DUODENAL ULCER IN SERVICEMEN

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SUMMARY: Six weeks treatment with Cimetidine in a dosage of one gram daily healed only 27 per cent of duodenal ulcers in a series of 30 young soldiers. Half of the patients in whom the ulcer persisted remained deceptively symptom free whilst on Cimetidine. Subsequent truncal vagotomy and pyloroplasty healed 90 per cent of the Cimetidine-resistant ulcers at three months.

This suggests that duodenal ulcers in young soldiers may be comparatively resistant to Cimetidine therapy but that truncal vagotomy and pyloroplasty is an effective treatment at least in the short term.

Introduction

It is now accepted that Cimetidine heals up to 70 per cent of duodenal ulcers in the short term¹ but it is also known that relapse occurs in 24 per cent during full dose maintenance treatment and in 43 per cent within six months when it is withdrawn². Long term maintenance treatment with Cimetidine 400 mg twice daily is only partially successful in preventing relapse and probably should be continued indefinitely if proved to be safe³. This paper reports the responses of a group of young soldiers to Cimetidine therapy assessed endoscopically.

Patients and methods

Thirty young men between the ages of 21 and 34 years (mean age 25 years) with endoscopically proved uncomplicated duodenal ulcers were given Cimetidine 200 mg tds and 400 mg at night. Endoscopy was performed at six weeks and if healing had occurred the patients were given Cimetidine 400 mg at night for three months. If healing had not occurred Cimetidine one gram daily in divided doses was given for a further six weeks and endoscopy was then repeated. At this stage surgery was considered for non-responders and for those who relapsed. A further endoscopy was performed after either three months on maintenance Cimetidine therapy or three months after a truncal vagotomy and pyloroplasty.

Results

After six weeks therapy with Cimetidine 1 gm daily, eight patients were found to have healed their ulcers, whilst in 22 patients the ulcers persisted. Eleven of those with persistent ulcers had no symptoms while on Cimetidine.

The eight patients who had healed received Cimetidine 400 mg at night, and three of these had relapsed endoscopically at three months. Of the 22 patients with persistent ulcers, 13 received a further six week course of Cimetidine in full dosage and at endoscopy two of these had healed their ulcers, the rest had active disease.

Ten patients whose ulcers had not healed on Cimetidine proceeded to vagotomy and pyloroplasty. Nine of these had healed at endoscopy three months later. The

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tenth patient was symptomatic and had an ulcer. A Hollander's test suggested an incomplete vagotomy.

Discussion

Duodenal ulcers relapse and remit over a long period of time. Fry⁴ in general practice found that the activity of the disease reaches its peak at eight years in males. Griebe and colleagues⁵ reviewed 154 patients at 12 years after diagnosis and found that 63 per cent were still symptomatic or had had surgery. They also found that it was not possible to predict the outcome of an individual case.

In this small series only 26.6 per cent of patients were healed at six weeks, and 16.6 per cent three months later. These rates are much worse than those for placebo in all controlled trials. As worrying is the large number of patients with asymptomatic duodenal ulcers while taking Cimetidine, with all the attendant dangers of active asymptomatic disease.

Peptic ulcer is the commonest single cause of medical invaliding from the British Army⁶. The disease in servicemen is common, severe, appears unusually refractory to Cimetidine treatment, and may reflect the unusual life style of the soldier. The excellent symptomatic response to Cimetidine could allow this life style to continue in the presence of active disease, thus delaying healing.

Drug compliance can never be presumed in a series of this nature, nor can observer impartiality. However, the medical treatment of duodenal ulcer in young soldiers remains difficult.

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