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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(Accepted 28 January 1981)

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