

Table 1—*H pylori* status of seven patients after three courses of eradication treatment

Case No	First treatment		Second treatment		Third treatment		<i>H pylori</i> status after third treatment	Duration of follow up (months)
	Drug	No of days	Drug	No of days	Drug	No of days		
1	Omeprazole 20 mg twice daily Amoxicillin 1 g twice daily	14	Omeprazole 20 mg daily Tinidazole 500 mg twice daily Clarithromycin 250 mg twice daily	7	Omeprazole 20 mg twice daily Amoxicillin 1 g twice daily Clarithromycin 250 mg twice daily	7	Positive	9
2	Omeprazole 20 mg twice daily Amoxicillin 1 g twice daily Tinidazole 500 mg twice daily	14	Omeprazole 20 mg twice daily Amoxicillin 1 g twice daily	14	Omeprazole 20 mg twice daily Amoxicillin 1 g twice daily Clarithromycin 250 mg twice daily	7	Negative	11
3	Bismuth 120 mg four times daily Tetracycline 250 mg eight times daily Metronidazole 250 mg six times daily	14	Omeprazole 20 mg twice daily Amoxicillin 1 g twice daily Metronidazole 250 mg four times daily	14	Omeprazole 20 mg daily Tinidazole 500 mg twice daily Clarithromycin 250 mg twice daily	7	Positive	13
4	Omeprazole 20 mg daily Tinidazole 500 mg twice daily Clarithromycin 250 mg twice daily	7	Omeprazole 20 mg daily Amoxicillin 1 g twice daily Clarithromycin 250 mg twice daily	7	Bismuth 120 mg four times daily Omeprazole 20 mg twice daily Amoxicillin 1 g twice daily	7	Positive	9
5	Omeprazole 20 mg twice daily Amoxicillin 1 g twice daily Metronidazole 250 mg six times daily	14	Omeprazole 20 mg daily Tinidazole 500 mg twice daily Clarithromycin 250 mg twice daily	7	Omeprazole 20 mg daily Amoxicillin 1 g twice daily Clarithromycin 250 mg twice daily	7	Negative	15
6	Bismuth 120 mg four times daily Tetracycline 250 mg eight times daily Metronidazole 250 mg six times daily	14	Omeprazole 20 mg daily Tinidazole 500 mg twice daily Clarithromycin 250 mg twice daily	7	Omeprazole 20 mg twice daily Amoxicillin 1 g twice daily Clarithromycin 250 mg twice daily	7	Positive	12
7	Omeprazole 20 mg daily Amoxicillin 1 g twice daily Clarithromycin 250 mg twice daily	7	Omeprazole 20 mg twice daily Amoxicillin 1 g twice daily Metronidazole 250 mg six times daily	7	Bismuth 120 mg four times daily Tetracycline 250 mg eight times daily Metronidazole 250 mg six times daily	14	Positive	11

*H pylori* is difficult,<sup>4</sup> and the need to culture the bacterium from several gastric sites in a single patient because of the possible coexistence of several strains compounds this difficulty.

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- Rubin G, Stevens R. Laboratory tests for *Helicobacter pylori* should be more widely available. *BMJ* 1996;313:172-3. (20 July.)
- Cellini L, Allocati N, Di Campi E, Masulli M, Di Bartolomeo S, Dainelli B. *Helicobacter pylori* isolated from stomach corpus and antrum: comparison of DNA patterns. *J Infect* 1996;32:219-21.
- Glupczynski Y, Labbe M, Hansen W, Crokaert F, Yourassowsky E. Evaluation of the E test for quantitative antimicrobial susceptibility testing of *Helicobacter pylori*. *J Clin Microbiol* 1991;29:2072-5.
- DeCross AJ, Marshall BJ, McCallum RW, Hoffman SR, Barrett LJ, Guerrant RL. Metronidazole susceptibility testing for *Helicobacter pylori*: comparison of disk, broth, and agar dilution methods and their clinical relevance. *J Clin Microbiol* 1993;31:1971-4.

## Complementary medicine

### Most private medical insurers will pay for certain forms of complementary medicine

EDITOR,—The news article about the use of complementary medicine in various countries raises several points of interest, such as the variability in the recognition of, and in the attitudes towards, complementary medicine among the public and the medical profession.<sup>1</sup> Little is

known about private medical insurers' reimbursement policies for complementary medicine. The findings of a survey that a colleague and I recently carried out may be of interest.<sup>2</sup> We sent a modified questionnaire<sup>3</sup> to a random sample of 100 rheumatologists across Britain. We also sent a questionnaire to the 20 main private medical insurers, asking about company policy towards reimbursement for complementary treatment.

Seventy one rheumatologists responded. Acupuncture was the most popular discipline (n = 42), followed by osteopathy (n = 24) and the Alexander technique (n = 18). A third (23) of the rheumatologists thought that osteopathy should be available on the NHS, and over half (40) thought the same for acupuncture; other treatments were regarded as less desirable. Rheumatologists generally supported the suggestion that certain disciplines, such as acupuncture, should be taught to medical students and physiotherapists, though they were less supportive of this for other disciplines.

Rheumatologists generally considered osteopathy, acupuncture, and chiropractic to be more effective in treating rheumatic complaints than other complementary treatments. Patients were usually referred to these disciplines after conventional treatment and rarely at their initial consultation. Only a quarter of the respondents were aware that private medical insurers paid for certain forms of complementary medicine.

Of the 20 companies to which we sent questionnaires, 17 responded. Most of the companies paid for chiropractic, osteopathy, homoeopathy, acupuncture, and the Alexander technique. Other treatments were paid for less commonly. In certain disciplines, such as acupuncture, homoeopathy, and the Alexander technique, only consultant referrals were paid for. Some disciplines, such as herbal medicine, naturopathy, reflexology, and aromatherapy, were not paid for even on consultant referral.

Despite much controversy, complementary

medicine is popular with the general public. In the new consumer conscious NHS, trusts must take into account the attitudes of the public as well as of various specialists when planning or purchasing such treatments.

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- Goldbeck-Wood S, Dorozynski A, Lie LG, Zinn C, Josefson D, Ingram M. Complementary medicine is booming worldwide. *BMJ* 1996;313:131-3. (20 July.)
- Pal B, Morris J. Rheumatologists and complementary medicine. *Rheumatology in Practice* 1996;3(2):18-20.
- Perkin MR, Pearcy RL, Fraser JS. Comparison of the attitudes shown by general practitioners, hospital doctors and medical students towards alternative medicine. *J R Soc Med* 1994;87:523-5.

### Norwegian ministry of health is discussing whether to authorise various treatments

EDITOR,—In the article about the use of complementary medicine in various countries, Norway is one of those discussed.<sup>1</sup> We would like to point out an error and to give some more information.

Firstly, it is incorrect to state that no state funding is available for research into complementary medicine. Each year since 1993 the Norwegian Ministry of Health and Social Affairs has given 1.5m Norwegian kroner (£151 500; \$227 250) for research into complementary medicine.

Secondly, the article does not mention chiropractic. Chiropractic is relatively widely practised in Norway, and chiropractors became authorised a few years ago, in 1988. The cost of chiropractic treatment is partly reimbursed.

Finally, we would point out that alternative medicine is still under discussion in the Norwegian Ministry of Health and Social Affairs. One of the questions being discussed is