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NEWS AND NOTES

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CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters should be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included.

Failure of endoscopy to reduce complication rate in peptic ulcer disease

SIR,—Dr G Holdstock and Dr S Colley (6 August, p 393) are to be congratulated for showing so clearly that the increased availability of endoscopy alone will not reduce ulcer complications.

I suspect that this could have been foreseen for several reasons. Firstly, for every patient with proved ulcer disease there are others in whom the diagnosis has not been made. This is partly because of a relative lack of diagnostic facilities and partly because the symptoms may not be troublesome enough to warrant referral for radiological or endoscopic examination (or sometimes the patient may have refused to have the investigations). Thus increased availability of diagnostic services in areas previously underserved may result in increased detection of ulcer disease; but even good diagnostic services are unlikely to pick up many patients with minor symptoms. Yet complications can and do occur in patients with and without appreciable symptoms, and this is not necessarily related to the severity and duration of previous symptoms.

Dr Holdstock and Dr Colley suggest that earlier treatment of those with known ulcer disease when their symptoms recur might reduce complications, but this may not happen. During a relapse complications can occur either without warning—that is, it is the first indication that the ulcer has recurred—or early, after mild symptoms for a few days, or later on, after pain has been established for several days. Patients who are asymptomatic will not have any reason to seek help before the complications occur, even if ulcer disease has been diagnosed in the past; and those with mild symptoms may not wish to do so, unless of course they have had complications previously and are apprehensive of even minor symptoms. It is, therefore, only patients with established symptoms who may seek help earlier and in whom antiulcer treatment *may* forestall complications. Indeed, Dr Holdstock and Dr Colley have shown that only about one third of patients have symptoms at the time of admission with complications and less than one tenth had attended their family doctor with ulcer problems in the four weeks before admission.

Finally, though about one third of patients with ulcers develop complications at some stage, within individual relapses the chances of complications are small and unpredictable. To reduce this still further would necessitate substantially reducing recurrence of ulcers, either by surgery or by maintenance treatment with cimetidine or ranitidine (although it remains to be proved whether drug treatment will reduce the complications of ulcers, as opposed to the recurrence alone). Surgery is applicable to relatively few patients; and prolonged if not permanent maintenance treatment is still not widely used unless previous symptoms were severe or there have been complications, and even then with considerable hesitation in younger patients.

Thus, even if more patients with ulcer disease were diagnosed, most would not be receiving treatment just before complications occur, either because there were no appreciable symptoms or because of prescribing practice, and it is unlikely that there will be any substantial change in the complication rate. If treatment policy changes, however, unless there is a massive reduction in the subsequent complication rate, it will be difficult to prove whether the treatment policy or an altered clinical course was responsible for the change.

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A lottery for life

SIR,—In the Yorkshire Television programme about which Dr A J Wing has written (13 August, p 492) Dr Miriam Stoppard explored the theme of doctors playing God in selecting patients for renal dialysis and transplant. I first heard of this programme in 1982, when the producer rang to ask if I knew of any eligible patients who had been refused dialysis. As it happened, I had a boy who was turned down at 18 and who was accepted only after something of a battle with the Cardiff renal unit. At that time three out of four applicants had to be refused, the criteria for selection were inevitably arbitrary, and, I think, equally inevitably, socially biased.

My patient was keen to take part if this would help others in a similar plight, and this spring Dr Stoppard arrived with her travelling circus to film him and to interview me on the mountain against our village background. It was a fierce encounter on both sides. Dr Stoppard was interested in just one issue: how doctors choose who shall live and who shall die. I was interested in another: how society chooses that doctors must choose.

The cost of one Trident missile is about the same as our entire renal dialysis and transplant programme for one year, and one missile used in earnest would kill about a million people. Dr Stoppard regarded this as irrelevant to her theme. As pushing my patient on to the dialysis programme meant pushing someone else off,