

# Peptic ulcer disease

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This issue's special feature, on which these questions are based, was commissioned from independent authors. The Life-long Learning scheme is supported by an educational grant from Mayne Pharma but the company has no editorial input. The scheme is open to all pharmacists. The information in the box below should help readers to identify knowledge gaps and undertake continuing professional development. Readers are also invited to complete the questions overleaf on peptic ulcer disease, to test their knowledge of the articles, and send their answers, together with a stamped and addressed A5 envelope, to:

**Life-long Learning – PUD**  
**Hospital Pharmacist**  
**1 Lambeth High Street**  
**London SE1 7JN**

Entries must be received by 4 September. Results will be returned with a certificate of completion.

Mayne Pharma is offering a place as part of its delegation to the European Association of Hospital Pharmacists conference in spring 2007 to the entrant who achieves the highest marks overall in this series of exercises. The best eight scores from the ten exercises in the series (September 2005 – July/August 2006) will be taken into



consideration. This is the tenth set of questions.

The runner-up will receive registration and expenses for the *Hospital Pharmacist* conference in 2007. Third and fourth place, respectively, will receive Pharmaceutical Press vouchers and British Society for the History of Pharmacy china mugs. Further details on this scheme can be found in *Hospital Pharmacist* (2004;11:436) and at [www.pjonline.com/lifelong](http://www.pjonline.com/lifelong)

Your name, address and scores will be held on a database for the purpose of awarding prizes. Should you wish your details not to be held in this way, please tick the box. If you do this, you will be sent a certificate, but you will be ineligible for a prize.

Name: \_\_\_\_\_

RPSGB registration number: \_\_\_\_\_

Address: \_\_\_\_\_

Post code: \_\_\_\_\_

## How to undertake continuing professional development

### Identify knowledge gaps

- ◆ To understand the causes and clinical presentation of peptic ulcer disease
- ◆ To understand the techniques used to diagnose the condition and the treatment options available

### Act

- ◆ Read the articles in this issue
- ◆ Test your knowledge by answering the multiple-choice questions on peptic ulcer disease overleaf

### Evaluate

- ◆ What have you learnt?
- ◆ How has it added value to your practice?

- ◆ What will you do now and how will this be achieved?

The feature on peptic ulcer disease has been accredited by the College of Pharmacy Practice against the Royal Pharmaceutical Society's general and hospital practice areas of competence, which can be accessed via *Hospital Pharmacist* online ([www.pjonline.com/links/hp](http://www.pjonline.com/links/hp))

Reading the feature and completing the questions will help readers to fulfil aspects of the following competency areas, depending on their area of practice and application of learning: G1, G5, G8, G9, HP1, HP2, HP4, HP5, HP10.

Completion of the questions entitles undergraduates to one point towards the Professional Development Certificate, a joint initiative between the British Pharmaceutical Students' Association and the College.



The assistance of the College of Pharmacy Practice is acknowledged in producing the CPD elements of this month's special feature.

Further information on how hospital pharmacists are approaching the challenges of CPD can be found in articles in the February 2005 issue of *Hospital Pharmacist* (2005;12:65–72).



To answer the questions, tick either the True or False column

	True	False		True	False
<b>1. Regarding the epidemiology of peptic ulcer disease (PUD):</b>			<b>6. Concerning therapy for acute bleeding:</b>		
a) The lifetime prevalence of PUD in the UK population is about 10 per cent			a) If reversal of anticoagulation is required, vitamin K 10mg is recommended		
b) Duodenal ulcers are four times more common than gastric ulcers			b) It may take up to 12 hours for vitamin K to reverse anticoagulation fully		
c) The overall incidence of <i>Helicobacter pylori</i> -related PUD is increasing in the developed world			c) Blood transfusion should be considered if a patient's haemoglobin level is <10g/dl		
d) <i>H pylori</i> infection has prevalence rates of up to 80 per cent in the developing world			d) Intravenous proton pump inhibitor (PPI) therapy should be given to all patients with peptic ulcer bleeding		
e) NSAIDs are the most common cause of PUD			e) Antibiotic prophylaxis is required for all patients before endoscopy		
<b>2. Concerning risk factors for PUD:</b>			<b>7. Regarding ulcers and NSAIDs:</b>		
a) <i>H pylori</i> infection and NSAID use are independent and synergistic risk factors for complicated peptic ulcers			a) NSAIDs should be stopped where possible in patients with PUD		
b) Smoking has a protective role in PUD			b) Concomitant use of steroids increases the risk of gastrointestinal complications in patients taking NSAIDs		
c) Life difficulties and lower socio-economic status are associated with PUD			c) Eradicating <i>H pylori</i> increases healing rates in NSAID-associated ulcers		
d) Advanced age increases the risk of PUD			d) Ulcers can be healed while a patient continues to take NSAIDs		
e) First degree relatives of patients who have had a duodenal ulcer have a two- to three-fold increase in risk of developing an ulcer themselves			e) Prophylactic drug therapy for PUD is indicated for all patients taking NSAIDs		
<b>3. Concerning <i>H pylori</i> and NSAIDs in PUD:</b>			<b>8. Concerning <i>H pylori</i> eradication</b>		
a) Almost all people infected with <i>H pylori</i> will develop PUD			a) Eradication increases the rate of healing of duodenal ulcers		
b) <i>H pylori</i> infection of the gastric antrum accounts for the majority of PUD			b) Eradication decreases the recurrence of gastric and duodenal ulcers		
c) <i>H pylori</i> infection leads to increased gastric acid secretion and reduced duodenal bicarbonate secretion			c) Eradication therapy should be taken for 14 days		
d) Topical preparations and enteric coated NSAIDs do not cause PUD			d) There are concerns that the PMC250 regimen may induce resistance to metronidazole and clarithromycin		
e) The risk of peptic ulcer bleeding has been found to be lower for ibuprofen and diclofenac than piroxicam and indometacin			e) First line eradication regimens achieve eradication rates of 70-75 per cent		
<b>4. Regarding the clinical presentation of PUD:</b>			<b>9. Concerning follow up after PUD treatment:</b>		
a) Peptic ulcer pain can be periodic, with each episode lasting for a few weeks			a) Duodenal ulcers should be rescoped to check healing		
b) NSAID-induced ulcers can be asymptomatic until the patient develops complications			b) The carbon-13 urea breath test is the preferred test for confirmation of eradication of <i>H pylori</i>		
c) Abdominal pain is a good predictive measure for PUD			c) Retesting of gastric ulcers should take place six to eight weeks after starting treatment		
d) Typical duodenal ulcer pain is relieved by food or antacids			d) Acid suppression treatment may produce false positive results for <i>H pylori</i>		
e) Typically, patients with duodenal ulcers will lose weight			e) Repeat courses of eradication therapy should use different antibiotics from those used previously		
<b>5. Concerning the diagnosis and complications of PUD:</b>			<b>10. Concerning the prophylaxis of NSAID-associated ulcers</b>		
a) The rapid urease test for <i>H pylori</i> is an invasive technique requiring endoscopic biopsy			a) Prevention of serious gastrointestinal bleeds is the most important outcome measure in trials		
b) Perforation is the most common complication of PUD, followed by bleeding and pyloric obstruction			b) Misoprostil is better tolerated than PPIs		
c) The introduction of endoscopic therapy for peptic ulcer bleeding has significantly decreased mortality rates			c) Ranitidine has been shown to prevent symptomatic ulcers		
d) Following endoscopic therapy, the risk of rebleeding in high risk patients in the first 48 to 72 hours is around 20 per cent			d) COX-2 inhibitors can be used in patients with a history of peripheral vascular disease		
e) Blood tests are useful for confirmation of <i>H pylori</i> eradication			e) Using a PPI and low dose aspirin causes less recurrent bleeding than clopidogrel		

Answers will appear in the October 2006 issue

