

Sent on Saturday, 2012 February 25

Search: "Endoscopy, Gastrointestinal"[Mesh] OR ("Endoscopy, Gastrointestinal/contraindications"[Mesh] OR "Endoscopy, Gastrointestinal/methods"[Mesh] OR "Endoscopy, Gastrointestinal/mortality"[Mesh] OR "Endoscopy, Gastrointestinal/standards"[Mesh] OR "Endoscopy, Gastrointestinal/statistics and numerical data"[Mesh] OR "Endoscopy, Gastrointestinal/trends"[Mesh] OR "Endoscopy, Gastrointestinal/utilization"[Mesh])
Limits: Limits: added to PubMed in the last 60 days, published in the last 60 days

PubMed Results

Items 1 - 3 of 3

1 Can J Gastroenterol. 2012 Jan;26(1):17-31.

• [Canadian Association of Gastroenterology consensus guidelines on safety and quality indicators in endoscopy.](#)

[Armstrong D](#), [Barkun A](#), [Bridges R](#), [Carter R](#), [de Gara C](#), [Dube C](#), [Enns R](#), [Hollingworth R](#), [Macintosh D](#), [Borgaonkar M](#), [Forget S](#), [Leontiadis G](#), [Meddings J](#), [Cotton P](#), [Kuipers EJ](#); [Canadian Association of Gastroenterology Safety and Quality Indicators in Endoscopy Consensus Group](#).

Source

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Comment in

- [Can J Gastroenterol. 2012 Jan;26\(1\):15-6.](#)

Abstract

BACKGROUND:

Increasing use of gastrointestinal endoscopy, particularly for colorectal cancer screening, and increasing emphasis on health care quality, highlight the need for clearly defined, evidence-based processes to support quality improvement in endoscopy.

OBJECTIVE:

To identify processes and indicators of quality and safety relevant to high-quality endoscopy service delivery.

METHODS:

A multidisciplinary group of 35 voting participants developed recommendation statements and performance indicators. Systematic literature searches generated 50 initial statements that were revised iteratively following a modified Delphi approach using a web-based evaluation and voting tool. Statement development and evidence evaluation followed the AGREE (Appraisal of Guidelines, REsearch and Evaluation) and GRADE (Grading of Recommendations, Assessment, Development and Evaluation) guidelines. At the consensus conference, participants voted anonymously on all statements using a 6-point scale. Subsequent web-based voting evaluated recommendations for specific, individual quality indicators, safety indicators and mandatory endoscopy reporting fields. Consensus was defined a priori as agreement by 80% of participants.

RESULTS:

Consensus was reached on 23 recommendation statements addressing the following: ethics (statement 1: agreement 100%), facility standards and policies (statements 2 to 9: 90% to 100%), quality assurance (statements 10 to 13: 94% to 100%), training, education, competency and privileges (statements 14 to 19: 97% to 100%), endoscopy reporting standards (statements 20 and 21: 97% to 100%) and patient perceptions (statements 22 and 23: 100%). Additionally, 18 quality indicators (agreement 83% to 100%), 20 safety indicators (agreement 77% to 100%) and 23 recommended

endoscopy-reporting elements (agreement 91% to 100%) were identified.

DISCUSSION:

The consensus process identified a clear need for high-quality clinical and outcomes research to support quality improvement in the delivery of endoscopy services.

CONCLUSIONS:

The guidelines support quality improvement in endoscopy by providing explicit recommendations on systematic monitoring, assessment and modification of endoscopy service delivery to yield benefits for all patients affected by the practice of gastrointestinal endoscopy.

PMCID: PMC3275402 [Available on 2013/1/1] **Free Article**

PMID: 22308578 [PubMed - indexed for MEDLINE]

[Related citations](#)

2 Can J Gastroenterol. 2012 Jan;26(1):15-6.

. [Reaching a consensus of what an endoscopy service should be doing: a critical step on the road to excellence in endoscopy.](#)

[Valori R.](#)

Comment on

- [Can J Gastroenterol. 2012 Jan;26\(1\):17-31.](#)

PMCID: PMC3275401 [Available on 2013/1/1] **Free Article**

PMID: 22288067 [PubMed - indexed for MEDLINE]

[Related citations](#)

3 Am J Gastroenterol. 2012 Jan;107(1):139; author reply 139. doi: 10.1038/ajg.2011.331.

. [Re: screening colonoscopy for the underserved.](#)

[Yarze JC](#), [Rugge J.](#)

Comment on

- [Am J Gastroenterol. 2011 Jul;106\(7\):1193-5.](#)

PMID: 22218034 [PubMed - indexed for MEDLINE]

[Related citations](#)

Sent on Saturday, 2012 March 03:

PubMed Results

Items 1 - 6 of 6

1. N Engl J Med. 2012 Feb 23;366(8):759-60.

. [Colonoscopy as a triage screening test.](#)

[Bretthauer M](#), [Kalager M.](#)

Comment on

- [N Engl J Med. 2012 Feb 23;366\(8\):687-96.](#)
- [N Engl J Med. 2012 Feb 23;366\(8\):697-706.](#)

PMID: 22356330 [PubMed - indexed for MEDLINE]

[Related citations](#)

2 N Engl J Med. 2012 Feb 23;366(8):744.

. [Images in clinical medicine. Sigmoid perforation in association with colonoscopy.](#)

[Lu A](#), [Aronowitz P.](#)

Source

Loma Linda University, Loma Linda, CA, USA. allu@llu.edu

Free Article

PMID: 22356327 [PubMed - indexed for MEDLINE]

[Related citations](#)

3 N Engl J Med. 2012 Feb 23;366(8):697-706.

[Colonoscopy versus fecal immunochemical testing in colorectal-cancer screening.](#)

[Quintero E](#), [Castells A](#), [Bujanda L](#), [Cubiella J](#), [Salas D](#), [Lanas Á](#), [Andreu M](#), [Carballo F](#), [Morillas JD](#), [Hernández C](#), [Jover R](#), [Montalvo I](#), [Arenas J](#), [Laredo E](#), [Hernández V](#), [Iglesias F](#), [Cid E](#), [Zubizarreta R](#), [Sala T](#), [Ponce M](#), [Andrés M](#), [Teruel G](#), [Peris A](#), [Roncales MP](#), [Polo-Tomás M](#), [Bessa X](#), [Ferrer-Armengou O](#), [Grau J](#), [Serradesanferm A](#), [Ono A](#), [Cruzado J](#), [Pérez-Riquelme F](#), [Alonso-Abreu I](#), [de la Vega-Prieto M](#), [Reyes-Melian JM](#), [Cacho G](#), [Díaz-Tasende J](#), [Herreros-de-Tejada A](#), [Poves C](#), [Santander C](#), [González-Navarro A](#); COLONPREV Study Investigators.

Collaborators: [Lanas A](#), [Gonzalez-Rubio F](#), [Moya-Calvo A](#), [Polo-Tomas M](#), [Roncales MP](#), [Sebastian-Martínez P](#), [Valencia-Doblas MÁ](#), [Valero-Capilla N](#), [Bujanda L](#), [Alkiza ME](#), [Altzibar J](#), [Amiano P](#), [Arenas J](#), [Artiñano E](#), [Cosme A](#), [Egitegi I](#), [Elorriaga K](#), [Elósegui JL](#), [Enriquez-Navascués JM](#), [Erce C](#), [Gil I](#), [Gutiérrez-Stampa MA](#), [Herreros M](#), [Hijona E](#), [Jaúregui M](#), [Laredo E](#), [Martínez R](#), [Mitxelena MJ](#), [Montalvo I](#), [Placer C](#), [Portillo I](#), [Quintero E](#), [Alarcón O](#), [Alonso-Abreu I](#), [Carrillo-Palau M](#), [de la Vega-Prieto M](#), [Díez-Fuentes ML](#), [Gimeno-García A](#), [González-Méndez Y](#), [Hernández-Guerra M](#), [Linertová R](#), [Nicolás-Perez D](#), [Reyes-Melián JM](#), [Andreu M](#), [Álvarez C](#), [Augé JM](#), [Balaguer F](#), [Barau M](#), [Bessa X](#), [Bory F](#), [Burón A](#), [Castells A](#), [Castells X](#), [Comas M](#), [Cuatrecasas M](#), [Estrada M](#), [Ferrer O](#), [Garrell I](#), [Grau J](#), [Guayta R](#), [Hernández C](#), [López-Cerón M](#), [Macià F](#), [Moreira L](#), [Ocaña T](#), [Pellisé M](#), [Piracés M](#), [Polbach S](#), [Puigvehí M](#), [Rodríguez C](#), [Sala M](#), [Seoane A](#), [Serradesanferm A](#), [Sivilla J](#), [Trilla A](#), [Cubiella J](#), [Aguado MB](#), [Aldecoa S](#), [Almazán R](#), [Alonso A](#), [Castro I](#), [Cid E](#), [Cid L](#), [Clofent J](#), [de Castro ML](#), [Estévez P](#), [Fernández AB](#), [González MD](#), [González S](#), [González-Mao MC](#), [Hernández V](#), [Iglesias B](#), [Iglesias F](#), [Iglesias P](#), [López-Martínez Á](#), [Macenlle R](#), [Martínez A](#), [Martínez D](#), [Menéndez C](#), [Méndez C](#), [Hermo JA](#), [Pérez I](#), [Portasany C](#), [Rionda M](#), [Rivera C](#), [Rodríguez B](#), [Rodríguez R](#), [Rubio M](#), [Santiago MI](#), [Vázquez M](#), [Vázquez JÁ](#), [Vega P](#), [Vidal MC](#), [Zubizarreta R](#), [Morillas JD](#), [Abreu L](#), [Amador FJ](#), [Arroyo M](#), [Bandrés F](#), [Barba M](#), [Blanco JM](#), [Cacho G](#), [Cantero J](#), [Carrasco J](#), [Carrascosa B](#), [Castellano G](#), [Colina F](#), [Chaparro M](#), [Díaz-Rubio M](#), [Díaz-Tasende J](#), [Esteban JM](#), [Fernández C](#), [Fernández-Díez S](#), [Fernández-Gil M](#), [Ferrándiz J](#), [Franco A](#), [García-Álvarez G](#), [Garrido A](#), [Garrido S](#), [Gisbert JP](#), [Gómez-Haba M](#), [Gómez-Molins I](#), [González-Navarro A](#), [González MJ](#), [Herranz B](#), [Herranz P](#), [Herreros A](#), [Iglesias R](#), [Izquierdo S](#), [López C](#), [López-Rubio MA](#), [Marín A](#), [Marín JC](#), [Martín MC](#), [Martínez JL](#), [Martínez R](#), [Moliner C](#), [Moreno JM](#), [Moreno R](#), [Nogueiras A](#), [Pérez MT](#), [Píriz R](#), [Plaza C](#), [Polentinos E](#), [Povés C](#), [Ruíz P](#), [Salces I](#), [Sánchez-Ceballos F](#), [Santander C](#), [Sastre R](#), [Valentín V](#), [Carballo F](#), [Alajarín M](#), [Alberca F](#), [Bermejo J](#), [Carrillo J](#), [Cruzado J](#), [López P](#), [Martínez M](#), [Navarro MD](#), [Ono A](#), [Parra S](#), [Pérez-Riquelme F](#), [Riquelme-Tenza P](#), [Salas D](#), [Andrés M](#), [Calvo C](#), [Jimenez M](#), [Málaga A](#), [Pérez E](#), [Peris A](#), [Ponce M](#), [Jover R](#), [Sala T](#), [Teruel G](#).

Source

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Comment in

- [N Engl J Med. 2012 Feb 23;366\(8\):759-60.](#)

Abstract

BACKGROUND:

Colonoscopy and fecal immunochemical testing (FIT) are accepted strategies for colorectal-cancer screening in the average-risk population.

METHODS:

In this randomized, controlled trial involving asymptomatic adults 50 to 69 years of age, we compared one-time colonoscopy in 26,703 subjects with FIT every 2 years in 26,599 subjects. The primary outcome was the rate of death from colorectal cancer at 10 years. This interim report describes rates of participation, diagnostic findings, and occurrence of major complications at completion of the baseline screening. Study outcomes were analyzed in both intention-to-screen and as-screened populations.

RESULTS:

The rate of participation was higher in the FIT group than in the colonoscopy group (34.2% vs. 24.6%, $P < 0.001$). Colorectal cancer was found in 30 subjects (0.1%) in the colonoscopy group and 33 subjects (0.1%) in the FIT group (odds ratio, 0.99; 95% confidence interval [CI], 0.61 to 1.64; $P = 0.99$). Advanced adenomas were detected in 514 subjects (1.9%) in the colonoscopy group and 231 subjects (0.9%) in the FIT group (odds ratio, 2.30; 95% CI, 1.97 to 2.69; $P < 0.001$), and nonadvanced adenomas were detected in 1109 subjects (4.2%) in the colonoscopy group and 119 subjects (0.4%) in the FIT group (odds ratio, 9.80; 95% CI, 8.10 to 11.85; $P < 0.001$).

CONCLUSIONS:

Subjects in the FIT group were more likely to participate in screening than were those in the colonoscopy group. On the baseline screening examination, the numbers of subjects in whom colorectal cancer was detected were similar in the two study groups, but more adenomas were identified in the colonoscopy group. (Funded by Instituto de Salud Carlos III and others; ClinicalTrials.gov number, NCT00906997.).

PMID: 22356323 [PubMed - indexed for MEDLINE]

[Related citations](#)

4 N Engl J Med. 2012 Feb 23;366(8):687-96.

[Colonoscopic polypectomy and long-term prevention of colorectal-cancer deaths.](#)
[Zauber AG](#), [Winawer SJ](#), [O'Brien MJ](#), [Lansdorp-Vogelaar I](#), [van Ballegooijen M](#), [Hankey BF](#), [Shi W](#), [Bond JH](#), [Schapiro M](#), [Panish JF](#), [Stewart ET](#), [Waye JD](#).

Source

Department of Epidemiology and Biostatistics, Memorial Sloan-Kettering Cancer Center, New York, NY 10065, USA. zaubera@mskcc.org

Comment in

- [N Engl J Med. 2012 Feb 23;366\(8\):759-60.](#)

Abstract

BACKGROUND:

In the National Polyp Study (NPS), colorectal cancer was prevented by colonoscopic removal of adenomatous polyps. We evaluated the long-term effect of colonoscopic polypectomy in a study on mortality from colorectal cancer.

METHODS:

We included in this analysis all patients prospectively referred for initial colonoscopy (between 1980 and 1990) at NPS clinical centers who had polyps (adenomas and nonadenomas). The National Death Index was used to identify deaths and to determine the cause of death; follow-up time was as long as 23 years. Mortality from colorectal cancer among patients with adenomas removed was compared with the expected incidence-based mortality from colorectal cancer in the general population, as estimated from the Surveillance Epidemiology and End Results (SEER) Program, and with the observed mortality from colorectal cancer among patients with nonadenomatous polyps (internal control group).

RESULTS:

Among 2602 patients who had adenomas removed during participation in the study, after a median of 15.8 years, 1246 patients had died from any cause and 12 had died from colorectal cancer. Given an estimated 25.4 expected deaths from colorectal cancer in

the general population, the standardized incidence-based mortality ratio was 0.47 (95% confidence interval [CI], 0.26 to 0.80) with colonoscopic polypectomy, suggesting a 53% reduction in mortality. Mortality from colorectal cancer was similar among patients with adenomas and those with nonadenomatous polyps during the first 10 years after polypectomy (relative risk, 1.2; 95% CI, 0.1 to 10.6).

CONCLUSIONS:

These findings support the hypothesis that colonoscopic removal of adenomatous polyps prevents death from colorectal cancer. (Funded by the National Cancer Institute and others.).

PMID: 22356322 [PubMed - indexed for MEDLINE]

[Related citations](#)

5 Br J Surg. 2012 Feb;99(2):300; author reply 300-1. doi: 10.1002/bjs.8671.

. [Letter 2: Routine colonoscopy following acute uncomplicated diverticulitis \(Br J Surg 2011; 98: 1630-1634\).](#)

[Colvin HS](#), [Velineni R](#), [Robertson AG](#), [Yalamarathi S](#), [Driscoll PJ](#).

Comment on

- [Br J Surg. 2011 Nov;98\(11\):1630-4.](#)

PMID: 22222809 [PubMed - indexed for MEDLINE]

[Related citations](#)

6 Br J Surg. 2012 Feb;99(2):300; author reply 300-1. doi: 10.1002/bjs.8670.

. [Letter 1: Routine colonoscopy following acute uncomplicated diverticulitis \(Br J Surg 2011; 98: 1630-1634\).](#)

[Page AA](#), [Khan A](#), [Davies RJ](#).

Comment on

- [Br J Surg. 2011 Nov;98\(11\):1630-4.](#)

PMID: 22222807 [PubMed - indexed for MEDLINE]

[Related citations](#)

Sent on Saturday, 2012 March 10

PubMed Results

Items 1 - 2 of 2

1 Am J Surg Pathol. 2012 Feb;36(2):316-8.

. [Gastritis cystic profunda versus adenocarcinoma.](#)

[Greywoode G](#), [Chetty R](#).

Comment on

- [Am J Surg Pathol. 2011 Sep;35\(9\):1419-21.](#)

PMID: 22251946 [PubMed - indexed for MEDLINE]

[Related citations](#)

2 Am J Surg Pathol. 2012 Feb;36(2):316.

. [Gastritis cystica profunda versus invasive adenocarcinoma.](#)

[Odze RD](#), [Greenon J](#), [Lauwers G](#), [Goldblum J](#).

Comment on

- [Am J Surg Pathol. 2011 Sep;35\(9\):1419-21.](#)

PMID: 22251945 [PubMed - indexed for MEDLINE]

[Related citations](#)

Sent on Saturday, 2012 March 17

Items 1 - 4 of 4

1 JAMA. 2012 Mar 14;307(10):1053-61.

[Endoscopic transgastric vs surgical necrosectomy for infected necrotizing pancreatitis: a randomized trial.](#)

[Bakker OJ](#), [van Santvoort HC](#), [van Brunshot S](#), [Geskus RB](#), [Bollen TL](#), [van Eijck CH](#), [Fockens P](#), [Hazebroek EJ](#), [Nijmeijer RM](#), [Poley JW](#), [van Ramshorst B](#), [Vleggaar FP](#), [Boermeester MA](#), [Gooszen HG](#), [Weusten BL](#), [Timmer R](#); [Dutch Pancreatitis Study Group](#).

Collaborators: [Boermeester MA](#), [Bakker OJ](#), [Besselink MG](#), [Fockens P](#), [Gooszen HG](#), [van Ramshorst B](#), [van Santvoort HC](#), [Weusten B](#), [Timmer R](#), [Boermeester MA](#), [Bollen TL](#), [Bruno MJ](#), [Dejong CH](#), [van Eijck CH](#), [Fockens P](#), [van Goor H](#), [Gooszen HG](#), [Hofker HS](#), [Laméris JS](#), [van Leeuwen MS](#), [Nieuwenhuijs VB](#), [Schaapherder AF](#), [Timmer R](#), [Besselink MG](#), [Boermeester MA](#), [Gooszen HG](#), [van Ramshorst B](#), [Weusten BL](#), [van Santvoort HC](#), [Timmer R](#), [Bruno MJ](#), [Bosscha K](#), [Dejong CH](#), [van Goor H](#), [Hofker HS](#), [Nieuwenhuijs B](#), [Laméris JS](#), [van Leeuwen MS](#), [Schaapherder AF](#), [Schwartz MP](#), [Rijkers GT](#), [Besselink MG](#).

Source

Department of Surgery, University Medical Center Utrecht, Utrecht, The Netherlands. o.j.bakker@umcutrecht.nl

Comment in

- [JAMA. 2012 Mar 14;307\(10\):1084-5.](#)

Abstract**CONTEXT:**

Most patients with infected necrotizing pancreatitis require necrosectomy. Surgical necrosectomy induces a proinflammatory response and is associated with a high complication rate. Endoscopic transgastric necrosectomy, a form of natural orifice transluminal endoscopic surgery, may reduce the proinflammatory response and reduce complications.

OBJECTIVE:

To compare the proinflammatory response and clinical outcome of endoscopic transgastric and surgical necrosectomy.

DESIGN, SETTING, AND PATIENTS:

Randomized controlled assessor-blinded clinical trial in 3 academic hospitals and 1 regional teaching hospital in The Netherlands between August 20, 2008, and March 3, 2010. Patients had signs of infected necrotizing pancreatitis and an indication for intervention.

INTERVENTIONS:

Random allocation to endoscopic transgastric or surgical necrosectomy. Endoscopic necrosectomy consisted of transgastric puncture, balloon dilatation, retroperitoneal drainage, and necrosectomy. Surgical necrosectomy consisted of video-assisted retroperitoneal debridement or, if not feasible, laparotomy.

MAIN OUTCOME MEASURES:

The primary end point was the postprocedural proinflammatory response as measured by serum interleukin 6 (IL-6) levels. Secondary clinical end points included a predefined composite end point of major complications (new-onset multiple organ failure, intra-abdominal bleeding, enterocutaneous fistula, or pancreatic fistula) or death.

RESULTS:

We randomized 22 patients, 2 of whom did not undergo necrosectomy following percutaneous catheter drainage and could not be analyzed for the primary end point. Endoscopic transgastric necrosectomy reduced the postprocedural IL-6 levels compared

with surgical necrosectomy ($P = .004$). The composite clinical end point occurred less often after endoscopic necrosectomy (20% vs 80%; risk difference [RD], 0.60; 95% CI, 0.16-0.80; $P = .03$). Endoscopic necrosectomy did not cause new-onset multiple organ failure (0% vs 50%, RD, 0.50; 95% CI, 0.12-0.76; $P = .03$) and reduced the number of pancreatic fistulas (10% vs 70%; RD, 0.60; 95% CI, 0.17-0.81; $P = .02$).

CONCLUSION:

In patients with infected necrotizing pancreatitis, endoscopic necrosectomy reduced the proinflammatory response as well as the composite clinical end point compared with surgical necrosectomy.

TRIAL REGISTRATION:

isrctn.org Identifier: ISRCTN07091918.

PMID: 22416101 [PubMed - indexed for MEDLINE]

[Related citations](#)

2 Orv Hetil. 2012 Feb 12;153(6):205-13.

[\[Colonic diverticular disease: diagnosis and therapy\].](#)

[Article in Hungarian]

[Lakatos L](#), [Lakatos PL](#).

Source

Csolnoky Ferenc Megyei Kórház, Belgyógyászati Centrum

Veszprém. lakatos.lazlo@vmkorhaz.hu

Abstract

Colonic diverticular disease is one of the most common gastrointestinal disorders in the Western world, affecting approximately 50% of the population above the age of 70 years. Symptoms develop only in about one quarter of the affected individuals with complications in one-third of the symptomatic patients. Diagnosis is mostly confirmed by colonoscopy. Abdominal CT is the most sensitive for the diagnosis of complicated severe diverticulitis, while colonoscopy or in severe cases angiography may be performed in bleeding patients. Initial therapy of non-complicated symptomatic diverticulitis includes antibiotics and more recently non-absorbable antibiotics. In complicated cases should be treated with broad spectrum i.v. antibiotics, however surgery may become necessary in a minority of the cases. The proportion of patients needing acute surgical intervention has decreased in the last decades with the advancement of conservative management including medical therapy, endoscopy and imaging techniques and the indication of elective was also changed.

Free Article

PMID: 22296924 [PubMed - indexed for MEDLINE]

[Related citations](#)

3 Ugeskr Laeger. 2012 Jan 30;174(5):285.

[\[Picture of the month: esophageal foreign bodies\].](#)

[Article in Danish]

[Paulsen AT](#), [Faber CE](#).

Source

Øre-næse-halskirurgisk Afdeling F, Odense Universitetshospital,

Denmark. atp_sessions@hotmail.com

PMID: 22293079 [PubMed - indexed for MEDLINE]

4 J Dig Dis. 2012 Feb;13(2):94-9. doi: 10.1111/j.1751-2980.2011.00561.x.

[\[Video capsule endoscopy in celiac disease: current clinical practice.\]](#)

[Collin P](#), [Rondonotti E](#), [Lundin KE](#), [Spada C](#), [Keuchel M](#), [Kaukinen K](#), [DE Franchis R](#), [Jacobs MA](#), [Villa F](#), [Mulder CJ](#).

Source

Department of Gastroenterology and Alimentary Tract Surgery, Medical School, University of Tampere, Tampere, Finland. Pekka.Collin@uta.fi

Abstract**OBJECTIVE:**

A complete examination of the small intestine is possible by video capsule endoscopy (VCE). The aim of this study was to evaluate current indications for performing VCE in celiac disease.

METHODS:

In all 84 celiac disease patients on a gluten-free diet who had undergone VCE were enrolled at five centers in Europe. The indications, findings and clinical impact of VCE were recorded by a structured questionnaire. VCE was also carried out in 34 consecutive patients with untreated celiac disease (controls) in another center.

RESULTS:

Out of the 84 patients, 34 had overt symptoms and small intestinal histology compatible with refractory celiac disease. VCE was normal in 9 patients, and 7 had only proximal and one distal atrophy, 14 had intestinal ulcer and 2 an intestinal stricture. VCE was used in the adjustment of immunosuppressive treatment in 9 patients. In the remaining 50 patients, a VCE was performed because of less severe symptoms, 31 of which had an earlier histological recovery. The VCE showed proximal small bowel atrophy in 21 and distal atrophy in 3 patients, and 3 ulcers were seen. In this group the patients received mainly advice with a view to achieving better dietary compliance. Of the 34 newly detected celiac patients, 4 were normal, 27 proximal and 3 had distal small intestinal atrophy in the VCE.

CONCLUSIONS:

VCE has a definite impact on the management of refractory sprue. In the remaining patients with established celiac disease, the procedure plays a more limited role.

© 2012 The Authors. Journal of Digestive Diseases © 2012 Chinese Medical Association Shanghai Branch, Chinese Society of Gastroenterology, Renji Hospital Affiliated to Shanghai Jiaotong University School of Medicine and Blackwell Publishing Asia Pty Ltd. PMID: 22257477 [PubMed - indexed for MEDLINE]

[Related citations](#)

Sent on Saturday, 2012 March 24

PubMed Results

Items 1 - 2 of 2

1 Br J Radiol. 2012 Feb;85(1010):e31-4.

[Gastric haemolymphangioma: a literature review and report of one case.](#)

[Li QY](#), [Xu Q](#), [Fan SF](#), [Zhang Y](#).

Source

Radiology Department, Taizhou Hospital affiliated to Wenzhou Medical College, Linhai, Zhejiang Province, China.

Abstract

Gastric haemolymphangioma is a very rare benign tumour. Pathologically, it is composed of lymphatic vessels and blood vessels. Only a few cases of haemolymphangioma have been reported in the literature so far, all of which developed at sites other than the stomach. The authors believe that a haemolymphangioma occurring in the stomach has not been previously reported. The patient was a healthy 68-year-old male who had felt light epigastric discomfort for 3 months. A CT scan and a gastrofiberscope examination revealed a well-demarcated mass on the posterior wall of the stomach near the lesser curvature. The mass was successfully removed by surgery. During the 18-month follow-

up period, the patient was asymptomatic with no recurrence. In this case report, we discuss the imaging findings as well as the pathological features of this unusual case, with a review of the related literature.

PMID: 22308223 [PubMed - indexed for MEDLINE]

[Related citations](#)

2 BMJ. 2012 Jan 31;344:e783. doi: 10.1136/bmj.e783.

• [Two tests may be better than one in bowel cancer screening, finds study.](#)

[Hawkes N.](#)

PMID: 22293386 [PubMed - indexed for MEDLINE]

[Related citations](#)

Sent on Saturday, 2012 March 31

PubMed Results

Items 1 - 4 of 4

1 JAMA. 2012 Mar 21;307(11):1200-1.

• [Assessing the value of "discretionary" clinical care: the case of anesthesia services for endoscopy.](#)

[Fleisher LA.](#)

Comment on

- [JAMA. 2012 Mar 21;307\(11\):1178-84.](#)

PMID: 22436962 [PubMed - indexed for MEDLINE]

[Related citations](#)

2 JAMA. 2012 Mar 21;307(11):1178-84.

• [Utilization of anesthesia services during outpatient endoscopies and colonoscopies and associated spending in 2003-2009.](#)

[Liu H](#), [Waxman DA](#), [Main R](#), [Mattke S](#).

Source

RAND Corporation, Boston, MA 02116, USA.

Comment in

- [JAMA. 2012 Mar 21;307\(11\):1200-1.](#)

Abstract

CONTEXT:

The frequency with which anesthesiologists or nurse anesthetists provide sedation for gastrointestinal endoscopies, especially for low-risk patients, is poorly understood and controversial.

OBJECTIVE:

To quantify temporal comparisons and regional variation in the use of and payment for gastroenterology anesthesia services.

DESIGN, SETTING, AND PATIENTS:

A retrospective analysis of claims data for a 5% representative sample of Medicare fee-for-service patients (1.1 million adults) and a sample of 5.5 million commercially insured patients between 2003 and 2009.

MAIN OUTCOME MEASURES:

Total number of upper gastrointestinal endoscopies and colonoscopies, proportion of gastroenterology procedures with associated anesthesia claims, payments for gastroenterology anesthesia services, and proportion of services and spending for gastroenterology anesthesia delivered to low-risk patients (American Society of Anesthesiologists physical status class 1 or 2).

RESULTS:

The number of gastroenterology procedures per million enrollees remained largely unchanged in Medicare patients (mean, 136,718 procedures), but increased more than 50% in commercially insured patients (from 33,599 in 2003 to 50,816 in 2009). In both populations, the proportion of procedures using anesthesia services increased from approximately 14% in 2003 to more than 30% in 2009, and more than two-thirds of anesthesia services were delivered to low-risk patients. There was substantial regional variation in the proportion of procedures using anesthesia services in both populations (ranging from 13% in the West to 59% in the Northeast). Payments for gastroenterology anesthesia services doubled in Medicare patients and quadrupled in commercially insured patients.

CONCLUSIONS:

Between 2003 and 2009, utilization of anesthesia services during gastroenterology procedures increased substantially. Anesthesia services are predominantly used in low-risk patients and show considerable regional variation.

PMID: 22436958 [PubMed - indexed for MEDLINE]

[Related citations](#)

3 Lancet. 2012 Mar 17;379(9820):978.

· [New guidance for colorectal cancer screening.](#)

[No authors listed]

PMID: 22423870 [PubMed - indexed for MEDLINE]

[Related citations](#)

4 Laeknabladid. 2012 Feb;98(2):97-102.

· [\[Percutaneous endoscopic gastrostomy in Iceland over 10 year period: a retrospective study of indications, complications and ethical issues\].](#)

[Article in Icelandic]

[Birgisson S.](#)

Source

Internal medicine, University Hospital Landspítali. sigurbj@landspitali.is

Abstract

OBJECTIVE:

Percutaneous endoscopic gastrostomy (PEG) is the preferred method for long term enteral feeding. No nationwide study has reported on the experience and outcome of PEG procedure. The aim of this study was to describe the frequency, indications, complications, mortality and ethical issues related to PEG procedures in Iceland.

MATERIAL AND METHODS:

A retrospective study was performed on all adult patients who had PEG procedures in Iceland between 2000-2009. Medical charts from patients found were reviewed and data regarding demographics, indications, complications, mortality and ethically controversial cases was obtained.

RESULTS:

A total of 278 patients had PEG procedures during the 10 year study period. There were 163 men and 115 women with a median age of 70 years. The mean annual incidence of PEG procedures was 12.8/100.000. Sufficient medical data for evaluation was obtained from 263 patients. The most common indications were neurological disorders (61%) and malignancies (13%). Dementia accounted for only 0.8% of the indications. Total complication rate was 6.5% with 1.9% being major and 4.6% minor complications. Peritonitis was the most common (2.7%) complication followed by peristomal skin infection (1.9%). Operative mortality was 0.8% and 30 day mortality rate was 13%. In seven (2.7%) cases the PEG procedure was considered to be ethically and medically controversial.

CONCLUSION:

This is the first published nationwide study on the experience of PEG procedures. The complication and mortality rates in Iceland are among the lowest reported. The indications reported here are in agreement with national guidelines with the rate of PEG procedures in ethically controversial cases being very rare.

PMID: 22314511 [PubMed - indexed for MEDLINE]

[Related citations](#)

Sent on Saturday, 2012 April 21

Search: "Endoscopy, Gastrointestinal"[Mesh] OR ("Endoscopy, Gastrointestinal/contraindications"[Mesh] OR "Endoscopy, Gastrointestinal/methods"[Mesh] OR "Endoscopy, Gastrointestinal/mortality"[Mesh] OR "Endoscopy, Gastrointestinal/standards"[Mesh] OR "Endoscopy, Gastrointestinal/statistics and numerical data"[Mesh] OR "Endoscopy, Gastrointestinal/trends"[Mesh] OR "Endoscopy, Gastrointestinal/utilization"[Mesh])
Limits: Limits: added to PubMed in the last 60 days, published in the last 60 days

Click [here](#) to view complete results in PubMed (Results may change over time.)

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PubMed Results

Items 1 - 2 of 2

1 Dtsch Med Wochenschr. 2012 Mar;137(11):529-32. Epub 2012 Mar 6.

[\[Ulcerating tumor of the esophagus as a primary manifestation of extrapulmonary tuberculosis\].](#)

[Article in German]

[Rügamer J](#), [Kaaden R](#).

Source

Innere Medizin - Gastroenterologie, Krankenhaus Grafenau.

Abstract

HISTORY AND ADMISSION FINDINGS:

The patient, a 36-year-old man from Somalia, who had moved to Germany a year before, was referred for a diagnostic work-up of an ulcerating tumour. He suffered from thoracic tightness for the last weeks albeit without any further symptoms. There were no pre-existing illnesses. No further pathological signs were found during a preliminary physical examination.

INVESTIGATIONS:

After ruling out any malignancies by means of an analysis of biopsy samples, further differential diagnostic measures were undertaken. Besides mechanical and chemical factors, an infectious genesis of the esophageal lesion was considered and investigated further through histological, immunohistochemical, laboratory and microbiological tests.

DIAGNOSIS, TREATMENT AND COURSE:

Mycobacterium tuberculosis was detected in cultures sampled from biopsy material. This strain turned out to be responsive to medical treatment. Further diagnostics regarding a potential primary pulmonary tuberculosis were negative. Histological analysis of a liver biopsy confirmed noncaseating epithelioid cellular granuloma as typically seen in granulomatous hepatitis without any direct evidence of mycobacteria. Thus, tuberculosis of the liver appeared most likely considering the differential diagnosis of a granulomatous hepatitis. The patient underwent standard treatment using antituberculous drugs over six months. Endoscopic control after two months showed a

significant reduction of the ulcerating lesion.

CONCLUSION:

Ulcerating tumors of the esophagus are primarily classified as potential malignancies. Crohn's disease is an important differential diagnosis. Apart from mechanical and chemical causes, infectious diseases should be taken into consideration. However, tuberculosis is one of the most relevant differential diagnoses, particularly in patients immigrating from TB-prone countries, pre-existing immune deficiency or environmentally induced elevated infection risk.

© Georg Thieme Verlag KG Stuttgart · New York.

PMID: 22396236 [PubMed - indexed for MEDLINE]

[Related citations](#)

2 Br J Cancer. 2012 Feb 28;106(5):805-16. doi: 10.1038/bjc.2011.580. Epub 2012 Feb 16.

[Cost-effectiveness of population-based screening for colorectal cancer: a comparison of guaiac-based faecal occult blood testing, faecal immunochemical testing and flexible sigmoidoscopy.](#)

[Sharp L](#), [Tilson L](#), [Whyte S](#), [O'Ceilleachair A](#), [Walsh C](#), [Usher C](#), [Tappenden P](#), [Chilcott J](#), [Staines A](#), [Barry M](#), [Comber H](#).

Source

National Cancer Registry Ireland, Cork Airport Business Park, Building 6800, Kinsale Road, Cork, Ireland. linda.sharp@ncri.ie

Abstract

BACKGROUND:

Several colorectal cancer-screening tests are available, but it is uncertain which provides the best balance of risks and benefits within a screening programme. We evaluated cost-effectiveness of a population-based screening programme in Ireland based on (i) biennial guaiac-based faecal occult blood testing (gFOBT) at ages 55-74, with reflex faecal immunochemical testing (FIT); (ii) biennial FIT at ages 55-74; and (iii) once-only flexible sigmoidoscopy (FSIG) at age 60.

METHODS:

A state-transition model was used to estimate costs and outcomes for each screening scenario vs no screening. A third party payer perspective was adopted. Probabilistic sensitivity analyses were undertaken.

RESULTS:

All scenarios would be considered highly cost-effective compared with no screening. The lowest incremental cost-effectiveness ratio (ICER vs no screening euro 589 per quality-adjusted life-year (QALY) gained) was found for FSIG, followed by FIT euro 1696) and gFOBT (euro 4428); gFOBT was dominated. Compared with FSIG, FIT was associated with greater gains in QALYs and reductions in lifetime cancer incidence and mortality, but was more costly, required considerably more colonoscopies and resulted in more complications. Results were robust to variations in parameter estimates.

CONCLUSION:

Population-based screening based on FIT is expected to result in greater health gains than a policy of gFOBT (with reflex FIT) or once-only FSIG, but would require significantly more colonoscopy resources and result in more individuals experiencing adverse effects. Weighing these advantages and disadvantages presents a considerable challenge to policy makers.

PMCID: PMC3305953 [Available on 2013/2/28]

PMID: 22343624 [PubMed - indexed for MEDLINE]

[Related citations](#)

Items 1 - 5 of 5

1 Johns Hopkins Med Lett Health After 50. 2012 Mar;24(1):7.

. [Why does my doctor insist I undergo a standard colonoscopy when a virtual colonoscopy sounds easier?](#)

[No authors listed]

PMID: 22493824 [PubMed - indexed for MEDLINE]

[Related citations](#)

2 Am J Gastroenterol. 2012 Mar;107(3):488-9. doi: 10.1038/ajg.2011.464.

. [Chronic rectal bleeding due to Lymphogranuloma venereum proctocolitis.](#)
[Geisler WM](#), [Kapil R](#), [Waites KB](#), [Smith PD](#).

PMID: 22388034 [PubMed - indexed for MEDLINE]

[Related citations](#)

3. Am J Gastroenterol. 2012 Mar;107(3):343. doi: 10.1038/ajg.2012.32.

[Images of the month.](#)

[No authors listed]

PMID: 22388017 [PubMed - indexed for MEDLINE]

[Related citations](#)

4 Am J Gastroenterol. 2012 Mar;107(3):339-42. doi: 10.1038/ajg.2011.426.

. [Management of delayed postpolypectomy bleeding: a decision analysis.](#)
[Sonnenberg A](#).

Source

Portland VA Medical Center and Oregon Health & Science University, Portland, Oregon 97239,USA. sonnenbe@ohsu.edu

Abstract

OBJECTIVES:

The benefit of repeat colonoscopy in managing delayed postpolypectomy bleeding is unknown. This study aimed to assess the outcome of repeat colonoscopy to achieve hemostasis.

METHODS:

Endoscopic management of postpolypectomy bleeding is modeled as a decision tree, measuring the expected overall fraction of patients who benefit from therapeutic hemostasis and the number of patients needed to treat (NNT) in order to achieve one beneficial hemostasis.

RESULTS:

A repeat colonoscopy to identify and treat postpolypectomy bleeding is beneficial in about 22% of patients, corresponding to an NNT of 4.5 patients. The outcome of the model is sensitive to assumptions underlying the fractions of patients who need treatment and would benefit from successful endoscopic hemostasis. Varying these probabilities over a broad range changes the fraction of patients benefiting from endoscopy between 3% and 33% and the NNT between 28 and 3 patients, respectively.

CONCLUSIONS:

The expected outcome of repeat colonoscopy justifies the endoscopic attempts at therapeutic hemostasis. The results also suggest that in many patients expectant management aimed at spontaneous resolution of the bleeding remains a valid option.

PMID: 22388016 [PubMed - indexed for MEDLINE]

[Related citations](#)

5. Lancet Oncol. 2012 Mar;13(3):e90.

[CT colonography screening.](#)

[Gupta S](#), [Rockey D](#).

Comment on

- [Lancet Oncol. 2012 Jan;13\(1\):55-64.](#)

PMID: 22381936 [PubMed - indexed for MEDLINE]

[Related citations](#)

Sent on Saturday, 2012 May 05

PubMed Results

Items 1 - 4 of 4

1 Rofo. 2012 Apr;184(4):372-3. Epub 2012 Jan 13.

[\[Boerhaave syndrome in norovirus infection\].](#)

[Article in German]

[Münster S](#), [Noshari S](#), [Langwieler TE](#), [Weber C](#).

PMID: 22426870 [PubMed - indexed for MEDLINE]

2 Dis Colon Rectum. 2012 Apr;55(4):400-6.

[Comparative quality of life in patients following abdominoperineal excision and low anterior resection for low rectal cancer.](#)

[How P](#), [Stelzner S](#), [Branagan G](#), [Bundy K](#), [Chandrakumar K](#), [Heald RJ](#), [Moran B](#).

Source

Pelican Cancer Foundation, Basingstoke, UK. pd_how@hotmail.com

Abstract

BACKGROUND:

It is widely believed that quality of life is worse after abdominoperineal excision than after low anterior resection. However, this view is not supported unequivocally.

OBJECTIVE:

The aim of this study was to compare quality of life in patients 1 year following low anterior resection and abdominoperineal excision for low rectal cancer.

DESIGN:

Data were collected prospectively on 62 patients undergoing low anterior resection (32) and abdominoperineal excision (30) for low rectal adenocarcinoma within 6 cm of the anal verge. Patients with metastatic disease were excluded. Quality of life was assessed by the use of the European Organization for Research and Treatment of Cancer's QLQ-C30 and QLQ-CR38 modules and Coloplast stoma quality-of-life questionnaire. Bowel function was assessed by using the St Mark's bowel function questionnaire. Quality of life in patients who had low anterior resection was compared with those who had abdominoperineal excision both preoperatively and 1 year after surgery.

SETTINGS:

This study was conducted at 3 centers in the United Kingdom and 1 center in Europe.

PATIENTS:

Included were consecutive patients with rectal cancer within 6 cm of the anal verge, all of whom provided written consent for participation.

MAIN OUTCOME MEASURES:

Mann-Whitney U test comparisons of QLQ-C30 and QLQ-CR38 module scores for patients undergoing low anterior resection and abdominoperineal excision were the main outcomes measured.

RESULTS:

Patients undergoing low anterior resection were younger (median age, 59.5 vs 67, $p = 0.03$) with higher tumors (4 vs 3, $p < 0.001$) and less likely to receive neoadjuvant therapy ($p = 0.02$). At 1 year postoperatively, global quality-of-life ratings were comparable, but patients undergoing abdominoperineal excision reported better cognitive (100 vs 83, $p = 0.018$) and social (100 vs 67, $p = 0.012$) function, and less symptomatology with respect to pain (0 vs 17, $p = 0.027$), sleep disturbance (0 vs 33, $p = 0.013$), diarrhea (0 vs 33, $p = 0.017$), and constipation ($p = 0.021$). Patients undergoing low anterior resection reported better sexual function (33 vs 0, $p = 0.006$), but 72% experienced a degree of fecal incontinence.

LIMITATIONS:

This study was limited by its relatively small sample size.

CONCLUSION:

Abdominoperineal excision should not be regarded as an operation that is inferior to low anterior resection in the management of low rectal cancer on the basis of quality of life alone.

PMID: 22426263 [PubMed - indexed for MEDLINE]

[Related citations](#)

3 Dis Colon Rectum. 2012 Apr;55(4):371-7.

. [Pretreatment high-resolution rectal MRI and treatment response to neoadjuvant chemoradiation.](#)

[Chang GJ](#), [You YN](#), [Park IJ](#), [Kaur H](#), [Hu CY](#), [Rodriguez-Bigas MA](#), [Skibber JM](#), [Ernst RD](#).

Source

Department of Surgical Oncology and Radiology, The University of Texas MD Anderson Cancer Center, Houston, TX, USA. gchang@mdanderson.org

Abstract**BACKGROUND:**

Use of rectal MRI evaluation of patients with rectal cancer for primary tumor staging and for identification for poor prognostic features is increasing. MR imaging permits precise delineation of tumor anatomy and assessment of mesorectal tumor penetration and radial margin risk.

OBJECTIVE:

The aim of this study was to evaluate the ability of pretreatment rectal MRI to classify tumor response to neoadjuvant chemoradiation.

DESIGN:

This study is a retrospective, consecutive cohort study and central review.

SETTING:

This study was conducted at a tertiary academic hospital.

PATIENTS:

Sixty-two consecutive patients with locally advanced (stage cII to cIII) rectal cancer who underwent rectal cancer protocol high-resolution MRI before surgery (December 2009 to March 2011) were included.

MAIN OUTCOME MEASURES:

The primary outcomes measured were the probability of good ($ypT0-2N0$) vs poor ($\geq ypT3N0$) response as a function of mesorectal tumor depth, lymph node status, extramural vascular invasion, and grade assessed by uni- and multivariate logistic regression.

RESULTS:

Tumor response was good in 25 (40.3%) and poor in 37 (59.7%). Median interval from MRI to surgery was 7.9 weeks (interquartile range, 7.0-9.0). MRI tumor depth was <1 mm in 10 (16.9%), 1 to 5 mm in 30 (50.8%), and >5 mm in 21 (33.9%). Lymph node

status was positive in 40 (61.5%), and vascular invasion was present in 16 (25.8%). Tumor response was associated with MRI tumor depth ($p = 0.001$), MRI lymph node status ($p < 0.001$) and vascular invasion ($p = 0.009$). Multivariate regression indicated >5 mm MRI tumor depth (OR = 0.08; 95% CI = 0.01-0.93; $p = 0.04$) and MRI lymph node positivity (OR = 0.12; 95% CI = 0.03-0.53; $p = 0.005$) were less likely to achieve a good response to neoadjuvant chemoradiotherapy.

LIMITATIONS:

Generalizability is uncertain in centers with limited experience with MRI staging for rectal cancer.

CONCLUSION:

MRI assessment of tumor depth and lymph node status in rectal cancer is associated to tumor response to neoadjuvant chemoradiotherapy. These factors should therefore be considered for stratification of patients for novel treatment strategies reliant on pathologic response to treatment or for the selection of poor-risk patients for intensified treatment regimens.

PMID: 22426259 [PubMed - indexed for MEDLINE]

[Related citations](#)

4 Arch Intern Med. 2012 Mar 12;172(5):393-4.

. [Consequences of not respecting patient preferences for cancer screening: opportunity lost.](#)

[Lin GA](#), [Trujillo L](#), [Frosch DL](#).

Source

Division of General Internal Medicine and Phillip R. Lee Institute for Health Policy Studies, University of California, San Francisco, 3333 California St, Ste 265, San Francisco, CA 94118, USA. glin@medicine.ucsf.edu

PMID: 22412105 [PubMed - indexed for MEDLINE]

[Related citations](#)

Sent on Saturday, 2012 May 12

PubMed Results

Items 1 - 2 of 2

1 J Surg Oncol. 2012 Apr 1;105(5):459-67. doi: 10.1002/jso.21704.

. [Novel molecular screening approaches in colorectal cancer.](#)

[Miller S](#), [Steele S](#).

Source

Department of General Surgery, Madigan Army Medical Center, Tacoma, Washington 98431, USA.

Abstract

Traditional methods for colorectal cancer (CRC) screening have reduced rates of malignancy and death; however, low compliance and morbidities associated with invasive techniques have encouraged efforts for establishing equally effective, less invasive novel screening approaches. We review the current state of novel screening approaches in CRC to include CT colonography, fecal DNA, DNA methylation, micro-RNA, and protein and molecular markers.

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PMID: 22441897 [PubMed - indexed for MEDLINE]

[Related citations](#)

2 Eur J Gastroenterol Hepatol. 2012 Apr;24(4):464-7.

[A new approach to gastrointestinal fistula closure: endoloop and clips technique using double endoscope.](#)

[Parlak E](#), [Dişibeyaz S](#), [Köksal AS](#), [Umit H](#), [Ulaş M](#).

Source

Department of Gastroenterology, Turkey Yüksek İhtisas Education and Training Hospital, Ankara, Turkey.

Abstract

Several endoscopic techniques have been described for closure of gastrointestinal fistulas. Herein, we describe a case of iatrogenic gastric fistula successfully treated with a new approach by simultaneous insertion of two endoscopes and using the endoloop and endoclips technique.

PMID: 22410716 [PubMed - indexed for MEDLINE]

[Related citations](#)

Sent on Saturday, 2012 May 19

PubMed Results

Items 1 - 6 of 6

1 Bangladesh Med Res Counc Bull. 2012 Apr;38(1):41-2.

[Constipation--presenting compliant and clinical marker of Parkinson's disease.](#)

[Rana AQ](#).

PMID: 22545352 [PubMed - indexed for MEDLINE]

[Related citations](#)

2 Bangladesh Med Res Counc Bull. 2012 Apr;38(1):33-8.

[Symptomatic overlap in patients with diarrhea predominant irritable bowel syndrome and microscopic colitis in a sub group of Bangladeshi population.](#)

[Rahman MA](#), [Raihan AS](#), [Ahamed DS](#), [Masud H](#), [Safiullah AB](#), [Khair KB](#), [Salimullah AS](#), [Islam MM](#).

Source

Department of Gastroenterology, Bangabandhu Sheikh Mujib Medical University (BSMMU), Dhaka.

Abstract

Microscopic Colitis (MC) and diarrhea predominant irritable bowel syndrome (IBS-D) has almost similar clinical feature but MC is diagnosed by histologic criteria and IBS is diagnosed by symptom-based criteria. There is ongoing debate about the importance of biopsies from endoscopically normal colonic mucosa in the investigation of patients with IBS-D. Aim of this study was to assess the prevalence of MC in patient with IBS-D and to determine the distribution of MC in the colon. This observational study was conducted in department of Gastroenterology, Bangabandhu Sheikh Mujib Medical University (BSMMU), Dhaka, Bangladesh from January 2008 to December 2009. Patients were evaluated thoroughly & who meet Rome-II criteria with normal routine laboratory tests, were included in the study. Colonoscopy was done and biopsies were taken from the caecum, transverse colon, descending colon, and rectum. Out of total 60 patients, 22 had Lymphocytic Colitis (LC), 28 had nonspecific microscopic colitis (NSMC) and 10 had irritable bowel syndrome noninflamed (IBSNI). The distribution of LC was restricted to proximal colon in 15 patients, in the left colon in 2 patients and diffuses throughout the colon in 5 patients. There is considerable symptom overlap between the patients of IBS-D and patients with microscopic colitis. Without colonoscopic biopsy from multiple sites, possibility of MC cannot be excluded in patients with IBS-D and it can be said that clinical symptom based criteria for irritable bowel syndrome are not sufficient enough to

rule out the diagnosis of microscopic colitis.

PMID: 22545349 [PubMed - indexed for MEDLINE]

[Related citations](#)

3 World J Gastroenterol. 2012 Mar 21;18(11):1243-8.

. [Adenoma incidence decreases under the effect of polypectomy.](#)

[Rosa I](#), [Fidalgo P](#), [Soares J](#), [Vinga S](#), [Oliveira C](#), [Silva JP](#), [Ferro SM](#), [Chaves P](#), [Oliveira AG](#), [Leitão CN](#).

Source

Gastroenterology Department, Instituto Português de Oncologia de Lisboa Francisco Gentil, EPE, 1099-023 Lisboa, Portugal. isaalr9@netcabo.pt

Abstract

AIM:

To investigate whether, under the influence of polypectomy, the incidence of adenoma decreases with age.

METHODS:

Consecutive patients with colonic adenomas identified at index colonoscopy were retrospectively selected if they had undergone three or more complete colonoscopies, at least 24 mo apart. Patients who had any first-degree relative with colorectal cancer were excluded. Data regarding number of adenomas at each colonoscopy, their location, size and histological classification were recorded. The monthly incidence density of adenomas after the index examination was estimated for the study population, by using the person-years method. Baseline adenomas were excluded from incidence calculations but their characteristics were correlated with recurrence at follow-up, using the χ^2 test.

RESULTS:

One hundred and fifty-six patients were included (109 male, mean age at index colonoscopy 56.8 ± 10.3 years), with follow-up that ranged from 48 to 232 mo. No significant correlations were observed between the number, the presence of villous component, or the size of adenomas at index colonoscopy and the presence of adenomas at subsequent colonoscopies ($P = 0.49, 0.12$ and 0.78 , respectively). The incidence of colonic adenomas was observed to decay from 1.4% person-months at the beginning of the study to values close to 0%, at 12 years after index colonoscopy.

CONCLUSION:

Our results suggest the sporadic formation of adenomas occurs within a discrete period and that, when these adenomas are removed, all neoplasia-prone clones may be extinguished.

PMCID: PMC3309914 **Free PMC Article**

PMID: 22468088 [PubMed - indexed for MEDLINE]

[Related citations](#)

4 World J Gastroenterol. 2012 Mar 21;18(11):1191-201.

. [Angiographic evaluation and management of acute gastrointestinal hemorrhage.](#)

[Walker TG](#), [Salazar GM](#), [Waltman AC](#).

Source

Division of Vascular Imaging and Intervention, Massachusetts General Hospital, Harvard Medical School, Boston, MA 02114, United States. tgwalker@partners.org

Abstract

Although most cases of acute nonvariceal gastrointestinal hemorrhage either spontaneously resolve or respond to medical management or endoscopic treatment, there are still a significant number of patients who require emergency angiography and transcatheter treatment. Evaluation with noninvasive imaging such as nuclear

scintigraphy or computed tomography may localize the bleeding source and/or confirm active hemorrhage prior to angiography. Any angiographic evaluation should begin with selective catheterization of the artery supplying the most likely site of bleeding, as determined by the available clinical, endoscopic and imaging data. If a hemorrhage source is identified, superselective catheterization followed by transcatheter microcoil embolization is usually the most effective means of successfully controlling hemorrhage while minimizing potential complications. This is now well-recognized as a viable and safe alternative to emergency surgery. In selected situations transcatheter intra-arterial infusion of vasopressin may also be useful in controlling acute gastrointestinal bleeding. One must be aware of the various side effects and potential complications associated with this treatment, however, and recognize the high re-bleeding rate. In this article we review the current role of angiography, transcatheter arterial embolization and infusion therapy in the evaluation and management of nonvariceal gastrointestinal hemorrhage.

PMCID: PMC3309908 **Free PMC Article**

PMID: 22468082 [PubMed - indexed for MEDLINE]

[Related citations](#)

5 World J Gastroenterol. 2012 Mar 21;18(11):1185-90.

[Pros and cons of colonoscopy in management of acute lower gastrointestinal bleeding.](#)

[Lhewa DY, Strate LL.](#)

Source

Division of Hospital and Specialty Medicine, Department of Medicine, Puget Sound Health Care System - Seattle Division, Seattle, WA 98108, United States.

Abstract

Acute lower gastrointestinal bleeding (LGIB) is a frequent gastrointestinal cause of hospitalization, particularly in the elderly, and its incidence appears to be on the rise. Endoscopic and radiographic measures are available for the evaluation and treatment of LGIB including flexible sigmoidoscopy, colonoscopy, angiography, radionuclide scintigraphy and multi-detector row computed tomography. Although no modality has emerged as the gold standard in the management of LGIB, colonoscopy is the current preferred initial test for the majority of the patients presenting with hematochezia felt to be from a colon source. Colonoscopy has the ability to diagnose all sources of bleeding from the colon and, unlike the radiologic modalities, does not require active bleeding at the time of the examination. In addition, therapeutic interventions such as cautery and endoclips can be applied to achieve hemostasis and prevent recurrent bleeding. Studies suggest that colonoscopy, particularly when performed early in the hospitalization, can decrease hospital length of stay, rebleeding and the need for surgery. However, results from available small trials are conflicting and larger, multicenter studies are needed. Compared to other management options, colonoscopy is a safe procedure with complications reported in less than 2% of patients, including those undergoing urgent examinations. The requirement of bowel preparation (typically 4 or more liters of polyethylene glycol), the logistical complexity of coordinating after-hours colonoscopy, and the low prevalence of stigmata of hemorrhage complicate the use of colonoscopy for LGIB, particularly in urgent situations. This review discusses the above advantages and disadvantages of colonoscopy in the management of acute lower gastrointestinal bleeding in further detail.

PMCID: PMC3309907 **Free PMC Article**

PMID: 22468081 [PubMed - indexed for MEDLINE]

[Related citations](#)

6 World J Gastroenterol. 2012 Mar 21;18(11):1159-65.

[Management of non-variceal upper gastrointestinal tract hemorrhage: controversies and areas of uncertainty.](#)

[Trawick EP](#), [Yachimski PS](#).

Source

Division of Gastroenterology, Hepatology and Nutrition, Vanderbilt University Medical Center, Nashville, TN 37232, United States. eric.p.trawick@vanderbilt.edu

Abstract

Upper gastrointestinal tract hemorrhage (UGIH) remains a common presentation requiring urgent evaluation and treatment. Accurate assessment, appropriate intervention and apt clinical skills are needed for proper management from time of presentation to discharge. The advent of pharmacologic acid suppression, endoscopic hemostatic techniques, and recognition of *Helicobacter pylori* as an etiologic agent in peptic ulcer disease (PUD) has revolutionized the treatment of UGIH. Despite this, acute UGIH still carries considerable rates of morbidity and mortality. This review aims to discuss current areas of uncertainty and controversy in the management of UGIH. Neoadjuvant proton pump inhibitor (PPI) therapy has become standard empiric treatment for UGIH given that PUD is the leading cause of non-variceal UGIH, and PPIs are extremely effective at promoting ulcer healing. However, neoadjuvant PPI administration has not been shown to affect hard clinical outcomes such as rebleeding or mortality. The optimal timing of upper endoscopy in UGIH is often debated. Upon completion of volume resuscitation and hemodynamic stabilization, upper endoscopy should be performed within 24 h in all patients with evidence of UGIH for both diagnostic and therapeutic purposes. With rising healthcare cost paramount in today's medical landscape, the ability to appropriately triage UGIH patients is of increasing value. Upper endoscopy in conjunction with the clinical scenario allows for accurate decision making concerning early discharge home in low-risk lesions or admission for further monitoring and treatment in higher-risk lesions. Concomitant pharmacotherapy with non-steroidal anti-inflammatory drugs (NSAIDs) and antiplatelet agents, such as clopidogrel, has a major impact on the etiology, severity, and potential treatment of UGIH. Long-term PPI use in patients taking chronic NSAIDs or clopidogrel is discussed thoroughly in this review.

PMCID: PMC3309904 [Free PMC Article](#)

PMID: 22468078 [PubMed - indexed for MEDLINE]

[Related citations](#)

Sent on Saturday, 2012 May 26

PubMed Results

Items 1 - 7 of 7

1 World J Gastroenterol. 2012 Mar 28;18(12):1410-3.

[A rare case of langerhans cell histiocytosis of the gastrointestinal tract.](#)

[Shankar U](#), [Prasad M](#), [Chaurasia OP](#).

Source

Internal Medicine, Mount Sinai School of Medicine at Queens Hospital Center, Jamaica, NY 11432, USA. dr.ushankar@gmail.com

Abstract

Langerhans cell histiocytosis (LCH) is a group of idiopathic disorders characterized by the proliferation of specialized, bone marrow-derived langerhans cells and mature eosinophils. The clinical spectrum ranges from an acute, fulminant, disseminated disease called Letterer-Siwe disease to solitary or few, indolent and chronic lesions of the bone or other organs called eosinophilic granuloma. Involvement of the

gastrointestinal tract is very rare in LCH. We present the case of a 53-year-old woman referred by her primary care physician for a screening colonoscopy. A single sessile polyp, measuring 4 mm in size, was found in the rectum. Histopathological examination revealed that the lesion was relatively well circumscribed and comprised mainly a mixture of polygonal cells with moderate-to-abundant pink slightly granular cytoplasm. The nuclei within these cells had frequent grooves and were occasionally folded. Immunohistochemical staining was positive for CD-1a which confirmed the diagnosis of LCH. On further workup, there was no evidence of involvement of any other organ. On follow up colonoscopy one year later, there was no evidence of disease recurrence. Review of the published literature revealed that LCH presenting as solitary colonic polyp is rare. However, with the increasing rates of screening colonoscopy, more colonic polyps may be identified as LCH on histopathology. This underscores the importance of recognizing this rare condition and ensuring proper follow-up to rule out systemic disease.

PMCID: PMC3319970 [Free PMC Article](#)

PMID: 22493557 [PubMed - indexed for MEDLINE]

[Related citations](#)

2 World J Gastroenterol. 2012 Mar 28;18(12):1404-9.

[Endoscopic stenting and concurrent chemoradiotherapy for advanced esophageal cancer: a case-control study.](#)

[Jiang XJ](#), [Song MQ](#), [Xin YN](#), [Gao YQ](#), [Niu ZY](#), [Tian ZB](#).

Source

Department of Gastroenterology, Qingdao Municipal Hospital affiliated to Qingdao University, Qingdao 266011, Shandong Province, China.

Abstract

AIM:

To evaluate the role of endoscopic stenting with or without concurrent 3-dimensional conformal chemoradiotherapy (3D-CRT) in patients with inoperable esophageal cancer.

METHODS:

Advanced esophageal cancer patients indicated for esophagectomy received esophageal stents. A part of patients completed 3D-CRT after stenting. Efficacy was assessed by endoscopy and computed tomographic scan before and 4 wk after completion of the treatment. The median survival, 3D-CRT toxicity and complications were compared between 3D-CRT and control groups.

RESULTS:

From 1999 to 2008, 99 consecutive patients with T3/T4 disease and unsuitable for esophagectomy were placed with esophageal stents. Sixty-seven patients received 3D-CRT, while 36 patients treated with endoscopic stents alone were recruited as controls. After 3D-CRT treatment, the median tumor volume of 3D-CRT patients were reduced significantly from $43.7 \pm 10.2 \text{ cm}^3$ to $28.8 \pm 8.5 \text{ cm}^3$ ($P < 0.05$). The complete and partial response rate was 85.1%, and no response was 14.9%. After 3D-CRT, the incidence rate of T2 and T3 disease evident on CT scan increased to 78.4% while T4 decreased from 66.7% to 21.6% ($P < 0.05$). 3D-CRT Karnofsky Performance Status improved in 3D-CRT patients compared with the control group ($P = 0.031$). 3D-CRT patients had a longer survival than the control group (251.7 d vs 91.1 d, $P < 0.05$). And the median half-year survival rate in 3D-CRT group (91%) was higher than in the control group (50%, $P < 0.05$). The most common toxicity was leukocytopenia in the 3D-CRT group (46.7% vs 18.8%, $P = 0.008$). The control group had a higher rate of restenosis than the 3D-CRT group (81.3% vs 9.0%, $P < 0.05$). The rate of nephrotoxicity was increased in 3D-CRT as compared with the control group (31.3% vs 15.6%, $P < 0.05$).

CONCLUSION:

3D-CRT can improve dysphagia in patients with inoperable esophageal carcinoma. 3D-CRT combined with stenting results in better survival as compared with endoscopic stents used alone.

PMCID: PMC3319969 **Free PMC Article**

PMID: 22493556 [PubMed - indexed for MEDLINE]

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3 Am J Gastroenterol. 2012 Apr;107(4):635-6. doi: 10.1038/ajg.2011.431.

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[Soncini M](#), [Chilovi F](#), [Triossi O](#), [Leo P](#).

PMID: 22475969 [PubMed - indexed for MEDLINE]

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. [Imaged-enhanced technologies for colorectal polyp detection and classification.](#)

[Ussui VM](#), [Wallace MB](#).

Comment on

- [Am J Gastroenterol. 2012 Apr;107\(4\):543-50.](#)

Abstract

An early diagnosis of colorectal polyp can be achieved through screening and surveillance programs. In the past few years, advances in endoscopic imaging of the colorectal mucosa have been extensively developed, leading to an increased detection of pre-malignant lesions as well as low-grade and nonneoplastic polyps. In order to reduce the overall cost of care with minimal impact on the quality of care in colorectal cancer prevention, the "diagnosis and discard" strategy has been considered. High-definition, narrow band imaging and confocal endomicroscopy are image enhancement technologies that have been widely studied lately. The studies from Pasha et al. and Kuiper et al. demonstrate the limitations of these new advanced imaging technologies and that further studies should continue to be developed.

PMID: 22475963 [PubMed - indexed for MEDLINE]

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6 Br J Radiol. 2012 Apr;85(1012):e76-8.

. [Radioiodine retention on percutaneous endoscopic gastrostomy tubes.](#)

[Scuffham JW](#), [Wood KA](#), [Clauss RP](#), [Kilfeather SA](#), [Hinton PJ](#).

Source

Royal Surrey County Hospital NHS Foundation Trust, Guildford,

UK. james.scuffham@nhs.net

Abstract

An 80-year-old male with recurrent thyroid cancer and a percutaneous endoscopic gastrostomy (PEG) tube in situ was referred for radioiodine therapy and was administered 5510 MBq I-131 sodium iodide intravenously. Sequential whole-body images taken over the subsequent 7 days for dosimetric evaluation revealed an area of persistent high uptake in the abdomen. Delayed imaging with single photon emission CT/CT at 15 days post administration revealed this uptake to be at the junction of the

PEG tube with the anatomically normal stomach wall. We hypothesise that the PEG tube became contaminated by radioiodine secreted in the gastric mucosa during therapy and this radioactivity subsequently decayed with an increased effective half-life relative to the stomach, leading to the apparent hot spot.

PMID: 22457411 [PubMed - indexed for MEDLINE]

[Related citations](#)

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[Ultraselective arterial embolization of vasa recta using 1.7-French microcatheter with small-sized detachable coils in acute colonic hemorrhage after failed endoscopic treatment.](#)

[Koganemaru M](#), [Abe T](#), [Iwamoto R](#), [Kusumoto M](#), [Suenaga M](#), [Saga T](#), [Hayabuchi N](#).

Source

Department of Radiology, Kurume University School of Medicine, Fukuoka, Japan. mkoganemaru@med.kurume-u.ac.jp

Abstract

OBJECTIVE: The purpose of this article is to document our experiences with ultraselective arterial embolization to manage acute colonic hemorrhage using a 1.7-French microcatheter with small-sized detachable coils and to discuss the feasibility and clinical efficacy of this new technique. CONCLUSION: We achieved technical success in all four patients with the sole use of short-segment embolization of the long branch of the vasa recta. Our findings suggest that this technique is useful for embolization in cases of colonic hemorrhage.

PMID: 22451575 [PubMed - indexed for MEDLINE]

[Related citations](#)

Sent on Saturday, 2012 June 02

PubMed Results

Items 1 - 4 of 4

1 World J Gastroenterol. 2012 Apr 7;18(13):1502-7.

[Diagnostic yield of small bowel capsule endoscopy depends on the small bowel transit time.](#)

[Westerhof J](#), [Koorstra JJ](#), [Hoedemaker RA](#), [Sluiter WJ](#), [Kleibeuker JH](#), [Weersma RK](#).

Source

Department of Gastroenterology and Hepatology, University Medical Center, University of Groningen, Groningen, The Netherlands.

Abstract

AIM:

To investigate whether the small bowel transit time (SBTT) influences the diagnostic yield of capsule endoscopy (CE).

METHODS:

Six hundred and ninety-one consecutive CE procedures collected in a database were analyzed. SBTT and CE findings were recorded. A running mean for the SBTT was calculated and correlated to the diagnostic yield with a Spearman's correlation test. Subgroup analyses were performed for the various indications for the procedure.

RESULTS:

There was a positive correlation between the diagnostic yield and SBTT (Spearman's rho 0.58, P < 0.01). Positive correlations between diagnostic yield and SBTT were found for the indication obscure gastrointestinal bleeding (r = 0.54, P < 0.01), for polyposis and carcinoid combined (r = 0.56, P < 0.01) and for the other indications (r = 0.90, P < 0.01),

but not for suspected Crohn's disease ($r = -0.40$).

CONCLUSION:

The diagnostic yield in small bowel capsule endoscopy is positively correlated with the small bowel transit time. This is true for all indications except for suspected Crohn's disease.

PMCID: PMC3319946 [Free PMC Article](#)

PMID: 22509082 [PubMed - indexed for MEDLINE]

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[Ajani S](#), [Shah NB](#), [Vlahakis NE](#).

Source

Department of Medicine, Mayo Clinic, Rochester, Minnesota, USA.

PMID: 22505754 [PubMed - indexed for MEDLINE]

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3 Arch Intern Med. 2012 Apr 9;172(7):582-3.

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[Levin TR](#).

Source

Department of Gastroenterology, Kaiser Permanente Medical Center, CA 94596,

USA. theodore.levin@kp.org

Comment on

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PMID: 22493464 [PubMed - indexed for MEDLINE]

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[Inadomi JM](#), [Vijan S](#), [Janz NK](#), [Fagerlin A](#), [Thomas JP](#), [Lin YV](#), [Muñoz R](#), [Lau C](#), [Somsouk M](#), [El-Nachef N](#), [Hayward RA](#).

Source

Division of Gastroenterology, Department of Medicine, University of Washington School of Medicine, Seattle, WA 98195, USA. jinadomi@medicine.washington.edu

Comment in

- [Arch Intern Med. 2012 Apr 9;172\(7\):582-3.](#)

Abstract

BACKGROUND:

Despite evidence that several colorectal cancer (CRC) screening strategies can reduce CRC mortality, screening rates remain low. This study aimed to determine whether the approach by which screening is recommended influences adherence.

METHODS:

We used a cluster randomization design with clinic time block as the unit of randomization. Persons at average risk for development of CRC in a racially/ethnically diverse urban setting were randomized to receive recommendation for screening by fecal occult blood testing (FOBT), colonoscopy, or their choice of FOBT or colonoscopy. The primary outcome was completion of CRC screening within 12 months after enrollment, defined as performance of colonoscopy, or 3 FOBT cards plus colonoscopy for any positive FOBT result. Secondary analyses evaluated sociodemographic factors

associated with completion of screening.

RESULTS:

A total of 997 participants were enrolled; 58% completed the CRC screening strategy they were assigned or chose. However, participants who were recommended colonoscopy completed screening at a significantly lower rate (38%) than participants who were recommended FOBT (67%) ($P < .001$) or given a choice between FOBT or colonoscopy (69%) ($P < .001$). Latinos and Asians (primarily Chinese) completed screening more often than African Americans. Moreover, nonwhite participants adhered more often to FOBT, while white participants adhered more often to colonoscopy.

CONCLUSIONS:

The common practice of universally recommending colonoscopy may reduce adherence to CRC screening, especially among racial/ethnic minorities. Significant variation in overall and strategy-specific adherence exists between racial/ethnic groups; however, this may be a proxy for health beliefs and/or language. These results suggest that patient preferences should be considered when making CRC screening recommendations. Trial Registration clinicaltrials.gov Identifier: NCT00705731.

PMCID: PMC3360917 [Available on 2012/10/9]

PMID: 22493463 [PubMed - indexed for MEDLINE]

[Related citations](#)

Sent on Saturday, 2012 June 23

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[Koczka CP](#).

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SUNY Downstate Medical Center, Brooklyn, New York, USA.

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[Woodward TA](#), [Heckman MG](#), [Cleveland P](#), [De Melo S](#), [Raimondo M](#), [Wallace M](#).

Source

Department of Gastroenterology, Mayo Clinic, 4500 San Pablo Road South, Jacksonville, Florida 32224, USA. woodward.timothy@mayo.edu

Abstract

OBJECTIVES:

We evaluated risk factors for residual neoplasia on first follow-up endoscopy after colonic endoscopic mucosal resections (EMRs).

METHODS:

This retrospective study in a high-volume EMR tertiary-referral center examined EMRs

on 423 colonic lesions in 313 patients.

RESULTS:

Residual neoplasia at first follow-up endoscopy was present following 12% of colonic EMRs. Single-variable analysis showed evidence of an increased risk of residual neoplasia for larger polyps, polyps without a lifting sign, and polyps removed piecemeal. In multivariable analysis, only use of the piecemeal method was independently associated with residual neoplasia.

CONCLUSIONS:

Additional procedures are needed to complete resection in more than 1 in 10 colonic EMRs. Residual neoplasia occurs more often with piecemeal resection. Close surveillance after EMR and the use of newer methods to further reduce residual neoplasia are needed.

PMID: 22552236 [PubMed - indexed for MEDLINE]

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Sent on Saturday, 2012 June 30

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Collaborators: [Berg CD](#), [Gohagan JK](#), [Prorok PC](#), [Hsing AW](#), [Lacey JV Jr](#), [Purdue M](#), [Hayes RB](#), [Black A](#), [Huang WY](#), [Simpson NK](#), [Cumberlin R](#), [Rossi S](#), [Yu K](#), [Zhu C](#), [Marquez G](#), [Browne JE](#), [Hoffman S](#), [Baca D](#), [Coleman DM](#), [Jackson C](#), [Lange E](#), [Loesch M](#), [McMillan D](#), [Papadopoulos E](#), [Sylver-Foust D](#), [Weiszer R](#), [Sullivan D](#), [Brown M](#), [Gaegler J](#), [Gray L](#), [Hansborough A](#), [Greenwald P](#), [Fraumeni JF](#), [Fagerstrom RM](#), [Hu P](#), [Izmirlian G](#), [Levin DL](#), [Pinsky P](#), [Xu JL](#), [Kreimer A](#), [Marcus PM](#), [Subar AF](#), [Greenwald P](#), [Kramer BS](#), [Hartge P](#), [Hoover RN](#), [Ziegler RG](#), [Costlow R](#), [Laine AF](#), [Miller AB](#), [Pearson D](#), [van Nagell JR](#), [Stallings FL](#), [Miller DS](#), [Chia D](#), [Dry S](#), [Seligson D](#), [Terasaki P](#), [Reiss J](#), [Tze S](#), [Acalinovich A](#), [Besada S](#), [Chan H](#), [Cheung-Lau G](#), [Corbett S](#), [Durongwong P](#), [Eeva M](#), [Folayan L](#), [Gruebel B](#), [Habeeb O](#), [Huynh K](#), [Kanegai C](#), [Kim H](#), [Kim S](#), [Ko A](#), [Kohlmeier S](#), [Lamb C](#), [Lu M](#), [Martin J](#), [Maynard S](#), [Noravian F](#), [Schirripa O](#), [Padilla G](#), [Rumbin A](#), [Shevlin L](#), [Ty R](#), [Wang Q](#), [Wong J](#), [Xu S](#), [Yu H](#), [Koci J](#), [Kopp W](#), [Rager H](#), [Smith C](#), [Roser D](#), [Cahill J](#), [O'Brien B](#), [Gardner S](#), [Carrick](#)

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Source

Department of Medicine, University of Pittsburgh, Pittsburgh, PA, USA. rschoen@pitt.edu

Comment in

- [Why you should care about screening flexible sigmoidoscopy](#). [N Engl J Med. 2012]

Why you should care about screening flexible sigmoidoscopy. *Inadomi JM. N Engl J Med. 2012 Jun 21; 366(25):2421-2. Epub 2012 May 21.*

Abstract

BACKGROUND:

The benefits of endoscopic testing for colorectal-cancer screening are uncertain. We

evaluated the effect of screening with flexible sigmoidoscopy on colorectal-cancer incidence and mortality.

METHODS:

From 1993 through 2001, we randomly assigned 154,900 men and women 55 to 74 years of age either to screening with flexible sigmoidoscopy, with a repeat screening at 3 or 5 years, or to usual care. Cases of colorectal cancer and deaths from the disease were ascertained.

RESULTS:

Of the 77,445 participants randomly assigned to screening (intervention group), 83.5% underwent baseline flexible sigmoidoscopy and 54.0% were screened at 3 or 5 years. The incidence of colorectal cancer after a median follow-up of 11.9 years was 11.9 cases per 10,000 person-years in the intervention group (1012 cases), as compared with 15.2 cases per 10,000 person-years in the usual-care group (1287 cases), which represents a 21% reduction (relative risk, 0.79; 95% confidence interval [CI], 0.72 to 0.85; $P < 0.001$). Significant reductions were observed in the incidence of both distal colorectal cancer (479 cases in the intervention group vs. 669 cases in the usual-care group; relative risk, 0.71; 95% CI, 0.64 to 0.80; $P < 0.001$) and proximal colorectal cancer (512 cases vs. 595 cases; relative risk, 0.86; 95% CI, 0.76 to 0.97; $P = 0.01$). There were 2.9 deaths from colorectal cancer per 10,000 person-years in the intervention group (252 deaths), as compared with 3.9 per 10,000 person-years in the usual-care group (341 deaths), which represents a 26% reduction (relative risk, 0.74; 95% CI, 0.63 to 0.87; $P < 0.001$). Mortality from distal colorectal cancer was reduced by 50% (87 deaths in the intervention group vs. 175 in the usual-care group; relative risk, 0.50; 95% CI, 0.38 to 0.64; $P < 0.001$); mortality from proximal colorectal cancer was unaffected (143 and 147 deaths, respectively; relative risk, 0.97; 95% CI, 0.77 to 1.22; $P = 0.81$).

CONCLUSIONS:

Screening with flexible sigmoidoscopy was associated with a significant decrease in colorectal-cancer incidence (in both the distal and proximal colon) and mortality (distal colon only). (Funded by the National Cancer Institute; PLCO ClinicalTrials.gov number, NCT00002540.)

PMID: 22612596 [PubMed - indexed for MEDLINE]

[Related citations](#)

3 Ann Surg. 2012 Jun;255(6):1121-5.

[Risk of colonic neoplasia after proctectomy for rectal cancer in hereditary nonpolyposis colorectal cancer.](#)

[Kalady MF](#), [Lipman J](#), [McGannon E](#), [Church JM](#).

Source

Department of Colorectal Surgery, Digestive Disease Institute, Cleveland Clinic, Cleveland, OH 44195, USA. kaladym@ccf.org

Abstract

OBJECTIVE:

To define the neoplastic risk in the remaining colon after proctectomy for rectal cancer in patients with hereditary nonpolyposis colorectal cancer (HNPCC).

BACKGROUND:

The extent of surgery for rectal cancer in HNPCC is controversial. In determining which operation to perform, surgeons and patients must consider cancer risk in the remaining colon as well as functional consequences of removing the entire colorectum. The natural history of colon neoplasia in this situation is understudied and is not well-defined.

METHODS:

A single-institution hereditary colorectal cancer database was queried for patients meeting Amsterdam criteria and with rectal cancer. Patient demographics, surgical

management, and follow-up were recorded.

RESULTS:

Fifty HNPCC patients with a primary diagnosis of rectal cancer treated by proctectomy were included. Detailed follow-up colonoscopy data were available for 33 patients. Forty-eight high-risk adenomas developed in 13 patients (39.4%). Five patients (15.2%) developed metachronous adenocarcinoma at a median of 6 years (range 3.5-16) after proctectomy, including 3 at advanced stage. One of these patients developed a high-risk adenoma before cancer. Mean interval between the last normal colonoscopy and cancer discovery was 42 months (range 23.8-62.1) with one developing within 2 years. Thus, 17 of 33 patients (51.5%) developed high-risk adenoma or cancer after proctectomy.

CONCLUSIONS:

Surgeons and patients need to be aware of substantial risk for metachronous neoplasia after proctectomy. Selection of operation should be individualized, but total proctocolectomy and ileoanal pouch should be strongly considered. If patients undergo proctectomy alone, close surveillance is mandatory.

PMID: 22549751 [PubMed - indexed for MEDLINE]

[Related citations](#)

Sent on Saturday, 2012 July 14

PubMed Results

Items 1 - 5 of 5

1 JAMA. 2012 Jun 27;307(24):2586-7; author reply 2587.

• [Anesthesia care for low-risk patients undergoing gastrointestinal endoscopies.](#)
[Nielsen J.](#)

Comment on

- [Utilization of anesthesia services during outpatient endoscopies and colonoscopies and associated spending in 2003-2009.](#) [JAMA. 2012]

Utilization of anesthesia services during outpatient endoscopies and colonoscopies and associated spending in 2003-2009. *Liu H, Waxman DA, Main R, Mattke S. JAMA. 2012 Mar 21; 307(11):1178-84.*

PMID: 22735417 [PubMed - indexed for MEDLINE]

[Related citations](#)

2 JAMA. 2012 Jun 27;307(24):2586; author reply 2587.

• [Anesthesia care for low-risk patients undergoing gastrointestinal endoscopies.](#)
[Perel A.](#)

Comment on

- [Utilization of anesthesia services during outpatient endoscopies and colonoscopies and associated spending in 2003-2009.](#) [JAMA. 2012]

Utilization of anesthesia services during outpatient endoscopies and colonoscopies and associated spending in 2003-2009. *Liu H, Waxman DA, Main R, Mattke S. JAMA. 2012 Mar 21; 307(11):1178-84.*

PMID: 22735416 [PubMed - indexed for MEDLINE]

[Related citations](#)

3 JAMA. 2012 Jun 27;307(24):2585-6; author reply 2587.

• [Anesthesia care for low-risk patients undergoing gastrointestinal endoscopies.](#)
[Rex DK.](#)

Comment on

- [Assessing the value of "discretionary" clinical care: the case of anesthesia](#)

[services for endoscopy](#). [JAMA. 2012]

Assessing the value of "discretionary" clinical care: the case of anesthesia services for endoscopy. *Fleisher LA. JAMA. 2012 Mar 21; 307(11):1200-1.*

- [Utilization of anesthesia services during outpatient endoscopies and colonoscopies and associated spending in 2003-2009](#). [JAMA. 2012]

Utilization of anesthesia services during outpatient endoscopies and colonoscopies and associated spending in 2003-2009. *Liu H, Waxman DA, Main R, Mattke S. JAMA. 2012 Mar 21; 307(11):1178-84.*

PMID: 22735415 [PubMed - indexed for MEDLINE]

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4 JAMA. 2012 Jun 27;307(24):2585; author reply 2587.

- [Anesthesia care for low-risk patients undergoing gastrointestinal endoscopies](#). *Scemama P, Lee B, Guimaraes E.*

Comment on

- [Utilization of anesthesia services during outpatient endoscopies and colonoscopies and associated spending in 2003-2009](#). [JAMA. 2012]

Utilization of anesthesia services during outpatient endoscopies and colonoscopies and associated spending in 2003-2009. *Liu H, Waxman DA, Main R, Mattke S. JAMA. 2012 Mar 21; 307(11):1178-84.*

PMID: 22735414 [PubMed - indexed for MEDLINE]

[Related citations](#)

5 Am J Clin Pathol. 2012 Jun;137(6):931-6.

- [Foxp3 expression patterns in microscopic colitides: a clinicopathologic study of 69 patients](#).

Bai S, Siegal GP, Jhala NC.

Source

Department of Pathology and Laboratory Medicine, University of Pennsylvania Hospital, Philadelphia, PA 19104, USA.

Abstract

Microscopic colitides, including lymphocytic (LC) and collagenous colitis (CC), are well-described pathologic conditions. An altered immune response is implicated in the pathogenesis of both entities. CD8+ T lymphocytes (CTLs) secrete interleukin 2 which stimulates proliferation of regulatory T cells (Tregs), and Tregs, in turn, inhibit CTLs, inducing cytotoxic tissue damage. In Tregs, Foxp3 regulates T-cell-related immune responses. The distribution of Tregs and CTLs in microscopic colitides has remained underexplored. To characterize differences in the distribution pattern of Foxp3 in biopsy specimens from patients with LC and CC, 71 colonic biopsy specimens from 69 consecutive patients were categorized into 1 of 3 diagnoses: no significant histopathologic abnormality (NSHPA), LC, or CC. Further immunohistochemical evaluation of all biopsy specimens was conducted using a panel of markers including CD8 and Foxp3. Our study demonstrated that CTL distribution pattern differences exist among these 2 colitides and that differences in the immunologic recruitment of Foxp3+ Tregs in the colonic mucosa correlate with differences in the spectrum of morphologic changes seen in patients with either LC or CC.

PMID: 22586052 [PubMed - indexed for MEDLINE]

[Related citations](#)

Sent on Saturday, 2012 August 11

Item 1 of 1

1 MMWR Morb Mortal Wkly Rep. 2012 Jun 15;61 Suppl:51-6.

Prevalence of colorectal cancer screening among adults--Behavioral Risk Factor Surveillance System, United States, 2010.

[Joseph DA](#), [King JB](#), [Miller JW](#), [Richardson LC](#); [Centers for Disease Control and Prevention \(CDC\)](#).

Source

Division of Cancer Prevention and Control, National Center for Chronic Disease Prevention and Health Promotion, CDC, 2858 Woodcock Blvd, Atlanta, GA 30341, USA. dvk5@cdc.gov

Abstract

Among cancers that affect both men and women, colorectal cancer is the second leading cause of cancer death. In 2007 (the most recent year for which data are available), >142,000 persons received a diagnosis for colorectal cancer and >53,000 persons died. Screening for colorectal cancer has been demonstrated to be effective in reducing the incidence of and mortality from the disease. In 2008, the U.S. Preventive Services Task Force (USPSTF) recommended that persons aged 50-75 years at average risk for colorectal cancer be screened by using one or more of the following methods: high-sensitivity fecal occult blood testing (FOBT) every year, sigmoidoscopy every 5 years with FOBT every 3 years, or colonoscopy every 10 years.

Free Article

PMID: 22695464 [PubMed - indexed for MEDLINE]

Sent on Saturday, 2012 September 22

PubMed Results

Items 1 - 4 of 4

1 N Engl J Med. 2012 Sep 13;367(11):1065; author reply 1065-6.

[Screening flexible sigmoidoscopy for colon cancer.](#)
[Matuchansky C](#).

Comment on

- [Colorectal-cancer incidence and mortality with screening flexible sigmoidoscopy.](#) [N Engl J Med. 2012]

Colorectal-cancer incidence and mortality with screening flexible sigmoidoscopy. *Schoen RE, Pinsky PF, Weissfeld JL, Yokochi LA, Church T, Laiyemo AO, Bresalier R, Andriole GL, Buys SS, Crawford ED, et al. N Engl J Med. 2012 Jun 21; 366(25):2345-57. Epub 2012 May 21.*

PMID: 22970954 [PubMed - indexed for MEDLINE]

[Related citations](#)

2 N Engl J Med. 2012 Sep 13;367(11):1064-5; author reply 1065-6.

[Screening flexible sigmoidoscopy for colon cancer.](#)
[Ramos-Esquivel A](#).

Comment on

- [Colorectal-cancer incidence and mortality with screening flexible sigmoidoscopy.](#) [N Engl J Med. 2012]

Colorectal-cancer incidence and mortality with screening flexible sigmoidoscopy. *Schoen RE, Pinsky PF, Weissfeld JL, Yokochi LA, Church T, Laiyemo AO, Bresalier R, Andriole GL, Buys SS, Crawford ED, et al. N Engl J*

Med. 2012 Jun 21; 366(25):2345-57. Epub 2012 May 21.
PMID: 22970953 [PubMed - indexed for MEDLINE]
[Related citations](#)

3 N Engl J Med. 2012 Sep 13;367(11):1064; author reply 1065-6.

• [Screening flexible sigmoidoscopy for colon cancer.](#)

[Hoch DH.](#)

Comment on

- [Colorectal-cancer incidence and mortality with screening flexible sigmoidoscopy.](#) [N Engl J Med. 2012]

Colorectal-cancer incidence and mortality with screening flexible sigmoidoscopy. *Schoen RE, Pinsky PF, Weissfeld JL, Yokochi LA, Church T, Laiyemo AO, Bresalier R, Andriole GL, Buys SS, Crawford ED, et al. N Engl J Med. 2012 Jun 21; 366(25):2345-57. Epub 2012 May 21.*

PMID: 22970952 [PubMed - indexed for MEDLINE]

[Related citations](#)

4 N Engl J Med. 2012 Sep 13;367(11):1064; author reply 1065-6.

• [Screening flexible sigmoidoscopy for colon cancer.](#)

[Mills J.](#)

Comment on

- [Colorectal-cancer incidence and mortality with screening flexible sigmoidoscopy.](#) [N Engl J Med. 2012]

Colorectal-cancer incidence and mortality with screening flexible sigmoidoscopy. *Schoen RE, Pinsky PF, Weissfeld JL, Yokochi LA, Church T, Laiyemo AO, Bresalier R, Andriole GL, Buys SS, Crawford ED, et al. N Engl J Med. 2012 Jun 21; 366(25):2345-57. Epub 2012 May 21.*

PMID: 22970951 [PubMed - indexed for MEDLINE]

[Related citations](#)