Complications of Carbenoxolone Therapy

Str.—The letter from Dr. A. N. Kingsnorth (31 August, p. 579) stimulated by the recent article by Dr. G. J. Davies and others (10 August, p. 400) tends to cloud the issue. The presentation of carbenoxolone side effects is not invariably congruous side failure, and this is clearly demonstrated in the original paper. In the absence of ileus the oral administration of potassium supplements is equally effective as, and less hazardous than, their intravenous infusion: to overcome the cumulative deficit of hundreds of milliequivalents of potassium will in any case require days rather than hours. Most serious of all, there is no "good case" for the use of an "aldosterone-antagonist-like diuretic agent." Quite the reverse, since it has been shown and is accepted in undergraduate textbooks that spironolactone will actually prevent the effect of carbenoxolone in healing gastric ulcers. Thiazide diuretics will prevent the fluid retention without altering the course of the disease, and further exacerbate potassium loss. The only way to combat this is to administer large quantities of potassium-containing drugs.

The best current policy is to use carbenoxolone only in patients with normal serum potassium and blood urea and without signs or history of heart failure or hypertension. The course of treatment should be carefully monitored to ensure prompt detection of weight loss, potassium loss, or hypokalaemia. If it is desired to reverse or prevent the fluid retention or potassium loss, then thiazides plus substantial amounts of potassium chloride are indicated on present information. The aldosterone antagonist spironolactone is definitely contraindicated.

In the situation where the patient is committed to three different drugs totally maybe more than a dozen tablets daily a single potassium diuretic tablet might well be preferable. Criteria for the ideal diuretic are adequate prevention of sodium and water retention, prevention of potassium loss, and freedom from antagonism of the therapeutic effect of the diuretic. Possibly useful agents available are triamterene and amiloride, which have both been proposed. Our search of the literature has not found any work establishing the value of either of these agents with carbenoxolone therapy and we are at present engaged in a trial to evaluate amiloride.—We are, etc.,

A. HULME
M. C. BATESON

University Department of Medicine,
Ninewells Hospital,
Dundee


Prazosin and Hydralazine in the Treatment of Hypertension

Str.—We noted with interest the preliminary report by Drs. G. S. Stokes and M. A. Weber (11 May, p. 298) on the anti-hypertensive effects of prazosin. We have conducted a double-blind crossover trial comparing the antihypertensive effects of prazosin and hydralazine in combination with a beta-blocking agent and a thiazide diuretic, the results of which will shortly be published.

The double-blind addition of capsules containing either 1 mg of prazosin or 25 mg of hydralazine produced a significant fall in the blood pressure in this study. We had assumed from open studies that 25 mg of hydralazine was equivalent to approximately 1 mg of prazosin, but the results of the controlled trial suggest that the hypotensive effects of 25 mg of hydralazine may be rather greater than those of 1 mg of prazosin.

B. A. J. PRIESTLEY
P. A. BRENNER

Department of Medicine,
Guy's Hospital, London SE1 1UL

3 A.B.P.I. Data Sheet Compendium 1974, p. 91.