A 68-year-old man with a history of previous surgery for peptic ulcer some 15 years before had had recurrent symptoms of duodenal ulcer over the past two years. Following a weight loss of one stone (6·4 kg) and a small haematemesis he was placed on the waiting list for further surgery. In the meantime he was given cimetidine 200 mg thrice daily and 400 mg at night with complete relief of symptoms. When reviewed at surgical outpatients he had recovered his weight loss and his operation was postponed indefinitely.

Six days after the withdrawal of cimetidine after five weeks' treatment he was admitted with a small perforation of his ulcer with contamination of the peritoneal cavity. Simple closure of the perforation was carried out.

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Cimetidine and gastric ulcer healing

SIR,—We were very interested to read that Dr F Frost and his colleagues in Denmark (24 September, p 795) had shown a significant increase in the healing of gastric ulcers in patients treated for six weeks with cimetidine. However, we do not feel that the place of this drug in the management of gastric ulceration (in contrast to duodenal ulceration) is finally proved.

We have been conducting a similar trial, whose design has been described elsewhere.[1] Although our study is larger than the Danish one (54 patients have completed the trial to date), a significant difference in healing rate between cimetidine and placebo groups has yet to emerge. The treatment period in our trial is two weeks shorter, yet the healing rate in our cimetidine group (69%) is very close to that in the Danish study. The principal difference, however, lies in the placebo groups. In our study 54% of gastric ulcers healed in a four-week period, whereas only 27% healed in six weeks in the Danish series. High placebo healing rates have also been described in another recent gastric ulcer trial.[2]

Dr Frost and his colleagues have had to contend with all the difficulties inherent in a multicentre trial and perhaps the most important effect of these has been that their two groups of patients are not strictly comparable. The sex ratios vary and in the placebo group the ulcer history is nearly twice as long as in the cimetidine group—possibly an important factor in their low placebo healing rate.

Studies of the treatment of gastric ulcer are inevitably beset by difficulties arising from the high spontaneous healing rate which occurs in this condition. Healing of 19 out of 20 gastric ulcers has been reported following injections of distilled water.[3] Clearly much more work is required with larger and better-balanced trials before the place of cimetidine in the management of gastric ulceration can finally be assessed.

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[1] Ciclitira, P J, *et al*, in *Cimetidine*, ed W R Burland and M A Simkins, p 283. Amsterdam, Excerpta Medica, 1977.
[2] Multicentre Trial, in *Cimetidine*, ed W R Burland and A Simkins, p 287. Amsterdam, Excerpta Medica, 1977.
[3] Gill, A M, *Lancet*, 1947, **1**, 291.

MRC treatment trial for mild hypertension

SIR,—Dr G H Hall, in his letter about the MRC treatment trial for mild hypertension (23 July, p 266), expresses his view that the decision on the future of the full-scale trial should be taken on the basis of the *results* of the pilot trial and is surprised that they were not disclosed in our report (4 June, p 1437).

It is customary in the management of all such large-scale trials to restrict knowledge of the "events" in treatment and control groups to the small number of people immediately responsible for monitoring their progress; they in turn alert an ethical committee if trends approach statistical significance. Any alternative would allow the trials' future to be jeopardised by the leakage of information which might suggest trends which were of no significance.

The working party's estimate that this trial requires the observation of 18 000 people for an average of five years is partly determined by the statistical criteria in its design. Like all estimates it is subject to error, but it is not likely to be so seriously incorrect as it would have to be if useful data on events could be gained from 1849 persons, most of whom were under observation for less than two years.

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Care of the elderly sick

SIR,—I do not doubt Mr V H Cross's (24 September, p 816) conclusions that the prejudice of hospital staff and the image and role of the geriatrician contribute materially to recruitment problems in geriatric medicine. I am at a loss to understand how his proposed solution would cope with the problem. Indeed, the diagram of his new scheme seems not so much a blueprint for the future as an epitome of the worst aspects of the past. If we cannot recruit British graduates into contemporary geriatric medicine with its emphasis on acute and rehabilitative care how will we recruit Mr Cross's "physicians to the elderly," doomed to oscillate eternally between domiciliary services and "chronic hospital beds"?

Two of the features which distinguish the geriatrician and which reflect particular needs of old people are his commitment to provide personally continuous and comprehensive care for his patients from acute illness through to long-term care, if necessary, and his responsibility to a defined population. It is from this last feature, which contrasts with the traditional view of a doctor's responsibility as restricted to those persons he has chosen to accept as patients, that both the moral glory and the political weakness of the geriatrician derive. All too often he is given the responsibility while others retain control of the resources he needs to discharge it.

I suspect that this is one manifestation of a general principle. Attempts to help members of an underprivileged group such as the elderly by separating them from the rest of the human race with reserved resources or special staff may overcome some difficulties, but will in the long term create or consolidate others. If a consultant is prepared to provide comprehensive care for a defined population of elderly people does it matter whether he calls himself a geriatrician or a general physician? Ultimately the way forward will be seen to be the disappearance of both specialties as we now understand them and the evolution of appropriately trained hospital physicians charged with providing comprehensive general medical care for all adults. This is unlikely to happen in less than a generation and to be successful it must come about by consensus rather than by imposition, but the training recommendations of the report of the Royal College of Physicians Working Party on Medical Care of the Elderly[1] contain encouraging signs of possible progress.

Should we not press for implementation of these recommendations as a modest development that commits nobody to anything but which might lead to more co-operation and courtesy between our jarring sects? This would in itself reduce one of the problems Mr Cross identifies.

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[1] Royal College of Physicians of London, *Lancet*, 1977, **1**, 1092.

Joint appointments in general and geriatric medicine

SIR,—The enormous projected increase in the population aged 75 and over through the rest of this century is possibly the most serious single factor facing medical practice today—and it is by no means clear that the profession as a whole is seriously facing up to this fact. To this end the recent report[1] of the Royal College of Physicians Working Party on Medical Care of the Elderly (of which we were members) has proposed increasing the number of physicians practising geriatric medicine by the establishment of joint appointments between geriatric and general medicine.

In some areas the implementation of such appointments is now being discussed. Their success will depend on a careful structuring of the duties of the new specialists to cover all aspects of geriatric care and also on the adequate training of such specialists in both general and geriatric medicine. The primary objective of geriatric medicine is to maintain fitness and independence to as near the end of life as possible—and to maintain old people in the community rather than in institutions. This involves careful diagnosis and medical treatment. It also requires the management of rehabilitation, day hospital care, community liaison, and, where all else fails, of long-term care. These together are the irreducible minima of geriatric medicine and clearly no specialist can accomplish this in two or three sessions a week.

We therefore believe that the following three requirements are essential to the setting up of viable joint appointments in general and geriatric medicine. (1) At least half of the sessions must be in geriatric medicine (and preferably six to seven sessions a week). (2) The physician must be trained as a senior