The second point, the proper function of doctors and how they should be used, may also cause a little anxiety. Which of us is confident that he "constitutes a good buy for the public"? The advocated structuring of postgraduate training is probably already in hand. I speak from knowledge of internal medicine training and the activities of the Royal Australasian College of Physicians in New Zealand. Whether it is advocated, or indeed whether such training *should* be used to manipulate the senior manpower availability, is a moot point. But just reading the words, one must agree that there can be no doubt than "an effective planning mechanism must for the first time be developed." And last, but no longer least—although it probably has been for too long—the voice of the people of whose careers and aspirations we are speaking must be heard. The Student Association is on record as raising the spectre

of high pressure competition in family medicine as an alternative to unemployment, and of making an eloquent plea with rational positive suggestions on deployment of the superfluity of manpower to the benefit of the public. This latest report¹ says that junior doctors are unhappy—"disillusioned" is the word used—that while they are a clear-thinking body with viable and vital ideas, for too long they have been channelled by an authoritarian seniority to which they have been allowed no material voice—sic transit gloria?

Reference

- ¹ New Zealand. Advisory Committee on Medical Manpower. *Specialist medical manpower in New Zealand*. Wellington: Management Services and Research Unit, Department of Health, 1980.

Dealing with the Disadvantaged

Overweight patients

PAMELA GIBBONS

The attitude of a doctor may make or break the confidence a fat person has in him or her, so perhaps one who has experienced this may be permitted to make some observations.

Diet

(1) For many people, sensible dieting is a straightforward way to lose weight, but there are those who do not respond to the accepted norm of diet sheets. Please do not greet them with that awful cliché, "Nobody fat ever came out of Belsen," or suggest that they must be cheating.

(2) Do not offer a negative diet. One only has to read the forbidden list to yearn for something on it. A positive list is far more helpful, however short.

(3) Perhaps one week you could try the diet you prescribe for yourself—and prepare it yourself. Dieting is much more difficult when one is cooking for a family than it is when someone else prepares, weighs, and cooks the meal and just sets it on the table.

(4) Do not be afraid to suggest far less food than many so-called balanced diets. After years of following them, interspersed with crash diets (milk, banana, Mayo—eggs and grapefruit), then Weight Watchers, I steadily gained weight. It is only now, on a diet of two Oxo cubes, two yoghurts, and up to two pints of skimmed milk per day, that I am losing weight and feeling better than I have for the past 20 years. That, plus a Multivite and a ferrous sulphate tablet, was worked out for me by the medical research unit at a London hospital during a three-week stay and after many tests. I would digress here to beg for more centres for the overweight to be attached to provincial hospitals.

(5) Apart from the fact that only trial and error can establish the right diet, the ways in which the right amount of calories can be taken or absorbed vary enormously. Suggest, therefore, that the patient is weighed weekly by your nurse and has a monthly check up by you to monitor a particular diet.

(6) Try to appear reasonably sympathetic if you feel the patient has really tried, even if the result is disappointing. Just imagine how depressed the dieter is feeling.

General points

(1) Do not suggest enlisting the help of one's friends. It just does not work. Friends will offer false platitudes, and tell you they like you as you are, usually adding, "If you get thin you wouldn't be you—it suits you to be well covered."

(2) Some experts advise telephoning a hostess before going to dinner and asking her not to offer any forbidden food—do not suggest this. The modern hostess is adventurous, often extravagant, and she would rather her invitation was refused (with the reason) than be expected to modify her menu or provide plain alternatives.

(3) Please do not refer to a fat person to his face as obese or grossly obese. To the layman the word has a different connotation; it sounds like obscene, and many fat people really feel obscene.

We asked Dr John Garrow, who specialises in treating the overweight, for any additional comments. He writes:

The objective of treatment is to make life more tolerable for the patient. The doctor must inform himself about the mortality and morbidity associated with obesity, especially in young people, to enable him to give an honest analysis of the relative risks and inconveniences of dieting on the one hand or of remaining obese on the other. Unless the balance is in favour of dieting why should the patient diet? Doctors should be aware that it is more difficult and less profitable for the patient to lose weight as he gets older. It is, therefore, a good plan to

tackle the problem early rather than to wait until disabilities develop that will be hard to rectify.

Overweight patients need long-term supervision. If the doctor is unable to provide this himself he should refer the patient to someone who can—perhaps a hospital-based slimming group.

Remember that patients differ. Whenever a woman's maga-

zine features a "Slimmer of the Year," who has lost (she says) 10 stones in six months, readers think that everyone should be able to attain this: they cannot. One or two pounds a week is a reasonable long-term rate of weight loss for most people. Very rapid weight loss involves loss of lean tissue, and this is disadvantageous for the overweight patient.

Lesson of the Week

Duodenal ulceration—is endoscopic biopsy necessary?

M J GREENALL, M H GOUGH, M G W KETTLEWELL

Because of the benign characteristics of duodenal ulceration the diagnosis is usually made solely on the appearances at endoscopic examination or by a barium meal examination. Not all ulcers in the duodenum are peptic in origin, however, and in these cases biopsy is required to establish the correct diagnosis. We report on two patients in whom the wrong initial diagnosis was made because of the reliance on the endoscopic appearances of duodenal ulceration and the assumption that such ulcers are always benign.

Case reports

Case 1—A 61-year-old man had had a two-week history of epigastric pain and vomiting. Abdominal examination showed no abnormality and basic haematology and biochemical tests were normal. A barium meal examination showed a 0.5 cm ulcer in the first part of the duodenum, and this was confirmed endoscopically. The patient was treated with cimetidine, but as there was no improvement in his symptoms after two weeks laparotomy was performed. This showed a carcinoma of the head of the pancreas eroding the first part of the duodenum and affecting adjacent lymph nodes. The tumour was biopsied and a gastroenterostomy performed. The patient made a good recovery and lived for 15 months but died of abdominal carcinomatosis and jaundice. Examination of the biopsy specimen confirmed adenocarcinoma arising from the head of the pancreas.

Case 2—A 74-year-old woman had had a six-week history of episodic epigastric pain and weight loss. Examination of the abdomen was unremarkable, and an initial clinical diagnosis of gastric ulceration or carcinoma was made. Endoscopic examination showed a normal stomach, but a typical peptic ulcer was seen in the first part of the duodenum. The patient was started on cimetidine treatment but her condition deteriorated. Because of persistent vomiting a laparotomy was performed, which showed a pancreatic carcinoma invading the first part of the duodenum. The tumour was biopsied and a gastroenterostomy performed. Although the patient made a satisfactory recovery she died three

Not all duodenal ulcers are benign

months later from jaundice and cachexia. Examination of the biopsy specimen confirmed adenocarcinoma arising from the pancreatic head.

Comment

The endoscopic appearances of carcinoma of the head of the pancreas producing mucosal nodularity and hyperaemia have been described,¹ but the presentation as apparently a simple ulcer typical of benign peptic ulceration is unusual. The vast majority of duodenal ulcers seen on endoscopic examination are peptic in origin, but primary carcinomas,² lymphomas,³ Crohn's disease,⁴ and tuberculosis⁵ have been reported to produce ulcers or strictures in the duodenum. Both patients described here presented with a short history of upper abdominal pain, and on the endoscopic appearances alone the diagnosis of peptic ulceration was made. If the ulcers had been biopsied the correct diagnosis would have been made earlier.

We suggest that, especially in elderly patients and in those with either an atypical history or no previous symptoms of dyspepsia, the endoscopic appearances of peptic ulceration in the duodenum should be regarded with suspicion and that biopsy should be performed to confirm the diagnosis.

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