9% as ulcer-like dysphagia. Endoscopic diagnoses were peptic disease in 12% of the patients with duodenal ulcer in 3.5%, reflux-oesophagitis in 39%, gastric ulcer in 1%, etc. The prevalence of an organic disease was clearly higher in patients with reflux-like and ulcer-like dysphagia (14.4% and 32% of peptic disease resp.) than in patients with dysmotility-like or non-specific dysphagia (peptic disease in 7% and 6% resp.). The overall incidence of malignant disease (9%) was 0.4% and 3.3% in the final diagnostic groups differing from the initial presumptive diagnosis.

Conclusion: In dysphagia patients without so-called risk factors therapy with cisapride is warranted, particularly in patients with unspecific or motility-like dysphagia. Initial endoscopy should preferably be advised in ulcer- and reflux-like dysphagia. Control endoscopy is compulsory in non-responders, even though the diagnostic yield is minimal.


An high seroprevalence of IgG to Helicobacter pylori (H pylori) in a large asymptomatic blood donors population (42%, 322/1010) has been previously reported. Endoscopy was offered to all this population. Among these subjects after interviewing (n=366, 87%) 288 (79%) (M/F: 169/119; age range 18-65; mean 45 yrs) underwent upper gastrointestinal endoscopy. Biopsies of antral biopsies were taken for CP-Test (1), culture (2), microcopy (Giemsa and Hematoxilin & Eosin staining) (2) and venous blood was collected and IgG to H pylori were re-assessed by an in house ELISA assay previously standardized with a sensitivity and a specificity up to 94%

Results: The endoscopic findings were: 1 gastric cancer, 1 leiomyosarcoma, 50 duodenal ulcers, 19 gastric ulcers, 39 erosive duodenits, 30 antral erosions, 109 antral gastritis and 39 endoscopically normal. 267 out of 288 (93%) were found to be colonized by H pylori assessed by Giemsa, CP-TEST and/or culture and high levels of IgG. In all of them active on chronic histologic gastritis was found. Twenty-one patients (7%) were not colonized by H pylori assessed by all the four methods. Interestingly in 19 of these 21 the levels of IgG had fallen by the time of endoscopy.

Conclusion: This study for the first time has shown the clinical relevance of high levels of IgG to H pylori in screening population. We confirmed the high prevalence (24%) of undiagnosed peptic ulcers in asymptomatic subjects.