# POSTGASTRECTOMY PATIENTS

IT has been known for over 30 years that patients who have had gastrectomies are at risk. The prevalence of such patients in the community is about two per thousand which is equivalent to about five such patients in the average sized list.

The medical complications that occur are not surprising in view of the functional importance of this organ and the extent of the stomach tissue usually removed (between two-thirds and three-quarters). They can conveniently be classified into early or symptomatic and deferred or silent complications.

*Symptomatic complications*

The early complications include the various forms of the dumping syndrome, which, although inconvenient to the patient will often improve with time and will rarely require further surgery. Such syndromes are usually obvious as not only do they occur soon after operation but they present symptoms to the patient.

Other complications are those of steatorrhoea which is often associated with loss of weight, and intestinal hurry which may occur independently of steatogghoea. Such syndromes by definition produce symptoms which usually lead to treatment being sought.

*The silent complications*

The silent complications, by contrast, occur late. Whereas the early complications are often easy to diagnose but difficult to manage, the late complications are easy to manage but difficult to detect without positive screening. These complications consist of deficiency syndromes associated with failure of absorption. The two commonest are those of iron and the fat soluble vitamin D. The two commonest clinical conditions are therefore anaemia and osteomalacia. However, other fat soluble vitamins such as A and E, and water soluble vitamins B and C may also be affected.

Professor Clarke (1970) has reported that as many as 40 per cent of the first 100 patients seen at one London postgastrectomy clinic were anaemic, and others have estimated that the incidence of postgastrectomy bone disease is more than 15 per cent of patients ten years after operation. In osteomalacia blood calcium and phosphate usually fall and the serum alkaline phosphatase rises. The symptoms of osteomalacia can be those of bone pain and muscle weakness which may well be confused with, or associated with, conditions of old age, and in particular osteoarthrosis.

*Surveillance*

The need for surveillance of this group is clear. The only question is whether it should be organised by general practice or the hospital service. At first sight it seems appropriate that a special hospital clinic should do the work, as all these patients will have had inpatient hospital care and such surveillance can be regarded as an extended form of follow-up. The patient's interests, however, are probably best served if such care takes place in general practice. There are several reasons for this.

The late complications occur many years after operation when the patient may not be living anywhere near the hospital at which his operation was carried out. Secondly, continuity of care is one of the essential features of general practice. Thirdly, it must be preferable for the patient to have his checks carried out routinely by his own personal doctor, in his own local practice rather than travelling to some distant, large district hospital to be seen by ever-changing junior hospital staff. Finally, any treatment that becomes necessary will usually be prescribed and supervised by the general practitioner.

*An annual appointment*

Initially, annual examinations are probably enough. The patient is seen once a year, is offered an opportunity of reporting any symptoms, is weighed, and has his blood taken. It is probable that adequate care is being provided if such tests include a blood film, haemoglobin, serum calcium, serum phosphate, serum alkaline phosphatase and a serum vitamin $B_{12}$ estimations. The serum alkaline phosphatase is a particularly useful test as its rise may be the first sign of an impending osteomalacia due to vitamin D deficiency. Such an appointment need only last five minutes.

Serum folate examinations are time consuming and expensive and are probably not yet indicated unless some other abnormality is present. Some practitioners prefer to request a serum iron investigation routinely and undoubtedly sometimes this is low when the haemoglobin may be reported within normal limits (sideropenia). Other practitioners routinely request serum proteins as a broad index of malabsorption.

*Practice organisation*

If all such patients are seen each year it is unlikely that many general practitioners would have more than half a dozen examinations per annum. These patients, if told about the problem, are perfectly able to attend once a year for this purpose; most do so when offered the chance. One convenient administrative method is to ask such patients to attend in the month of their birthday as this is normally clearly marked on the front of the National Health Service envelope. If a suitable tabbing system is in use in the practice the general practitioner, by glancing at the outside of the record, is able to tell when the next check is due.

Most patients who have had gastrectomies are probably not receiving proper supervision. This is to be regretted. The need is clear, the necessary access to pathology is usually available, and the work is not excessive. There seems no reason why this care should not normally be provided in general practice today.

# BETTER LATE THAN NEVER

THIS month British patients will normally receive their drugs labelled. The Health Service prescriptions of general practitioners will be printed with the letters NP (*nomen proprium*).

This marks the end of a story lasting more than ten years, and occurs because agreement has now been reached between the Department of Health and Social Security and the Central N.H.S. Chemist Contractors Committee, the negotiating body for pharmacists.

One of the main causes for the delay was a disagreement between doctors and pharmacists. On the one hand the medical profession, having once made up its mind that the change was desirable, felt that the will of the prescriber should be enough.

On the other hand, the pharmacists stressed the extra work that was involved and noted that despite the medical policy, in practice only about eight per cent of National Health Service prescriptions were marked NP by general practitioners.

There is general agreement that the change will benefit the patient, despite the surprisingly common practice of some patients placing tablets in different bottles. The prescriber's privilege is safeguarded as the letters can always be crossed out.

This reform is to be welcomed, it has already been implemented in many hospitals. The delay in its general introduction is to be regretted. This represents one of those unfortunate examples where, in a clash between two of the caring professions, the patient's interest was lost.