Short-term open trial in the treatment of peptic ulceration with ranitidine

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A considerable amount of works has been undertaken to evaluate the place of the new histamin H2-receptor antagonist, ranitidine in the treatment of both gastric and duodenal ulcers.

In 1980, a double blind study of short-term cimetidine in treatment of duodenal ulcer, showed a result of 76% healing rate at 6 wks in our unit. The study demonstrated an increased symptoms response but not an acceleration of healing in duodenal ulcer treated with cimetidine.

Three years later, in the Spring of 1983, we had an opportunity to study the new histamin H2-receptor antagonist ranitidine in the treatment of both duodenal and gastric ulcer by open trial.

In the Spring of 1983, thirty endoscopically proven patients including 22 cases of duodenal ulcer and 8 cases of gastric ulcer, entered the ranitidine open and short-term study.

Patients were treated with 150 mg ranitidine b.d. for two, four or six weeks. They were followed up in out outpatient department weekly to record the general conditions and the consumptions of the trial tablets. Endoscopy was done on the day before the treatment and was repeated by the same endoscopist after two, four or six weeks of treatment. The ulcers were staged endoscopically according to Dr. Sakita's classification. The requirement of all patients in this study was the presence of active fresh ulcer crater and the criteria of ulcer healed were when ulcers entered to scaring stage, $S_1$ or $S_2$ and improved result were evaluated as ulcers were turned into healing stage, $H_2$-$H_3$.

The healing rate of active round duodenal ulcer after 2, 4 or 6 weeks therapy of ranitidine were 43.8%, 72.7% and 75%, respectively, and symptoms relief rate were 83.3%, 87.5% and 90%, respectively. It appeared to be as effective as cimetidine for the healing of active duodenal ulcer. The healing rate of linear duodenal ulcer was only 33.3% after 6 weeks ranitidine therapy. It was significantly different in comparison with round duodenal ulcer. At the end of 2 and 4 weeks ranitidine therapy, the healing rate of gastric ulcer were 25% and 57.1%, respectively. There are no remarkable side effect after short-term use of ranitidine except some oral dryness and dizziness cases.

This study showed ranitidine had good effects in the short term treatment of duodenal ulcer for ulcer healing and symptoms relief without evidence of side effect. In comparison with our previous study of cimetidine for duodenal ulcer (healing rate 76% and symptoms relief rate 100% at the end of 6 weeks therapy) both of them almost had the some effects.

Long term study and follow up is necessary to evaluate the efficacy, recurrence rate and side effects.


Villous tumors of the gastrointestinal tract

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Conclusion: 1. Villous tumors found in the colon are rather common as compared with the stomach and small bowel. They represent about 11% of all colorectal polyps.

2. We found three cases coexisting with benign adenomatous polyps, one case with Ca. of rectum and another with multiple polyposis which later appeared as frank malignant change.

3. The malignant change and its size is not paralleled. Benign villous adenoma could be larger than 8 cm while malignant villous tumors could be noted less than 1.1 cm.

4. Carcinoma in situ usually can be treated adequately by local resection. Multiple biopsies or even total excision by polypectomy can make accurate histological diagnosis. Piece-meal endoscopic polypectomy for larger villous adenoma should be carried out with extreme care.

5. If invasive carcinoma is found or the lesion is huge and/or broad based, formal resection should be performed.

6. Lymph nodes metastasis are quite rare in malignant villous tumors. The natural history of villous tumor is different from that of primary adeno­carcinoma of the colon.

Twenty-seven cases of cholangiocellular carcinoma

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In Taiwan, most of the primary liver carcinoma belongs to hepatocellular carcinoma, and the ratio of hepatocellular carcinoma to cholangiocarcinoma is about 35-25 to 1. However, the remarkable progress made in recent years in the diagnosis of hepatobiliary disease by such procedures as direct cholangiography including PTC & ERCP, liver scintiscanning, celiac angiography, AFP determination and abdominal ultrasonography has made it possible, if not always, to differentiate clinically the two major types of primary liver carcinoma.

From 1979 till the end of September 1982, 27 cases of histopathologically proved cholangiocarcinoma were encountered in Taipei Municipal Jen­Ai Hospital. Ten out of 27 cases were discovered in the past year, the ratio of Hepatocellular carcinoma to Cholangiocarcinoma became 15 to 1.

In these 27 cases, 14 were male & 13 were female. Their age was from 29 to 80 years, mean age 55. Ten cases were classified as hilar type and 17 as peripheral type. Ten out of the 17 peripheral type cholangiocarcinoma were coexistence with liver stones and stones within the tumor was found in 4 cases.

Either in cases of hilar type or peripheral type cholangioma, most of the patients complained of epigastric or right upper quadrant pain, fever and jaundice on admission. In anatomical situation, jaundice always developed earlier in hilar tumor than peripheral tumor and also Charcot's triad due to cholangitis caused by biliary tract obstruction. Body weight loss and hepatomegaly was not uncommon in both type cholangiocarcinoma. Since hilar type cholangiocarcinoma could cause obstructive jaundice in its early stage, it is easier to get the earlier diagnosis. By contrast, peripheral type tumor is difficult to diagnose by symptomatology and ERCP in the early stage. Scintiscanning finding is not specific. In the past two years, we got some experiences in diagnosing cholangiocarcinoma by ultrasonography. Cholangiocarcinoma could be classified into 3 U.S. patterns: (1) liver stones coexist with hypo or hyperechoic mass or only positive marginal