Items 1 - 10 of 10 (19/06/2010)

1. Johns Hopkins Med Lett Health After 50. 2010 May;22(3):6-7.

Know your colon screening options.

[No authors listed]
PMID: 20518139 [PubMed - indexed for MEDLINE]
Related citations

2 BMJ. 2010 Jun 1;340:c2831. doi: 10.1136/bmj.c2831.
.

Which tool is best for colorectal cancer screening?

Bretthauer M.
PMID: 20516015 [PubMed - indexed for MEDLINE]
Related citations
Full Text
BMJ

3 Ann Intern Med. 2010 Jun 1;152(11):697-703.
.

Sex, age, and birth cohort effects in colorectal neoplasms: a cohort analysis.

Brenner H, Altenhofen L, Hoffmeister M.

German Cancer Research Center, Heidelberg, Germany.

Abstract

BACKGROUND: Prevalence of advanced colorectal neoplasms increases with age and is higher among men than women. Cross-sectional analyses estimated that men reach an equivalent prevalence at a much younger age than women. However, cross-sectional estimates may be confounded by birth cohort effects. OBJECTIVE: To estimate age and cohort effects in advanced colorectal neoplasms and to adjust risk-advancement periods for men compared with women for birth cohort effects. DESIGN: Age-cohort analyses. SETTING: German screening colonoscopy program, 2003 to 2007. PARTICIPANTS: 2 185 153 participants aged 55 to 75 years. MEASUREMENTS: Sex- and age-specific prevalence of colorectal cancer (CRC) and advanced neoplasms (CRC or advanced adenoma) were plotted with and without stratification by birth cohort. Risk-advancement periods with 95% CI for men compared with women were estimated from log-binomial regression models with and without cross-sectional analysis adjustment for birth cohort effects. RESULTS: Overall, 17 196 participants (0.8%) had CRC and 152 429 (7.0%) had any advanced neoplasm. Age-specific prevalence was higher in men than in women and in later birth cohorts. The apparent modest increase in prevalence by age in cross-sectional analysis was much steeper after birth cohort effects were controlled for. In cross-sectional analysis, risk-advancement periods (95% CI) for men compared with women were 8.4 years (CI, 7.7 to 9.0 years) and 16.1 years (CI, 15.8 to 16.5 years) for CRC and any advanced neoplasm, respectively, and 3.4 years (CI, 2.6 to 4.3 years) and 6.9 years (CI, 6.4 to 7.4 years) after controlling for birth cohort effects. LIMITATION: Information on covariates that could explain cohort effects was lacking. CONCLUSION:

In this population, strong cohort effects reduced age gradients in advanced colorectal neoplasms and inflated risk-advancement periods for men compared with women, but major risk advancement persisted, even after birth cohort effects were controlled for. Primary Funding Source: None.

PMID: 20513827 [PubMed - indexed for MEDLINE]
Related citations


4 J Surg Oncol. 2010 Jun 15;101(8):706-12.
.

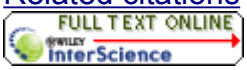
Ulcerative colitis and cancer.

Kulaylat MN, Dayton MT.

Department of Surgery, State University of New York-Buffalo, Kaleida Health, Buffalo General Hospital, Buffalo, New York 14203, USA. mkulaylat@kaleidahealth.org

Abstract

Patients with ulcerative colitis (UC) are at an increased risk for the development of colorectal cancer (CRC). Unlike sporadic CRC, the cancer in UC patients arises from a focal or multifocal dysplastic mucosa in areas of inflammation. The clinical features of UC-associated cancer are similar to those found in patients with hereditary non-polyposis colorectal cancer. As with other varieties of CRC, UC-associated cancer exhibits a variety of genetic and molecular changes/abnormalities. These abnormalities are however clustered in areas of mucosae with histological abnormalities. The magnitude and timing of these changes are however significantly different. Surveillance and identification of patients at risk for cancer are a challenging problem. (c) 2010 Wiley-Liss, Inc.

PMID: 20512947 [PubMed - indexed for MEDLINE]
Related citations


5 Dtsch Med Wochenschr. 2010 Jun;135(22):1123-4. Epub 2010 May 25.
.

[72-year-old patient with tumor and gas trointestinal bleeding]

[Article in German]

Gerber T.
PMID: 20503138 [PubMed - indexed for MEDLINE]
Related citations


6 Ugeskr Laeger. 2010 May 17;172(20):1532-4.
.

[Propofol for sedation during colonoscopy. A survey of a Cochrane review]

[Article in Danish]< /p>Høj AT, Vilmann P.

Gastroenheden, Herlev Hospital, 2730 Herlev, Denmark.

Abstract

The Cochrane collaboration metaanalysis of propofol use during colonoscopy found a faster patient recovery, higher patient satisfaction and unchanged complication rate compared to traditional sedatives. Patient groups consisted mostly of ASA I-II-patients, therefore the study is inconclusive with regard to the risks for sicker patients.

PMID: 20483101 [PubMed - indexed for MEDLINE]
Related citations

7 Orv Hetil. 2010 May 23;151(21):870-7.
.

[Postoperative recurrence of Crohn's disease, and its prevention]

[Article in Hungarian]

Lakatos L, Lakatos PL.

Csolnoky Ferenc Megyei Kórház, Belgyógyászati Centrum, Veszprém, Kórház u. 1. 8200. lakatos.laszlo@vmkorhaz.hu

Abstract

Crohn's disease is a chronic, progressive disabling condition ultimately leading to stricturing and/or penetrating complications. The need for surgery may be as high as 70% in patients with severe active disease or complications. However, relapse may develop in a significant proportion of the patients after surgery leading to frequent re-operations. Despite emerging data, postoperative prevention is still controversial. After careful evaluation of the individual risk a tailored therapy should be considered. In patients with small risk for relapse mesalazine or in selected cases no-treatment may be an option. In patients with a moderate-to-high risk azathioprine should be considered together with metronidazole in the three months. Follow-up ileocolonoscopy 6-12 months after the surgery is helpful in the determination of endoscopic severity and may assist in the optimization of the therapy. In most severe cases anti-TNF agents may be appropriate for postoperative prevention and therapy.

Free Article

PMID: 20462847 [PubMed - indexed for MEDLINE]
Related citations

8 J Am Anim Hosp Assoc. 2010 May-Jun;46(3):168-73.
.

Endoscopic polypectomy using endocautery in three dogs and one cat.

Foy DS, Bach JF.

Department of Medical Sciences, Veterinary Medical Teaching Hospital, University of Wisconsin-Madison, 2015 Linden Drive, Madison, Wisconsin 53706, USA.

Abstract

Endoscopic polypectomy has long been employed in humans with either gastric or colonic polyps. Despite the frequency of use in humans, reports in veterinary medicine remain scarce. The medical records of three dogs and one cat were reviewed. Two animals that were presented with hematochezia underwent colonoscopic polypectomy and were clinically normal 22 months and 6 months postpolypectomy. One animal that was presented with chronic vomiting underwent gastric polypectomy and was clinically normal 21 months postpolypectomy. One animal with an incidentally discovered gastric polyp underwent polypectomy without complication. Endoscopic polypectomy may be a viable alternative to surgery in veterinary patients with gastric or colonic polyps.

PMID: 20439939 [PubMed - indexed for MEDLINE]
Related citations


9 Dig Dis Sci. 2010 May;55(5):1194-6.
.

Colorectal cancer: what to do when logic and good intentions are not enough.

Ahnen DJ.

Comment on:

- Dig Dis Sci. 2010 May;55(5):1434-41.

PMID: 20414805 [PubMed - indexed for MEDLINE]
Related citations


10 Dig Dis Sci. 2010 May;55(5):1251-4. Epub 2010 Apr 22.
.

A tale of two peptic strictures: esophageal and duodenal.

Triadafilopoulos G, Raju JS, Kieturakis MJ.

Division of Gastroenterology and Hepatology, Stanford University Medical Center, Alway Building, Room M 211, 300 Pasteur Drive, MC 5187, Stanford, CA 94305-5187, USA. vagt@stanford.edu

PMID: 20411416 [PubMed - indexed for MEDLINE]

Related citations
SpringerLink FULL-TEXT ARTICLE

Items 1 - 3 of 3

1 Am Fam Physician. 2010 Jun 1;81(11):1320.
.

Learning about prevention the hard way. A patient's perspective.

Babalola D.
PMID: 20521749 [PubMed - indexed for MEDLINE]
Related citations
Full text from AFP

2 Ned Tijdschr Tandheelkd. 2010 May;117(5):263-7.
.

[Nationwide colorectal cancer screening]

[Article in Dutch]

van Rossum LG, Laheij RJ, Jansen JB.

Afdeling Epidemiologie, Biostatistiek en Health Technology Assessment van het Universitair Medisch Centrum St Radboud. l.vanrossum@ebl.umcn.nl

Abstract

Usually, colorectal cancer presents with complaints in a late stage, but can be detected in an earlier stage, with better prognosis, by colonoscopy. Using colonoscopy, also precancerous tumours, adenomas, can be detected and excised, but only in a national screening programme. However primary screening with colonoscopy is too burdensome and expensive. Out of all the screening alternatives, only of the faecal occult blood tests (faeces tests) a decreased colorectal cancer mortality has been proven. It stands to reason that the new generation immunochemical faeces tests, can reduce colorectal cancer mortality more effectively, and these tests have, more than the alternatives, a good balance between efficiency, straightforwardness and costs. Recently, the Dutch National Health Council recommended to introduce nationwide colorectal cancer screening, using an immunochemical faecal occult blood test.

PMID: 20506902 [PubMed - indexed for MEDLINE]
Related citations

3 Nippon Shokakibyo Gakkai Zasshi. 2010 May;107(5):726-31.
.

[Capsule endoscopy]

[Article in Japanese]

Wakabayashi N, Handa O, Naito Y, Yoshikawa T.

Molecular Gastroenterology and Hepatology, Kyoto Prefectual University of Medicine Graduate School of Medical Science, Japan. naokiw@koto.kpu-m.ac.jp

PMID: 20460846 [PubMed - indexed for MEDLINE]
Related citations

Items 1 - 5 of 5 (10/07/2010)

1 BMJ. 2010 Jul 2;341:c3115. doi: 10.1136/bmj.c3115.
.

Novel approach to antibiotic prophylaxis in percutaneous endoscopic gastrostomy (PEG): randomised controlled trial.

Blomberg J, Lagergren P, Martin L, Mattsson F, Lagergren J.

Upper Gastrointestinal Research, Department of Molecular Medicine and Surgery, Karolinska Institutet, SE-171 76 Stockholm, Sweden. john.blomberg@karolinska.se

Comment in:

- BMJ. 2010;341:c2898.

Abstract

OBJECTIVE: To evaluate a new and simpler strategy of antibiotic prophylaxis in percutaneous endoscopic gastrostomy (PEG). DESIGN: Single centre, two arm, randomised, controlled, double blind clinical trial. SETTING: Endoscopy unit in Karolinska University Hospital, Stockholm, Sweden, between 3 June 2005 and 31 October 2009. PARTICIPANTS: 234 patients with an indication for PEG who gave informed consent to participate. INTERVENTION: A single 20 ml dose of the oral solution of sulfamethoxazole and trimethoprim (also known as co-trimoxazole or Bactrim; F Hoffmann-La Roche Ltd, Basel, Switzerland) deposited in the PEG catheter immediately after insertion. The control group received standard prophylaxis consisting of a single intravenous dose of 1.5 g cefuroxime (Zinacef; GlaxoSmithKline, London) administered before insertion of the PEG tube. MAIN OUTCOME MEASURE: Primary outcome was the occurrence of clinically evident wound infection within 14 days after insertion of the PEG catheter. Secondary outcomes were positive bacterial culture and blood tests (highly sensitive C reactive protein and white blood cell count). All randomised patients were included in an intention to treat analysis. RESULTS: Of the 234 patients included in this study, 116 were randomly assigned to co-trimoxazole and 118 to cefuroxime. At follow-up 7-14 days after insertion of the PEG catheter, wound infection was found in 10 (8.6%) patients in the co-trimoxazole group and 14 (11.9%) in the cefuroxime group, which corresponds to a percentage point difference of -3.3% (95% confidence interval -10.9% to 4.5%). The per protocol analysis, which comprised 100 patients in each group,

gave similar results-10% and 13% infection in the co-trimoxazole and cefuroxime groups, respectively (percentage point difference -3.0%, 95% CI -11.8% to 5.8%). Both these analyses indicate non-inferiority of co-trimoxazole compared with cefuroxime because the upper bounds of the confidence intervals are lower than the pre-determined non-inferiority margin of 15%. Analyses of the secondary outcomes supported this finding. CONCLUSION: 20 ml of co-trimoxazole solution deposited in a newly inserted PEG catheter is at least as effective as cefuroxime prophylaxis given intravenously before PEG at preventing wound infections in patients undergoing PEG. Trial registration Current Controlled Trials ISRCTN18677736.

PMCID: PMC2896486
PMID: 20601414 [PubMed - indexed for MEDLINE]
Related citations

2 BMJ. 2010 Jul 2;341:c2898. doi: 10.1136/bmj.c2898.
.

Antibiotic prophylaxis after percutaneous endoscopic gastros tomy.

Kurien M, Sanders DS.

Comment on:

- BMJ. 2010;341:c3115.

PMID: 20601413 [PubMed - indexed for MEDLINE]
Related citations

3 Gan To Kagaku Ryoho. 2010 Jun;37(6):1167-70.
.

[A case of ascending colon cancer with unresectable distant metastases treat ed by systemic chemotherapy]

[Article in Japanese]

Sugimoto K, Tashiro Y, Nagayasu K, Niwa K, Ono S, Ishiyama S, Hata M, Komiyama H, Takahashi M, Yaginuma Y, Kojima Y, Goto M, Tanaka M, Sengoku H, Okuzawa A, Tomiki Y, Sakamoto K.

Department of Coloproctological Surgery, Juntendo University.

Abstract

The patient, a male in his 70s, was referred to this hospital by his neighborhood doctor with what was said to be impaired hepatic function. Detailed examinations revealed a circumferential ascending colon cancer, diffuse hepatic metastases scattered over both liver lobes, and lymph node metastases in the left axilla. With the primary lesion-induced symptoms of stenosis controllable, the patient began systemic chemotherapy by mFOLFOX6 without a resection of the primary lesion. After completing a 10-course

treatment, the patient underwent surgery to resect the primary lesion in preparation for bevacizumab treatment. In the postoperative systemic chemotherapy, FOLFIRI and mFOLFOX6 were administered concomitantly with bevacizumab. After a total of 19 courses, the patient's systemic condition gradually deteriorated. He eventually died of cancer one year and seven months after diagnosis of the primary lesion or one year and one month subsequent to the resection of the primary lesion. No consensus has been reached on the necessity to resect the primary lesion in patients with advanced colorectal cancer who also have unresectable distal metastases. Systemic chemotherapy, nevertheless, can provide tumor control on both primary and metastatic lesions and could become a treatment option in the future.

PMID: 20567130 [PubMed - indexed for MEDLINE]
Related citations


4 MMW Fortschr Med. 2010 May 20;152(20):21.
.

[Young woman with recurrent cramping abdominal pain. What is in back of the submucous space occupying lesion of the sigmoid colon?]

[Article in German]

Stiefelhagen P.
PMID: 20552874 [PubMed - indexed for MEDLINE]
Related citations

5 Dig Dis Sci. 2010 Jun;55(6):1547-9. Epub 2010 May 11.
.

Caustic ingestion and upper digestive tract injury.

Lee M.

Division of Gastroenterology, Department of Medicine, Stanford University Medical Center, Alway Bldg. M211, Stanford, CA 94305-5187, USA. maxlee@stanford.edu

PMID: 20458618 [PubMed - indexed for MEDLINE]
Related citations


Items 1 - 3 of 3 (24/07/2010)

1 Gut. 2010 Jul;59(7):1004-5; author reply 1005.
.

Gastric retention and wireless capsule endoscopy in adults: a modified technique for direct duodenal deployment.

Qasim A, Ryan B, Breslin N, O'Morain C.

Comment on:

- Gut. 2009 Nov;58(11):1467-72.

PMID: 20581250 [PubMed - indexed for MEDLINE]
Related citations


2 Gut. 2010 Jul;59(7):975-86.
.

Peutz-Jeghers syndrome: a systematic review and recommendations for management.

Beggs AD, Latchford AR, Vasen HF, Moslein G, Alonso A, Aretz S, Bertario L, Blanco I, Bülow S, Burn J, Capella G, Colas C, Friedl W, Møller P, Hes FJ, Järvinen H, Mecklin JP, Nagengast FM, Parc Y, Phillips RK, Hyer W, Ponz de Leon M, Renkonen-Sinisalo L, Sampson JR, Stormorken A, Tejpar S, Thomas HJ, Wijnen JT, Clark SK, Hodgson SV.

Department of Clinical Genetics, St Georges, University of London, Cranmer Terrace, London, UK.

Abstract

Peutz-Jeghers syndrome (PJS, MIM175200) is an autosomal dominant condition defined by the development of characteristic polyps throughout the gastrointestinal tract and mucocutaneous pigmentation. The majority of patients that meet the clinical diagnostic criteria have a causative mutation in the STK11 gene, which is located at 19p13.3. The cancer risks in this condition are substantial, particularly for breast and gastrointestinal cancer, although ascertainment and publication bias may have led to overestimates in some publications. Current surveillance protocols are controversial and not evidence-based, due to the relative rarity of the condition. Initially, endoscopies are more likely to be done to detect polyps that may be a risk for future intussusception or obstruction rather than cancers, but surveillance for the various cancers for which these patients are susceptible is an important part of their later management. This review assesses the current literature on the clinical features and management of the condition, genotype-phenotype studies, and suggested guidelines for surveillance and management of individuals with PJS. The proposed guidelines contained in this article have been produced as a consensus statement on behalf of a group of European experts who met in Mallorca in 2007 and who have produced guidelines on the clinical management of Lynch syndrome and familial adenomatous polyposis.

PMID: 20581245 [PubMed - indexed for MEDLINE]
Related citations


3 Cancer. 2010 Jun 15;116(12):2922-31.
.

Association of local capacity for endoscopy with individual use o f colorectal cancer screening and stage at diagnosis.

Haas JS, Brawarsky P, Iyer A, Fitzmaurice GM, Neville BA, Earle C, Kaplan CP.

Division of General Medicine and Primary Care, Department of Medicine, Brigham and Women's Hospital and Harvard Medical School, Boston, MA, USA. jhaas@partners.org

Abstract

BACKGROUND: Limited capacity for endoscopy in areas in which African Americans and Hispanics live may be a reason for persistent disparities in colorectal cancer (CRC) screening and stage at diagnosis. METHODS: The authors linked data from the National Health Interview Survey on the use of CRC screening and data from Surveillance, Epidemiology, and End Results-Medicare on CRC stage with measures of county capacity for colonoscopy and sigmoidoscopy (endoscopy) derived from Medicare claims. RESULTS: Hispanics lived in counties with less capacity for endoscopy than African Americans or whites (for National Health Interview Survey, an average of 1224, 1569, and 1628 procedures per 100,000 individuals aged > or = 50 years, respectively). Individual use of CRC screening increased modestly as county capacity increased. For example, as the number of endoscopies per 100,000 residents increased by 750, the odds of being screened increased by 4%. Disparities in screening were mitigated or diminished by adjustment for area endoscopy capacity, racial/ethnic composition, and socioeconomic status. Similarly, among individuals with CRC, those who lived in counties with less endoscopy capacity were marginally less likely to be diagnosed at an early stage. Adjustment for area characteristics diminished disparities in stage for Hispanics compared with whites but not African Americans. CONCLUSIONS: Increasing the use of CRC screening may require interventions to improve capacity for endoscopy in some areas. The characteristics of the area where an individual resides may in part mediate disparities in CRC screening use for both African Americans and Hispanics, and disparities in cancer stage for Hispanics.

PMCID: PMC2889919 [Available on 2011/6/1]
PMID: 20564398 [PubMed - indexed for MEDLINE]