be erroneous conclusions if anhedonia were assessed by subjective scales rather than by physiological mechanisms. For example, Loas et al. used subjective scales and concluded that anhedonia does not identify a qualitatively distinct subgroup of depressed patients.

It is suggested that the service of physiologists should be enlisted in clinical research in order to devise valid standardised physiological methods to study both hedonism and anhedonia.

P. S. Gangdev

Department of Psychiatry
Medical University of Southern Africa
PO Box Medunsa
0204


Endometriosis and osteoporosis in practice

To the Editor: Not only nandrolone must be 'viewed with great circumspection in the light of the unambiguous warning by MIMS' of 'troublesome side-effects' in female patients; warnings issued by Martinade, Goodman and Gilman and in the world literature also require serious attention. MIMS issues equally 'serious' warnings on oral contraceptives, oestrogens, progesterones, amiloride (e.g. clomiphene citrate, isotretinoin, vitamins - as a matter of fact to most ethical medicines — so why 'the hysteria the fact to most ethical medicines - so why 'the hysteria...?' Danazol is accepted without any comment as one of the drugs of choice as therapy for endometriosis. Like nandrolone decanoate it is an anabolic steroid (synthetic ethinyl testosterone), but unlike nandrolone decanoate, it requires an added strong warning from MIMS, viz. 'SP: virilisat. not necess. revers.' Furthermore, oral danazol is more expensive and potentially more hepatotoxic than parenterally administered nandrolone decanoate.

Any ethical medicine administered at the dosages and frequency nandrolone decanoate is said to be used by bodybuilders will be likely to be dangerous, if not fatal. But, because qualified medical practitioners are aware of these dangers, their selection of a medication is not only motivated, but the dosage and frequency are adjusted to the individual's specific needs.

Dr MacDonald's heading 'Endometriosis and osteoporosis in practice' and the rest of her letter surely leave no doubt that the crux of the matter relates to 'those suffering from endometriosis [and] with current subnormal testosterone' and prevention of osteoporosis in these specific circumstances. It is amusing that the unpublished data used by Dr MacDonald are stigmatised as 'premature and misleading ... for the formulation of guidelines for hormonal therapy in osteoporosis', when the same unpublished data were allowed to be read as a scientific paper on osteoporosis at the opening of the SEMDSA and LASSA Wilderness Congress on 21 - 25 March 1994.

It is quite true that hyperprolactinaemia can be due to oestrogen deficiency, but, to reverse criticism, 'excessive oestrogen (e.g. oral contraceptives) can cause reduction of the prolactin-inhibiting factor (PIF)' with subsequent release of pituitary prolactin. Furthermore, oestrogen raises the sex hormone binding globulin (SHBG) more than prolactin can decrease it (R. Maartens — unpublished data on 5,466 hormone profiles), which in turn leaves less free oestrogen available to act on bone.

Roald Maartens

6 De Mist Avenue
Welegemoed
7559


Erratum

The following abstract was inadvertently omitted from the SAGES abstracts published in the September SAMJ.

ERADICATION RATES AND ULCER HEALING WITH TWO WEEKS LANSOPRAZOLE BASED H. pylori (HP) ERADICATION THERAPY. JA Louw1, C van Rensburg2, SK Price3, AK Caren3, E Wilken3, SJD O'Keeffe1, W Luckel1 and IN Marks1. GI Clinics & Departments of Medicine1 & Pathology3, Universities of Cape Town1 & Stellenbosch2, Groote Schuur1 & Tygerberg Hospitals3.

While considerable attention has been focussed on the efficacy of PPI-based dual therapy on HP eradication, it is unclear as to how long the PPI should be used to ensure an acceptable speed of ulcer healing. We report on the ulcer healing and eradication efficacy of two dual therapy regimens, based on lansoprazole (Lz) at two different doses. Methods: HP positive patients with active pyloroduodenal ulceration were randomly assigned to receive either Lz 30mg/day or bd, as well as amoxicillin 1g bd for a period of 14 days. Patients were endoscoped following 14 days of treatment and 4 weeks later. HP status was determined by urease reaction (antrum) and histology in both antrum and gastric body (modified Giemsa, two biopsies each).

Results: Eradicated = HP negative all sites, at 6 weeks (4 weeks after cessation of therapy). Healed = complete epithelialisation.

Healed, 14days: Lz 30mg oad 95% CI
ITT: 21/26(81%) 25/30(83%) -18 -23 %
Per Protocol: 20/25(80%) 25/28(89%) -10 -29 %

Unhealed: 5* 5

Eradication: ITT: 6/21(29%) 8/26(31%) -24 -28 %
Per Protocol: 5/20(25%) 8/25(32%) -21 -7 %

ITT = "intention to treat" */ 1 = symptomatic and withdrawn from study; 3 of the remaining 9 unhealed patients went on to heal at 6/52, while 5 remained unhealed but asymptomatic; no follow-up data on 3 patients. Patient tolerance acceptable with both regimes; one patient withdrawn due to allergic reaction.

Conclusion: Our data suggests that 14 day therapy with lansoprazole, 30mg/day or bd, heals 80% or more of pyloroduodenal ulcers. Although low, the eradication efficacy falls within the wide range reported for PPI-based dual therapy. Further studies are needed to define the optimal antibiotic co-therapy, with regard to both short term healing and HP eradication.