The age of H₂ antagonists for reflux has passed

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In 1976 the launch of cimetidine and subsequently ranitidine and other H₂ receptor antagonists changed the outlook for patients with peptic ulcer disease, but a cure for this disease only came with the discovery of Helicobacter Pylori. In the late seventies it became clear that the management of heartburn and oesophagitis was the more difficult area and to this date we do not have a cure for the disease. A reduced lower oesophageal sphincter tone and frequent relaxations of the sphincter probably underpin this condition which is apparently increasing in frequency world-wide. Treatments to alter sphincter pressure are virtually all surgical and thus symptomatic medical treatment has concentrated on decreasing the volume and acidity of gastric juice. It is clear that H₂ receptor antagonists are effective in this goal raising the median 24h pH to 1.7 or 2.0 in standard doses. In 1983 the first clinical pharmacological studies with proton pump inhibitors were published. We showed that omeprazole could raise the median 24h intragastric pH to 5.0 or higher and this has been emulated by subsequent PPIs. The greatest advance that these drugs have provided relates directly to this feature and in Europe they have taken over as the mainstay of treatment for all dyspeptic conditions. GERD is the predominant condition in which these agents have been used and the newer drugs like Rabeprazole have offered more cost-effective therapies in many countries.

Habit and a belief in the older class of drugs means that many patients continue to take H₂ receptor antagonists and suffer as a result. Symptomatic benefit from antisecretory drugs in GERD has been shown to be related directly to the duration and extent of acid inhibition in the stomach. The duration that pH in the oesophagus remains above pH4 seems critical and raising pH in the stomach to levels above this are therefore crucial to successful antisecretory therapy. There is now satisfactory evidence to show that once daily PPI offers superior healing, and faster or more prolonged symptom relief in patients with erosive, and non-erosive reflux disease compared to H₂ antagonists, prokinetics, antacids and alginates. Quality of life has been shown to improve with PPIs and in managed healthcare systems treatment with PPIs has been shown to be cost effective compared to H₂ antagonists. Thus to withhold PPIs from our patients in the new millennium is to deny them access to the best value and highest quality care available.

REFERENCES

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