papers in this issue) is for recording changes in prescribing and diagnoses, although too much reliance should not be placed on using these data for drug surveillance. Jick and colleagues decided not to collect prescribing information from the many practices with inadequate records: their evidence of adverse reactions to non-steroidal anti-inflammatory drugs therefore came from a highly selected group of doctors, who may have been more observant and careful prescribers. To identify problems early, schemes monitoring the safety of drugs should include a representative sample of doctors.

We believe that the potential for computerised databases in general practice is too important to leave to the vagaries of the market place. Motivated practices can record data to a high standard,[14 15] but this is more likely to occur when practices have training and support and every consulting desk has a computer terminal. Smaller list sizes and longer consultation times would also help.

More government investment in practice databases seems logical given the needs of the Department of Health and health authorities for epidemiological information. Inadequately reimbursing the costs of computers and limiting expenditure on practice staff—the legacy of the 1990 general practitioner contract—is likely to limit realising the full potential of general practice databases.

Agreement should be reached over what is recorded and how. Adopting the Read classification for primary care data is encouraging,[16] but confusion still exists over details such as codes identifying doctors and minimum data sets. Large databases in primary care could one day become powerful tools for research. Much of the hardware is already in place: the next step is convincing general practitioners of the value of keeping high quality records and persuading the NHS of the value of supporting such activity.

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What is a normal upper gastrointestinal tract?

One that has been underinvestigated?

What are we to make of the study by Johnsen and colleagues (p 749), which found that only one in 10 people had an entirely normal upper gastrointestinal tract?[1] This conclusion was reached after endoscopic and histological examinations of 309 people with dyspepsia and 310 without. Perhaps the humorist who remarked that "a normal person is someone who has been insufficiently investigated" was right.

Not all the abnormalities that were found caused symptoms. Although "visual" duodenitis was more common in patients with dyspepsia, "histological" duodenitis was slightly more common in those without. While active chronic gastritis was found more often in the dyspeptic group, well over half of the control subjects had evidence of gastritis on histological examination. No correlation was found between specific symptoms and endoscopic or histological findings.

This emphasises the need for endoscopists not only to document accurately the visual appearances but also, where appropriate, to biopsy—which may confirm or contradict their original opinion. They must also take special care when interpreting the findings for others. Non-specialists may not know that a condition such as diffuse atrophic gastritis is unlikely to cause symptoms. Its appearance on a report may lead to wrongly attributing clinically important symptoms to clinically irrelevant mucosal changes.

Endoscopy has taught us much about gastrointestinal disease, but its limitations should not be forgotten. While overt mucosal lesions are readily and accurately detected endoscopy is not as good at assessing function. Furthermore, the causes of symptoms may not be detectable. (The presence of clinically relevant gastrooesophageal reflux despite normal endoscopic appearances is a case in point.[2])

So what is a normal upper gastrointestinal tract? Normal is not the same as common: more than half the middle aged population is infected with *Helicobacter pylori*, but that does not make it normal. For the individual, a normal upper gut is one that does what is asked of it without complaint. For doctors and scientists, much more research stands between them and a working definition of normality.

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