**The Gastric Jews**

Gastorenterology was taught to us by three Jewish consultants, Gilbert Barbezat, Simi Banks and Solly Marks. They were clinicians in private practice working part-time at Groote Schuur Hospital and the medical school. Their lectures were extremely popular as they were very practically orientated and very humorous. Solly Marks was known for being dramatic. Everyone referred to the three gastroenterologists as the gastric Jews. They knew and thrived on this label and obviously embellished their lectures to get a reaction.

Their first lectures were on nutrition as this was categorized with gastroenterology. I remember Solly talking about brown bread, which everyone had assumed as being more wholesome because it was not as refined. My mother always told me it was better for me. I suspect it was bought because it was cheaper. Solly said, "Brown bread is simply dirty white bread." His sayings became known and recounted. A good one that he probably did not adhere to was, " A fish that doesn't open its mouth cannot be caught."

He gave a lecture on acute pancreatitis which was very common in the Western Cape because of the alcohol consumption over the weekend. Solly stated "The typical patient, is paid on a Friday. He goes to the shebeen (the illicit seller of liquor) and buys a gallon or two of cheap Lieberstein which he and a friend or two consume over a few hours. The next day he has an enormous hangover and doesn't do much. On the Sunday he awakes from the hangover and starts tottering around. He then develops intense epigastric pain. This is extremely intense, and he presents himself to the local emergency room. He is tender in the epigastrium and may or may not be in shock. There are other causes of pancreatitis, but this is the common one you will see." He hesitated for dramatic effect, just like Winston Churchill, used to pause: "The hallmark of this condition is pain that develops the day after the day that followed the night before." We had to think about this statement for a little while, but we did not have to worry too long as he repeated it again. " The hallmark of this condition is pain that develops the day after the day that followed the night before. It occurs in the binge drinkers not the chronic alcoholic."

He further described how you confirmed the diagnosis by measuring the amylase level in the blood and the treatment of acute pancreatitis, which was largely supportive. He then went on to describe the complications of the disease. "Eventually, the pancreas gets destroyed by the multiple bouts of inflammation. The pancreatic duct develops strictures and the patient develops chronic pain because the enzymes accumulate in the obstructed ducts. It is often worsened by eating. To avoid the pain, the patient cuts down on his eating and starts to lose weight." Solly was painting a dramatic picture that only he could do so well, and which is embedded in my memory almost 50 years later. "His weight loss is worsened by the development of diabetes. The endocrine function of the pancreas is now destroyed, and insulin is not being produced." Almost every sentence was separated by a dramatic pause: "The enzymatic function of the pancreas is lost. There are no enzymes secreted to assist in absorption of fat. What do you think happens? The fat passes through without being absorbed and the patient starts to pass large quantities of pale, frothy stools with a lot of gas. This condition is called steatorrhea. Because of the fat the stool floats in the pan. It leaves a horrible rim along the edge. The worse scenario is inability to control the liquid stool which becomes like butter, soils the underpants and leaks down the trouser legs into one’s shoes."

I do not think anyone in that lecture room forgot his description of chronic pancreatitis and steatorrhea. What he certainly did was influence the alcohol consumption of the class - it dropped markedly for the next few months.

Another lecture was on peptic ulcer disease. The prevailing attitude of the time was that peptic ulcers were due to excessive production of acid. Why some patient got peptic ulcer disease and others did not was presumed to be due to differences in acid production. There were various theories including excessive stimulation by the vagal glands, type A personality trait, etc. Acid production was measured by placing a nasogastric tube into the stomach and analyzing the volume of the fluid and its acidity. No one knew what caused the disease and complications of hemorrhage and perforation were very common. We were taught the surgical approaches, which varied depending on the amount of acid produced - Billroth I and II gastrectomies, vagotomies and antrectomies, vagotomies and gastroenterostomies. Recurrences of the disease were common, and the assumption was that the surgical procedure of vagotomy was incomplete. No one today does a Holland test, a test devised to assess the completeness of a vagotomy. Simi and Solly, the gastric Jews were prominent in investigating different therapeutic options for treating this disease and became internationally known for their work.

Solly reviewed the different symptoms and treatment options. At that time a gastric ulcer was thought to be due to a different mechanism than that causing a duodenal ulcer. He then described, with his dramatic pauses, what happened when there was chronic scarring of the duodenum. " The outflow of the stomach becomes obstructed, the patient continually feels bloated, he burps frequently, occasionally he vomits. What he brings up is food that was eaten days before. It smells. The patient has bad breath. He becomes a pariah. He loses weight. When you examine him you will notice an emaciated individual. The outline of the stomach may be seen. There may be visible peristalsis. If you tap the epigastrium and listen with a stethoscope you will hear a succussion splash which is pathognomonic." He then went off at a slight tangent with an anecdote. "We recently had a patient admitted with gastric outlet obstruction. He was watching a movie. It was dark in the theater and everyone was concentrating on the plot. He felt the urge to belch. Just then the person sitting next to him lit a match to light a cigarette (smoking in movie theatres and other public places was common then). As the match was lit the putrefied gases released from the stomach by the belch erupted into flames, extending outwards for about two feet, lighting up the theatre and frightening everyone. It was as if a dragon was belching flame in the movie theatre. The patient was admitted with second degree burns around his mouth." Laughter continued for about five minutes. Solly had succeeded in evoking a response again.

One day a famous gastroenterologist, a Dr Truelove the doyen of gastroenterology in Britain and an expert on inflammatory bowel disease, particularly ulcerative colitis, visited Cape Town. Specialists around South Africa with an interest in gastroenterology travelled to Cape Town to hear him give a series of lectures. Naturally, Solly dominated the proceedings. Dr Truelove was asked to accompany the staff on a ward round. Approximately twenty people were on the round all gathered to hear the pearls of wisdom that would fall from this expert. They came to a colored gentleman, thin and emaciated, scared and somewhat embarrassed to have everyone gathered around his bed. Solly stated to all who were gathered around the patient. "This is a very interesting patient. As you are aware Crohn's disease is extremely rare in the colored population." Everyone nodded. "This patient has Crohn’s disease and has had multiple operations to deal with complications of the disease."

Dr. Truelove was interested in this colored patient with the disease. He asked, "where does he come from?" as if this was important.

Solly asked the patient in Afrikaans. "Waarvandaan kom jy van?" - where do you come from?

"Ek kom van Springbok af" the overawed, thin embarrassed man answered.

"He comes from Springbok," Solly relayed.

"And where is Springbok?" Dr. Truelove enquired, implying that this was important to the pathogenesis of the disease.

"Springbok! Well, if the Cape Province was a patient, Springbok would be the place that you would insert the nozzle of an enema!" Solly exclaimed.

Towards the end of Solly's career, money was raised to establish an annual lecture in his name. Solly was asked to give the inaugural lecture. The lecture hall was crowded. Everyone knew what he was going to talk on. He was going to talk about a revolutionary new drug for peptic ulcer disease, Cimetidine. Solly had been the principal investigator in South Africa and the results had not yet been released. [Histamine](http://en.wikipedia.org/wiki/Histamine) is known to stimulate the secretion of stomach acid, but traditional [antihistamines](http://en.wikipedia.org/wiki/Antihistamine) had no effect on acid production. It was hypothesized that there must be more than one histamine receptor and the Smith Kline and French pharmaceutical team used a rational drug-design structure starting from the structure of histamine - the only design lead, since nothing was known of the then hypothetical H2-receptor. Hundreds of modified compounds were synthesized to develop a model of the receptor. Cimetidine, one of the first drugs discovered using this approach was tested to determine whether it would suppress stomach acid secretion. Sir James W. Black shared the 1988 Nobel Prize in Physiology or Medicine for the discovery of [propranolol](http://en.wikipedia.org/wiki/Propranolol) and also is credited for the discovery of cimetidine.

Solly came to the podium. "Thank you all for coming to this named Solly Marks lecture. By the way, I am Solly Marks."

"I guess you all know what the lecture is going to be about. One of the first things you will want to know is, does it work?" He gave his typical dramatic pause. " If you want to know, just look at my new car and new house!" The laughter and applause went on for about 5 minutes. Only Solly could lecture like this. When the laughter had died down and Solly was about to continue a side door to the lecture room opened and a sheepish person entered. He was obviously late for the lecture. Solly got up from the lectern, went up to him and took him by the arm and lead him to a seat. All the while the person was getting redder and redder. He was extremely embarrassed.

Solly returned to the lectern, "My family were shopkeepers. We learnt early on that that you must always look after a potential customer."

The whole spectrum of peptic ulcer disease changed with the new drugs that controlled acid production and changed again in the early 21st Century when an organism, *Helicobacter pylori* (*H. pylori*) bacteria, was discovered to be responsible for the disease. When I did general surgery peptic ulcer disease was extremely common and not a week went by when we did not need to deal with a perforated or bleeding peptic ulcer. Today these diseases are virtually non-existent; dual antibiotic therapy in combination with H2 blockers or a proton pump inhibitor are effective treatment regimens.