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Bran and policy on laxatives

SIR,—The editorial by Drs D N Bateman and J M Smith[1] and article by Mr D R Upton and colleagues[2] show that the cost of laxatives probably varies greatly among hospitals. Dietary fibre is mentioned as well as prescribed fibre. It is a pity that dietary fibre in the form of bran was not mentioned. Bran is cheaper and is a natural product. It can be made available on the wards, especially at meal times. Obviously it is useless for preparing the bowel for investigation or surgery but its use should be encouraged as a long term bulk former. It is cheap and patients can buy it themselves without needing a prescription.

Dietary fibre should be prescribed in the outpatient clinic to those who are to be admitted for non-urgent surgery. This makes recovery from rectal surgery more comfortable and lessens the chance of constipation through being confined to bed.

One aspect of official policy is puzzling. Laxatives derived from plants may be prescribed but Fybranta tablets, each of which contains 2 g of bran, can no longer be prescribed on form FP10. These tablets are a portable form of bran that can be used when patients are at work or away from home on holiday. It is strange that they cannot be prescribed when other expensive laxatives may be given freely at public expense.

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Anticoagulant drugs in the elderly

SIR,—This subject has remained controversial largely owing to lack of data specifically related to the elderly, particularly those receiving long term treatment with oral anticoagulant drugs,[1] and the correspondence on the topic would support this.[2,3] We think, however, that sufficient consideration has not been given to the way that we monitor anticoagulant control and follow up elderly patients.

We wish to draw attention to a study we recently published.[4] Forty nine patients aged 65-89 were treated for six months to six years, resulting in a total of over 195 patient years. Satisfactory mental state, good drug compliance, and proper understanding of the purpose of anticoagulant treatment were considered essential prerequisites for long term treatment. Our patients were seen only at the geriatric medical outpatient clinic at weekly intervals or less frequently. At each visit a comprehensive clinical assessment was carried out by the clinic doctor (usually a consultant or registrar).

In this selected group of patients we did not see any variation in the efficacy of anticoagulant control or the occurrence of complications or treatment failures with age, sex, social class, mobility, visual acuity, domiciliary supervision of medication, or the indication for anticoagulant treatment. We saw poor and erratic anticoagulant control in patients receiving drugs likely to interact with warfarin, those who were receiving multiple drug treatments, and those for whom multiple changes in drugs were made over the study period.

Our series showed a low incidence of haemorrhage (3·1 per 100 patient years) and no deaths due to anticoagulant treatment. Those who bled showed poor overall anticoagulant control from the outset, were assessed more frequently and had doses adjusted more frequently, and their haemorrhages were quickly recognised.

We think that if patients are selected carefully and the approach taken in our geriatric medical outpatient clinic, which emphasises regular patient monitoring with minimum use of other drugs, continuity in patient care, and comprehensive clinical documentation, is adopted the use of anticoagulant drugs in elderly outpatients can be valuable and safe.

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Clinical aspects of Hodgkin's disease

SIR,—Dr G M Mead and Professor J M A Whitehouse state that bone marrow trephine is necessary in Hodgkin's disease in patients with B symptoms and those with stage III and IV disease.[1] One might reasonably ask why they consider this to be so. Such patients would normally receive chemotherapy, and the findings from examination of bone marrow would not affect the treatment given. It would seem more logical not to carry out this unpleasant and often painful procedure unless it were necessary to determine treatment.

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1 Mead GM, Whitehouse JMA. Clinical aspects of Hodgkin's disease. *Br Med J* 1988;**297**:1562-4. (17 December.)

AUTHORS' REPLY,—Dr Watts has chosen to strike at one of the basic tenets of cancer management—the usefulness of staging.

A staging bone marrow examination provides useful prognostic information (stage IIB and IVBM+ have a widely differing prognosis) and allows comparison of treatment results between centres. Perhaps more importantly, the knowledge that marrow disease is present helps guide treatment; its presence reduces the likelihood that radiotherapy would be considered in the initial treatment plan; and patients with diseased marrow can easily be tested again after chemotherapy to provide histological confirmation of remission. Finally, initial chemotherapy will fail to benefit many patients, and high dose chemotherapy regimens supported by transfusion of autologous bone marrow are becoming an integral part of their treatment. Knowing that the bone marrow is affected can be important and may influence treatment decisions and results.

While staging laparotomy is used less commonly, examination of the bone marrow remains a simple and essential procedure for patients at high risk.

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Duodenal ulcers that are difficult to heal

SIR,—Dr Roy Pounder recommended a triple therapy regimen of amoxycillin, metronidazole, and a bismuth compound for the treatment of refractory duodenal ulcers on the basis that such ulcers may be associated with *Campylobacter pylori*.[1]

We have recently reported a pilot study of the use of metronidazole alone in the eradication of *C pylori*,[2] in which we found that eight out of 10 cases failed to show elimination of the organism. Two isolates showed resistance in vitro to metronidazole before treatment started and a further four showed resistance in vitro after a three week course of treatment.

Although metronidazole alone has been reported to be successful in treating duodenal ulceration,[3] further studies are obviously needed to determine whether metronidazole is playing an active part in the regimen recommended by Dr Pounder.

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Internuclear ophthalmoplegia in pernicious anaemia

SIR,—Drs R H Kandler and G A B Davies-Jones described internuclear ophthalmoplegia in a patient with pernicious anaemia.[1] In view of my recent experience I wondered if the patient might also have multiple sclerosis, although there is evidence against this interpretation.

Over five years I have observed three patients with multiple sclerosis and unusual vitamin B_{12} deficiencies. After reporting these cases[2,3] I received seven referrals from other neurologists in one year. Of the total of 10 patients, one had an internuclear ophthalmoplegia, but it was uncertain whether this was due to multiple sclerosis or vitamin B_{12} deficiency, or both.[4] Only two patients had pernicious anaemia, and in the remainder the cause of the vitamin B_{12} deficiency was obscure, but a vitamin B_{12} binding or transport problem was suspected.[2-4] The age at presentation was typical for multiple sclerosis, eight presenting before the age of 40, which is rare for vitamin B_{12} deficiency.