Often Okay to Skip the Scope in Ulcerative Colitis

BY HEIDI SPLETE
Senior Writer

WASHINGTON — Endoscopy is an invasive procedure that patients don't like, and it may not be necessary for the evaluation of ulcerative colitis, Peter Higgins, M.D., said at the Clinical Research 2005 meeting.

In a study of 66 consecutive adult ulcerative colitis (UC) patients, results from two noninvasive indices overlapped significantly with results from invasive indices, said Dr. Higgins of the University of Michigan, Ann Arbor, and his colleagues. Regular use of noninvasive indices to assess UC could lower costs and encourage more patients to participate in clinical trials, he noted.

Overall, endoscopy contributed very little to the assessment. 'We may not need endoscopy' to evaluate ulcerative colitis patients.

The investigators compared invasive and noninvasive indices in terms of how well each measured disease remission and other clinically important outcomes. The invasive indices used were the St. Mark's Index and the Ulcerative Colitis Disease Activity Index (UCDAI), and the noninvasive indices were the Simple Clinical Colitis Activity Index (SCCAI) and the Seo index. In addition, the doctors simply asked patients whether their disease was in remission.

Other indices are available in addition to those used in this study, Dr. Higgins said. "The problem is that none of them are validated, and none of them work that well."

The investigators measured the correlations between the various indices to determine whether the noninvasive tests could provide similar information to that provided by the invasive tests. The two noninvasive indices, SCCAI and Seo, correlated well with the invasive St. Mark's index, with correlations of 0.86 for the SCCAI and 0.70 for Seo.

When the two invasive indices were compared with each other, the UCDAI endoscopy item predicted only 0.04% of the variance in the St. Mark's index after adjustment for the three noninvasive items on the UCDAI index.

Overall, endoscopy contributed very little to the assessment—significantly less than the 10% that Dr. Higgins expected. "We may not need endoscopy" to evaluate UC patients, he said. One explanation for endoscopy's minor role might be that other items on the same scale have measured the same factors, which would make endoscopy redundant.

Dr. Higgins concluded that noninvasive indices could effectively predict remission. "We're not losing much by leaving out endoscopy," he said. The clinical practice of treating patients based on their reported symptoms is appropriate, and clinicians are correct to avoid rushing to scope.

"If the patient tells you they have 10 bloody stools, they are having a flare," he said at the meeting, sponsored by the American Federation for Medical Research. ■

Weaning From PPIs Easier in Patients With Milder Reflux

BY ROBERT FINN
San Francisco Bureau

SAN FRANCISCO — It may be appropriate to wean some patients from the daily use of proton pump inhibitors, but acid rebound can make this more difficult, David A. Peura, M.D., reported at the annual meeting of the American College of Physicians.

In his review of the evidence, Dr. Peura, professor of internal medicine at the University of Virginia, Charlottesville, drew a distinction between patients with gastroesophageal reflux disease (GERD) and those with the less serious nonerosive reflux disease (NERD).

Patients with NERD appear to have a much easier time discontinuing proton pump inhibitors (PPIs) or using them intermittently. In one study, 677 people with NERD who were asymptomatic after 2-4 weeks of PPI treatment were instructed to take a 2-week course of 20 mg of omeprazole, 10 mg of omeprazole, or 150 mg of ranitidine (a histamine$_2$ receptor blocker) whenever symptoms developed (BMJ 1999;318:502-7).

During the year, 40% of patients had no relapses, and 90% of them required three or fewer courses of therapy to maintain satisfaction. This study influenced the dosing recommendation for over-the-counter omeprazole, Dr. Peura said.

On the other hand, weaning patients with GERD from daily PPI therapy may be difficult. An as-yet-unpublished systematic review from the Cochrane Collaboration concluded that about 80% of patients with GERD would experience a relapse of symptoms or esophagitis within 6-12 months if switched to a placebo.

"You can decrease that by giving an individual a half-dose treatment," Dr. Peura said. "I personally never give half-dose PPIs because they're cost equivalent. The only reason you ever reduce the dose is if you worry about cost or safety. There's no safety issue with these doses, and they're flat priced."

When PPIs are stopped abruptly in patients who have been treated long term with PPIs, there's often an acid rebound. According to one study, this effect appears to be restricted to patients who are negative for *Helicobacter pylori* infection (Gastroenterology 2004;126:980-8).

Dr. Peura said that tapering works better than abrupt withdrawal. "If I have somebody who's been on a drug for a while, I won't just stop it. I'll treat them every other day for a while, then every third day, trying to get them off the drug." Tapering can be especially difficult in patients who have been taking twice-daily doses of a PPI, he said, making it important to use only the lowest effective dose.

Dr. Peura acknowledged serving on the speakers' bureaus of TAP Pharmaceutical Products Inc., AstraZeneca PLC, and Wyeth Pharmaceuticals, all of which make medications for gastric reflux. ■

Laparoscopic Appendectomy Cuts Recovery Time, Wound Infections

BY KATE JOHNSON
Montreal Bureau

MIAMI BEACH — Laparoscopic management of acute appendicitis decreases recovery time and wound infection rates while showing the same efficacy as the open technique, reported Dalibor Panuska, M.D., at a congress on laparoscopy and minimally invasive surgery.

The most important reason for doing the procedure laparoscopically is the opportunity to find other pelvic pathologies, such as gynecologic disease.

Although an increasing number of studies have shown the benefits of laparoscopic appendectomy in general, the advantages of the technique specifically for acute appendicitis are not yet been clearly established, reported Dr. Panuska from District Hospital Zvolen, in Slovakia.

In a retrospective study of 553 patients with acute appendicitis who were operated on using either laparoscopy (315) or open surgery (238), the laparoscopic technique resulted in shorter hospital stays (4.4 vs. 5.2 days), fewer doses of postoperative opioids (1.36 vs. 2. 56), and earlier resumption of peristalsis (19 vs. 28 hours), he said at the congress, which was sponsored by the Society of Laparoendoscopic Surgeons.

There was a 6% conversion rate from laparoscopy to open technique. The reasons for conversion were technical failure, perforated appendix, general peritonitis, cavum Douglasi abscesses, and gangrenous or phlegmonous appendix, Dr. Panuska reported.

Wound infections were considerably fewer in the laparoscopy group (1.6% vs. 7.5%). Late abdominal obstruction, a recognized complication of the open technique, was completely absent in the laparoscopic group but occurred in 0.3% of the open-surgery group.

Dr. Panuska said the most important reason for performing the procedure laparoscopically is the opportunity that it affords to pick up other pelvic—particularly gynecologic—pathologies.

"Laparoscopic appendectomy is safe and feasible even in severe, advanced, or destructive forms of acute appendicitis," he concluded. ■

Orthostatic Intolerance May Be On the Rise After Gastric Bypass

NEW ORLEANS — Look for a growing number of patients presenting with orthostatic intolerance as gastric bypass surgery booms in popularity, Blair P. Grubb, M.D., advised at the annual meeting of the Heart Rhythm Society.

The etiology of new-onset orthostatic intolerance caused by autonomic intolerance following gastric bypass surgery is unclear. What is increasingly clear, though, is that the problem is on the rise in clinical practice.

The type of weight-loss surgery doesn't appear to correlate with the patient's specific presenting symptoms.

However, orthostatic intolerance due to autonomic insufficiency does seem to occur preferentially in patients who experience relatively large and rapid weight loss as a result of the operation, according to Dr. Grubb of the Medical College of Ohio, Toledo.

Having anecdotally observed an increasing number of patients presenting with new-onset orthostatic intolerance due to autonomic insufficiency after undergoing gastric bypass surgery, Dr. Grubb and his coinvestigators decided to investigate the issue. They retrospectively collected data on a series of 11 affected patients.

The 10 women and 1 man, with a mean age of 42 years, had a preoperative body mass index of 47 kg/m^2 and lost a mean of 100 pounds after surgery.

All 11 patients presented with a complaint of severe lightheadedness. Five also experienced syncope, seven had near-syncope, and five had orthostatic tachycardia.

All the patients had a positive tilt table test. Six displayed a neurocardiogenic response to the test, three had a postural tachycardiac response, and two had a dysautonomic response.

Standard therapies for autonomic insufficiency, such as fludrocortisone and midodrine, were found to be effective in all the patients studied.

—Bruce Jancin