



Reduces gastric acid secretion.

New data now available.

1 Healing

Further experience in clinical trials confirms that 4-8 weeks 'Tagamet' treatment achieves remarkable results in duodenal ulcer,^{1,2,3} gastric ulcer,^{2,4,6} and reflux oesophagitis.^{2,5}

Overall Experience	TAGAMET % healed	PLACEBO % healed
Duodenal Ulcer	77% of 803 patients	41% of 252 patients
Gastric Ulcer	74% of 130 patients	45% of 64 patients
Reflux Oesophagitis*	62% of 39 patients	9% of 23 patients

*includes oesophageal ulcers and erosions: complete healing or marked improvement.

In addition to complete healing (proven endoscopically), early and dramatic symptomatic relief is achieved in most patients. With its convenient dosage and low incidence of side effects, 'Tagamet' is well suited to everyday treatment.

2 Recurrence

A group of duodenal ulcer patients was followed for periods of up to 6 months after completing 4-6 weeks 'Tagamet' treatment. Preliminary results show that the incidence of relapse was no greater than in a similar group who had healed their ulcers on placebo.^{2,7}



Artist's impression of H₂ receptor antagonist acting at receptor site in gastric mucosa.

3 Maintenance

377 chronic duodenal ulcer patients, who had healed their ulcers after 4-6 weeks treatment were entered into controlled, double-blind maintenance trials. They were maintained on 'Tagamet' or placebo therapy, at a reduced dosage, for periods of up to 6 months. Results from these ongoing studies have shown that only 5.7% of the 'Tagamet' group relapsed⁷ compared with 42.1% of the group who were maintained on placebo.



References

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7. Long-term treatment with cimetidine in duodenal ulceration (1977) *Lancet*, i, 900.

'Tagamet' (cimetidine) is available as 200mg film-coated tablets, 200mg/5ml syrup and 200mg/2ml ampoules.

Full prescribing information is available from Smith Kline & French Laboratories Limited, a SmithKline company, Welwyn Garden City, Hertfordshire, AL7 1EY. 'Tagamet' is a trade mark.

SK&F

Tagamet

(cimetidine, SK&F)



The H₂ receptor antagonist
Reduces gastric acid secretion

Advantages of Caved-(S) (deglycyrrhizinised liquorice) in the treatment of Peptic Ulcers

RELAPSE RATE

Caved-(S) has shown its effectiveness in preventing relapse and recurrence of duodenal ulcers.¹

PROTECTION OF MUCOSAL BARRIER

It is now assumed that bile salts may play an important role in the pathogenesis of gastric ulcer by breaking the gastric mucosal barrier and allowing back diffusion of hydrogen ions.² The deglycyrrhizinised liquorice of Caved-(S) has been demonstrated to protect the gastric mucosa against the damaging effect of bile.³

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Treatment of peptic ulcers with Caved-(S) gives the patient rapid symptomatic relief, and therefore additional antacids are not required.

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and allied conditions.

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the condition.

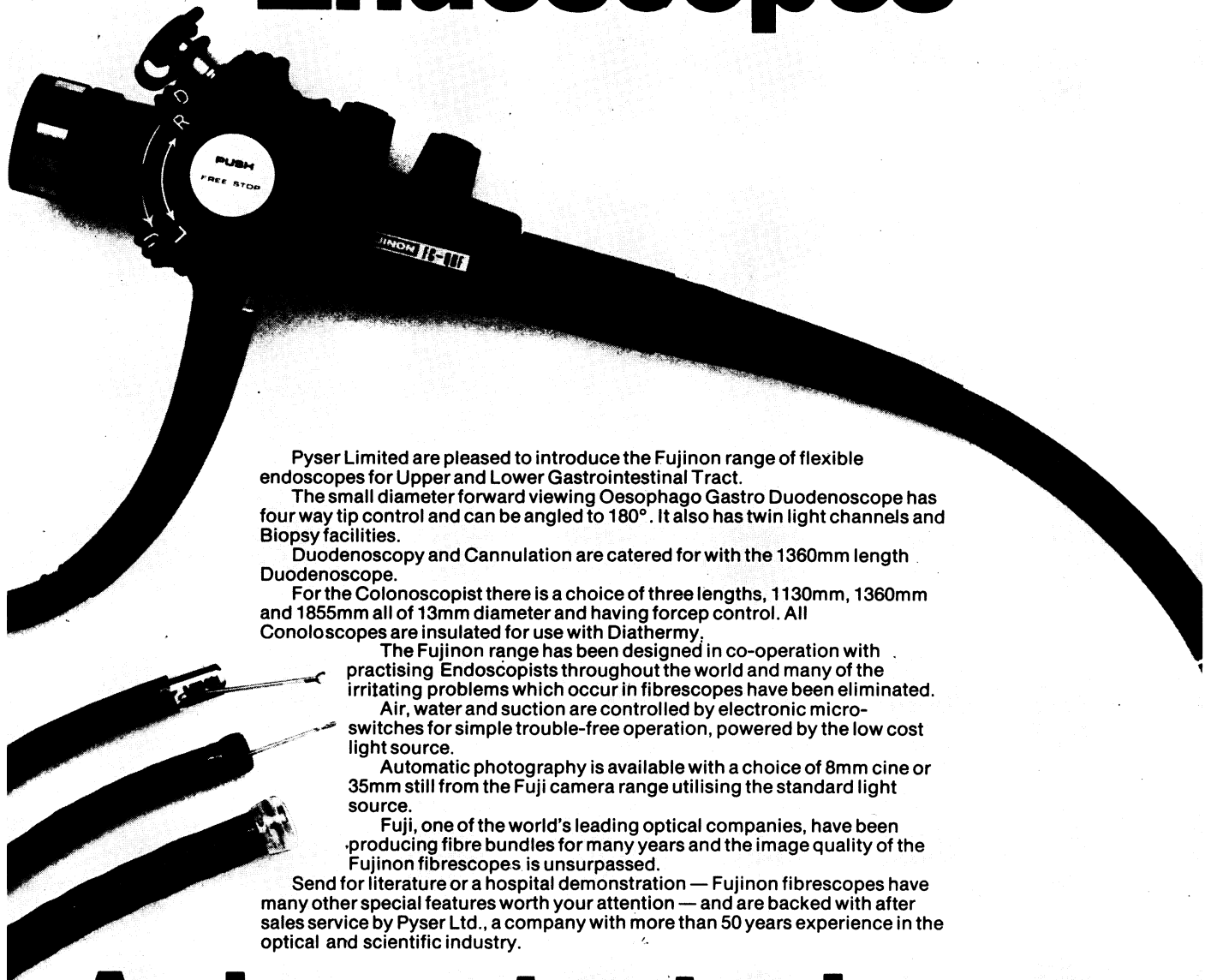
Caved-(S) – does not require additional
antacid therapy.

Caved-(S) – no reported side effects
other than rare cases
of mild diarrhoea.

REFERENCES

1. Tewari, S.N. and Wilson, A.K. (1973): *The Practitioner*, 210, 820.
2. Ivey, K.J. (1971): *Gastroenterology*, 61, 247.
3. Morris, T.J. et al (1974): *Digestion*, 11, 355.

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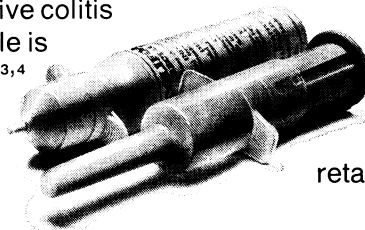
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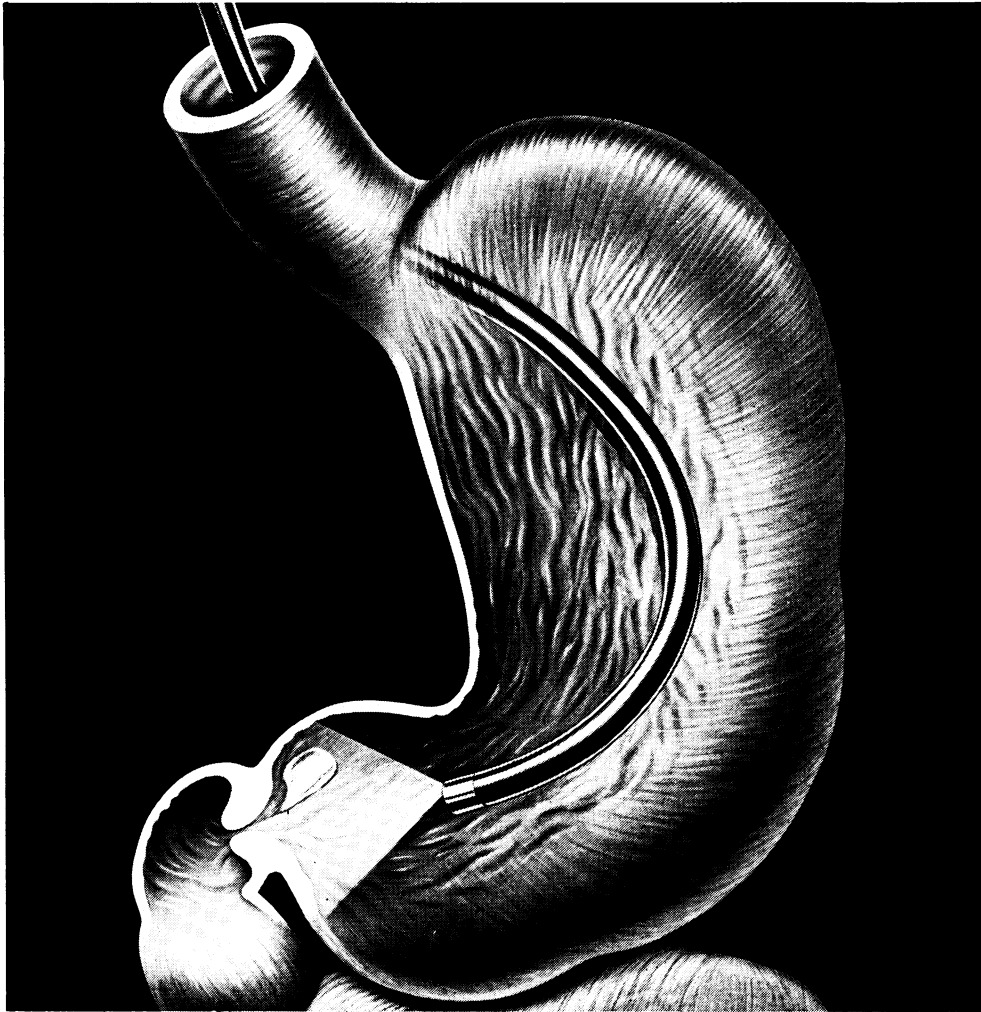
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Further information and a data sheet available on request from:
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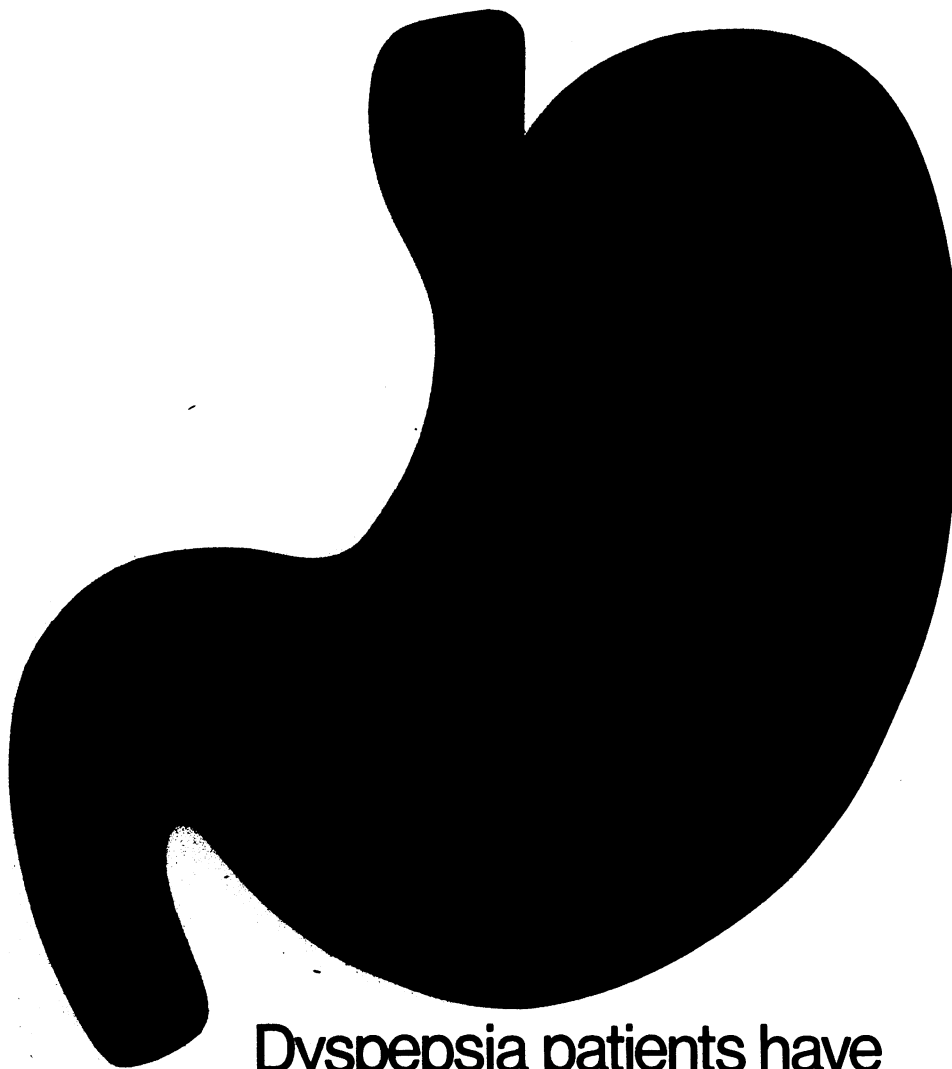
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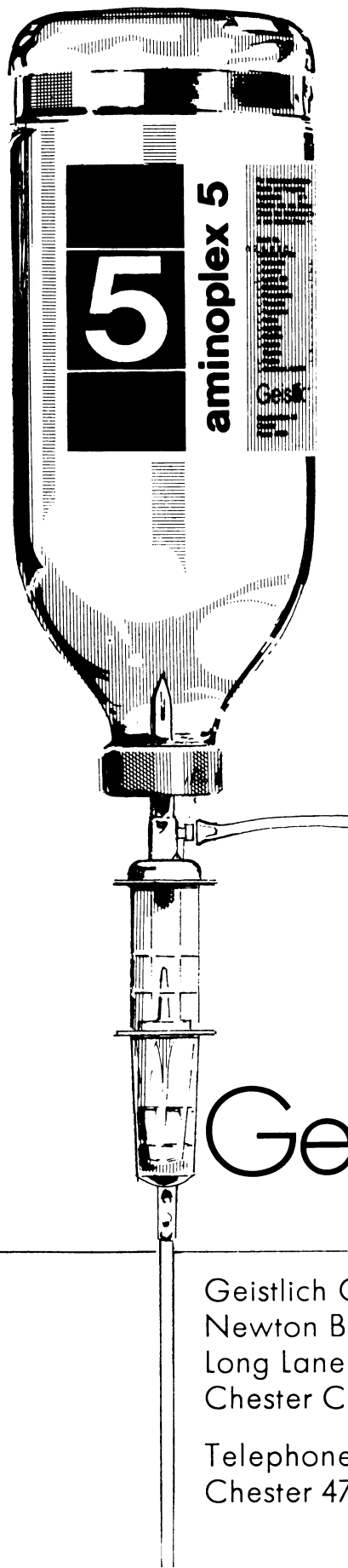


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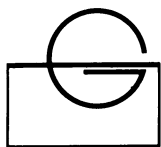
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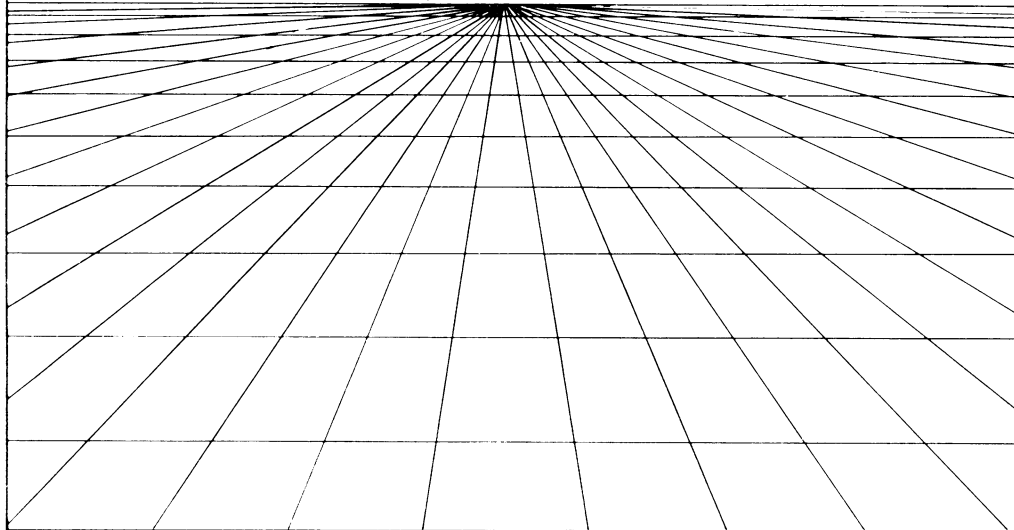
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Salazopyrin ad infinitum!



“It is concluded that maintenance treatment of ulcerative colitis with sulphasalazine (salazopyrin) should be continued indefinitely unless contraindicated by side effects.”¹

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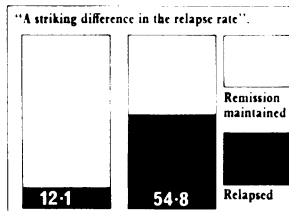
“Fortunately, Sulphasalazine tablets, 0.5 grams 4 times a day will prevent relapses in the majority

of patients with colitis, and only a few patients cannot tolerate this relatively small dose, which can be continued indefinitely since we do not know when, if ever, it can be safely stopped”.⁴

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1. Gut (1973) 14 923 - 926
2. Brit. med. J. (1959) 1 387 - 394
3. Lancet (1965) 1 188 - 189
4. General Practitioner (1972) April 7 p 11

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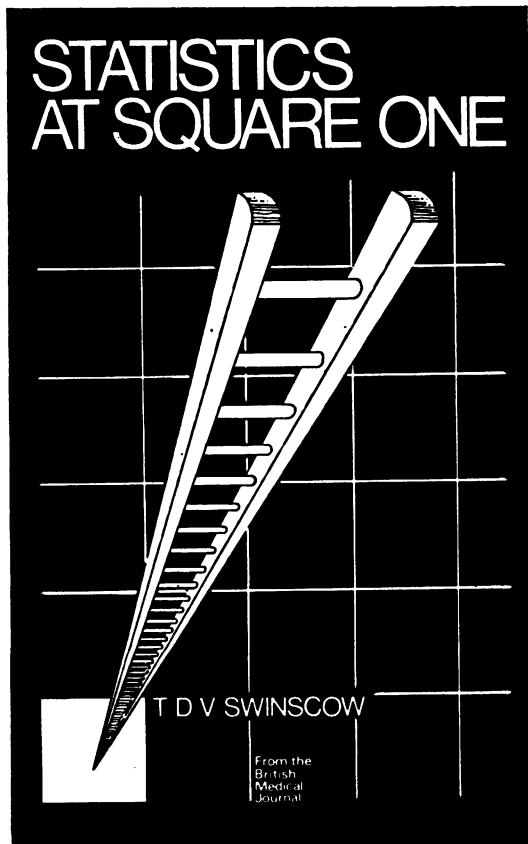
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**DETECTION AND MEASUREMENT OF
CIRCULATING SOLUBLE ANTIGEN-ANTIBODY
COMPLEXES AND ANTI-DNA ANTIBODIES**

Edited by R. N. Maini and E. J. Holborow

A supplement to the Annals of Rheumatic Diseases based on workshops to promote wider knowledge of laboratory methods available for measuring circulating immune complexes and anti-DNA antibodies has just been published.

The supplement is in two parts. 15 methods for detecting soluble immune complexes are described in Section A, including the following: detection by electron microscopy, ultracentrifugation, anti-complementary activity, ¹²⁵I-Clq binding activity, binding to Clq-coated tubes, inhibition of complement dependent rosette formation, polyethylene glycol fractionation, rheumatoid factors and Clq precipitation, C3 activity associated with macromolecules, inhibition of agglutination of IgG-coated particles by rheumatoid factor or Clq, cryoprecipitation, radio-bioassay using macrophages, platelet aggregation and inhibition of antibody-mediated lymphocyte cytotoxicity. Authors include: Almeida, Stanworth, Mowbray, Lambert, Hayward, Hay, Zubler, Winchester, Williams, Masson, Cream, Holborow, Penttinen, Panayi and Soothill.

Section B is divided into three parts. The first contains the details and evaluation of a joint experiment for the detection of anti-DNA antibodies conducted by 12 laboratories in Europe and USA on a panel of 8 sera. The following laboratories were represented: Aarden (Amsterdam), Barnett (Los Angeles), Federlin (W. Germany), Hughes (London), Johnson (Taplow), Lambert (Geneva), Maini (London), Schur (Boston), Steward (London), Stollar (Boston), Tan (La Jolla), Talal (San Francisco). In the second part the methods used by the participants are described. In the third Dr. Barnett, who has a long association with this field, presents a personal view on the present state and future developments in the clinical application of tests for anti-DNA antibodies.

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