# This month ● ulcers ● difficult patients ● chiropody ● bowel cancer screening

## No acid — no ulcer

HISTAMINE-2-RECEPTOR antagonists heal most, but not all, ulcers. Omeprazole is a new agent, which inhibits the cellular proton pump in the gastric mucosa to produce virtual achlorhydria after a single dose. Its potential for therapy in acid related diseases is enormous.

In this study of patients with ulcers resistant to extended treatment with high-dose ranitidine (450 or 600 mg daily), oral treatment with 40 mg daily of omeprazole produced healing of ulceration within four weeks in over three-quarters of the patients with 15% taking eight weeks to heal and a very small minority requiring an increase in dosage up to 60 mg daily. In three patients the ulcers did not heal at all. Many of these patients have now been taking long-term maintenance therapy with omeprazole for between one and four years. On this treatment no relapses have occurred, as determined by follow-up endoscopies, and no adverse drug effects have been observed. Serum gastrin levels, which were already high during the initial treatment with high-dose ranitidine, rose to four times normal at four weeks after the start of omeprazole treatment but, thereafter, no further increase in serum gastrin was observed even after four years of continuous treatment and observation.

These results are important because there has been anxiety about the effects of long-term acid suppression, not only with omeprazole but with $H_2$-receptor antagonists also. The possibility of the development of gastrinomas and other neoplastic endocrine tumours is very real and in experimental animals high dose omeprazole has also been shown to cause such neoplasia. Once its safety in clinical studies has been established, however, we will have a very powerful agent to use in peptic ulcer disease.

(R.J.)

Source: Brunner G, Creutzfeldt W, Harke U, Lamberts R. Therapy with omeprazole in patients with peptic ulcerations resistant to extended high-dose ranitidine treatment. *Digestion* 1988; **39:** 80-90.

## Difficult patients

A PAPER in the *Journal* this month by Corney and colleagues looks at strategies for dealing with difficult patients. It might be useful to read this in conjunction with a recent paper in *Family Medicine,* which draws up a taxonomy of difficult doctor–patient interactions with the same aim of helping the doctor to identify where the problems of the consultation lie and then to work towards obtaining accurate and precise information from the patient.

Difficult interactions were categorized into four general types: (1) process problems, which include technical difficulties, such as speech impairments, language barriers or dementia, and patient conversational styles, such as reticence, rambling or vagueness; (2) topical problems that result from discussing difficult topics for patient, doctor or both, such as drug and alcohol problems or sexual history; (3) personality styles, such as the patient who manipulates or makes excessive demands (Groves' categories); and (4) difficult feelings and defences, both the patient's (anger, anxiety, depression and denial) and the doctor's.

The authors have used the taxonomy as a teaching aid for medical students to break down the consultation into manageable sections — process, topic, personality and feeling state — and then focus on each in turn, with the emphasis on the two-sided nature of the problem.

(A.B.)

Sources: Corney RH, Strathdee G, Higgs R, *et al.* Managing the difficult patient: practical suggestions from a study day. *J R Coll Gen Pract* 1988; **38:** 349-352. Block MR, Coulehan JL. A taxonomy of difficult physician–patient interactions. *Fam Med* 1988; **20:** 221-223.

## Chiropody services

A SURVEY of people aged 75 years and over living at home in a large general practice found that about half of the thousand or so patients studied had difficulty caring for their feet. The problem was increased by visual impairment and a lack of manual dexterity and mobility. Only about two-thirds had received any chiropodist services from the National Health Service. This study highlights a lack of services which are of considerable importance for the elderly and other groups of patients. Only recently one district health authority refused to provide chiropody for a 64-year-old diabetic because the service was restricted to those aged 65 years or over. One solution might be to appoint chiropodists to groups of general practitioners with the district health authority paying 30% of the salary and the family practitioner committee reclaiming 70% reimbursement. An opportunity exists to do this before family practitioner committees become cash limited and while there is still encouragement to broaden the definition of attached staff in general practice who qualify for reimbursement.

(D.H.)

Source: McGrowther CW, Clarke M. Chiropody services: need, associated disabilities and utilisation. *Community Med* 1988; **10:** 14-18.

## Bowel cancer screening

THERE is growing support for population screening for cancer of the large bowel, the most frequent cancer in men after carcinoma of the lung and in women after carcinoma of the breast. It is responsible for many more deaths than carcinoma of the cervix and may be equally preventable.

One of the key ingredients of an effective screening programme is a simple, safe and specific test. At present guaiac-based methods such as the Hemoccult test are the most widely used tests for faecal occult blood, although immunological techniques may prove superior. The sensitivity of the Hemoccult test has recently been estimated in a review of over 1200 patients at high risk for cancer of the colon. When the results were adjusted for different compliance between the Hemoccult-positive and Hemoccult-negative subjects, the sensitivity of the test was 69% for cancer and 19% for adenomas with a corrected estimate for a false positive rate of 5%.

These results are concordant with a number of other studies, except that the sensitivity for adenomas is lower than other published data; they refer to high risk subjects (those with family or personal histories of neoplasia) so that the positive predictive value of 45% is almost twice that found in other studies of screening in the general population. The case for screening for colon cancer remains strong but this study emphasizes that we still do not have the perfect screening test.

(R.J.)

Source: Bertario L, Spinelli P, Gennari L, *et al.* Sensitivity of Hemoccult test for large bowel cancer in high-risk subjects. *Dig Dis Sci* 1988; **33:** 609-613.

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