International Perspectives

New Treatments for Duodenal Ulcer

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The management of duodenal ulcer has been one of a parading sequence of "new" treatments that have come and gone throughout its relatively short medical history. Duodenal ulcer became prominent in medical literature in the 1920s and has been onstage since.

Along the medical sidewalks and the surgical freeways of the past 50 years there have been some notable landmarks and signposts. Periods of near obsessional medical therapies have been associated with a variety of surgical procedures and operations.

Meticulous attention to diets of various degrees of blandness and monotony were combined with bedrest, hospitalization, seclusion and avoidance of worry-anxiety-stress, and courses of drugs as the bases of medical therapy.

Admission to a hospital for four to six weeks for a course of "medical treatment" for duodenal ulcer was not unusual even a decade past. The drugs available were a variety of antacids, antispasmodics, usually derivatives of atropine and barbiturate, and bromide sedatives. Continual milk drip-feeding through nasogastric tubes was popular.

Fashions in surgical assaults on the offending ulcer likewise have been trendy. The rage in gastroenterostomy soon ceased when high recurrence rates of duodenal and anastomotic ulcers were reported.

Partial gastrectomy was introduced to control associated excessive gastric acid production by excision of large parts of the acid producing areas of the stomach. Postoperative mortality and morbidity rates were not insignificant.

The era of sophisticated scientific gastric surgery was heralded with the advent of vagotomy, a procedure by which gastric acid production was reduced by cutting the vagus nerves that stimulated gastric acid cells. With its many amendments, vagotomy is the current favorite surgical procedure for duodenal ulcer, but it has its drawbacks. It is a surgical operation with all that this entails, including some risks to life and normal postoperative digestion.

Two recent events have changed our approach to the management of duodenal ulcer. Reliable and tolerable fiberoptic endoscopy has made it possible to *see* the ulcers and to assess their response to treatment. The other is the advent of the latest "miracle drug," cimetidine.

Cimetidine, a U2 receptor antagonist, is a most effective medical blocker of gastric acid secretion. It is remarkable in its efficacy and acts as a tempo-

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rary medical vagotomy. In appropriate cases, it is dramatically successful in controlling symptoms. Pain is relieved and dyspeptic symptoms disappear.

However, there are problems with cimetidine, as with all new drugs. Its long-term side effects are unknown. It is expensive. It is difficult to know how long to keep the patient on cimetidine, when to stop, or how best to arrange the medication.

There is another even more important matter that has to be taken into account—the natural history of duodenal ulcer. Before we rush in and prescribe the latest wonder drug, be it cimetidine or something else, we should be clear on what is likely to happen to our patients with duodenal ulcer without specific therapy? Not all ulcers will require surgery. Not all ulcers will produce complications. Not all will become chronic and continue to cause symptoms for ever and ever.

I have observed and followed-up over 250 patients with duodenal ulcer for up to 30 years.[1] In general terms I have found that ten percent were experiencing severe or moderate symptoms and 20 percent had had surgical treatment.

Family physicians in developed countries may expect to diagnose five to ten new cases of duodenal ulcer in a year and to be consulted by 20 to 30 other persons with ulcers annually. Each one of us has to develop his (or her) own policy of management of patients with duodenal ulcer. We must appreciate the good natural prognosis in order to decide on criteria for surgery, to plan for management of complications and, now, to plan for employment of new drugs and diagnostic tools.

Reference

1. Fry J: Common Diseases, ed 2. Lancaster, MTP Press, 1979