Two Studies Characterize People with Dyspepsia

First Detailed Analysis of Racial Differences
A recent study found that a significant portion of Americans suffering from functional dyspepsia also have irritable bowel syndrome (IBS). Functional dyspepsia is a disorder characterized by upper abdominal pain, indigestion, and bloating or fullness but with no specific cause. New onset dyspepsia occurs in about 10 percent of the population each year. Dyspepsia accounts for between 40 and 70 percent of GI complaints in general medical practice and has a significant impact upon quality of life.

A second study addressed epidemiological and clinical characteristics of functional dyspepsia in African Americans and Caucasian Americans, finding important differences.

In a study of functional dyspepsia, Ashok K. Tuteja, M.D., of the Department of Gastroenterology at University of Utah (Salt Lake City), Nicholas J. Talley, M.D., of Mayo Clinic (Rochester, MN), and Sandra K. Joss, Ph.D., and David H. Hickam, M.D., of the VA Medical Center (Portland, OR) mailed surveys to 1,069 employees. Of the 723 respondents, 14.7 percent had symptoms of dyspepsia, 8.9 percent had IBS symptoms, and 6.2 percent reported both dyspepsia and IBS.

“Seventy percent of subjects with IBS had functional dyspepsia and 43 percent of subjects with dyspepsia had IBS,” said Dr. Tuteja. “The association between the two syndromes was much greater than expected by chance.”

The employees who reported symptoms of both disorders were much more likely to consult a physician about their problems. Tuteja and colleagues found that 33 percent of those with both dyspepsia and IBS symptoms went to the doctor in the previous year, whereas only 4 percent of patients with dyspepsia alone and 25 percent with IBS alone visited their doctor.

“Patients seeking clinical services for gastrointestinal symptoms are likely to have more than one clinical disorder,” said Dr. Tuteja.

In another study, researchers for the first time provided a detailed comparison of the clinical and epidemiological characteristics of African Americans and Caucasian Americans who have functional dyspepsia.

William C. Wigington, D.O., and colleagues at the University of Mississippi Medical Center provided 444

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subjects with a questionnaire about demographic and clinical characteristics, including quality of life. About 23.2 percent of the respondents were found to meet the diagnostic criteria for functional dyspepsia.

“There are statistically significant variations between races concerning many demographic, medical, and psychological indicators,” said Dr. Wiginston. “These differences could have significant implications on policy-making in regards to management and allocation of health care resources.”

University of Mississippi Medical Center investigators found that African Americans with functional dyspepsia are younger and more likely than Caucasian Americans to be married.

The researchers also found that a greater proportion of Caucasian Americans with functional dyspepsia reported having chronic fatigue syndrome, heart palpitations, or urinary problems. In addition, Caucasians were more likely to have had an appendectomy.

When psychological characteristics were analyzed, the researchers noted that a much higher proportion of African Americans with functional dyspepsia reported “having lost interest in things.” Also, African Americans were more likely to report regular attendance at church.

**Inovera Introducing Forvia™ Sampling Program As Well As New, Patient-Friendly, 180-Tablet Bottle**

Inovera Bioscience, Inc., makers of Forvia® Multivitamin/mineral Tablets, has introduced a mail sampling program to selected gastroenterologists who treat IBD and it is also introducing a new, 180-tablet, patient-friendly bottle.

“We are finding a high demand for Forvia samples among physicians who treat ulcerative colitis and Crohn’s disease and want to start their patients on a multivitamin/mineral product specially designed to meet the nutritional deficits seen in these diseases,” said Inovera President Timothy R. Russell.

Russell says physicians express interest in what is not included in Forvia as well as the nutritional benefits of Forvia’s specially formulated vitamins and minerals. “For example, Forvia Tablets are gluten-free, lactose-free, and sugar-free—all important considerations for the IBD patient,” Russell adds.

Forvia does not need a prescription and can be obtained directly from Inovera (www.forvia.com). [ ]
Esophageal Candidiasis With Inhaled Corticosteroid Use

Upper GI endoscopy was performed on 49 patients with inhaled fluticasone propionate to examine the prevalence of esophageal candidiasis. Thirty-six of the patients had bronchial asthma and 13 had chronic obstructive pulmonary disease. To compare the prevalence with control patients, upper GI endoscopy was performed on 700 consecutive patients without malignancy or immunosuppression. The prevalence of esophageal candidiasis was 37 percent among patients treated with the inhaled preparation, whereas only 0.3% of the controlled patients had the infection. The prevalence was especially high among patients with diabetes mellitus or those who were treated with a high dose of fluticasone propionate. Moreover, a reduction in daily dose of the drug eliminated the infection in 4 of 5 patients.

It was concluded that esophageal candidiasis (as well as oropharyngeal candidiasis), is a common complication of inhaled corticosteroid use. (Kanda N, Yasuba H, Taka-hashi T, et al. “Prevalence of Esophageal Candidiasis Among Patients Treated With Inhaled Fluticasone Propionate.” Amer J Gastroenterol, 2003; 98, 2146-2148.)

Reduced Volume Lavage Solutions For Colonoscopy Colon Cleansing

At two centers, 200 patients undergoing colonoscopy for routine indications were randomized to receive the reduced volume of lavage regimen with two liters of sulfate-free electrolyte lavage solution (SF-ELS NuLYTELY), plus 20 mg of bisacodyl or the standard liter method. Those randomized to receive the reduced volume method received four 5mg bisacodyl tablets by mouth at noon. Six hours later, they received 2 liters of SF-ELS given as 10 oz. every ten minutes. Subjects randomized to receive the full solution drank it at 6 P.M. in a similar fashion.

Colonoscopists unaware as to the randomized preparation received, rated the efficacy of cleansing, patient tolerance and various hematologic and biochemical parameters. Physician assessment showed no differences between the two regimens in producing cleansing. There was a profound reduction in preparation side effects. There were no clinically significant changes in hematology or blood chemistry associated with either preparation.

It was concluded that reduced volume preparation with 2 liters of SF-ELS and bisacodyl is safe and effective. Clinical symptoms from the reduced volume preparation are significantly reduced, compared with the traditional 4 liter lavage. (DiPalma JA, Woflf BG, Meagher A, Cleveland M. “Comparison of Reduced Volume Versus Four Liters Sulfate-Free Electrolyte Lavage Solutions for Colonoscopy Colon Cleansing.” Amer J Gastroenterol, 2003; 98, 2187-2191.)

Dietary Treatment of Ulcerative Colitis

Topical Butyrate has been shown to be effective in the treatment of ulcerative colitis. Butyrate is derived from colonic fermentation of dietary fiber. Twenty-two patients with quiescent ulcerative colitis in a controlled pilot trial lasting 3 months were followed. The patients were instructed to add 60 grams of oat bran, corresponding to 20 grams of dietary fiber to the daily diet, maintaining it mainly as bread slices. Fecal short chain fatty acids, including Butyrate, disease activity and gastrointestinal symptoms were recorded every 4 weeks. During the oat bran intervention, the fecal Butyrate concentration increased by 36 percent at 4 weeks. The mean Butyrate concentration over the entire test period was 14, remaining fecal short chain fatty acid levels were unchanged. No patient showed signs of colitis relapse. Unlike controls, the patient showed no increase in gastrointestinal complaints during the trial period. Patients reporting abdominal pain and reflux complaints at entry showed significant improvement at 12 weeks, but returned to baseline 3 months later.

It was concluded in this pilot study that patients with quiescent ulcerative colitis can safely take a diet rich in oat bran, specifically to increase the fecal Butyrate level. This may have clinical implications in maintenance therapy of ulcerative colitis. (Hallert T, Bjorck I, Nyman M, et al. “Increasing Fecal Butyrate in Ulcerative Colitis Patients By Diet: Controlled Pilot Study.” Inflammatory Bowel Dis, Vol 9, (2), 116-121.)

Autoimmune Pancreatitis and Pancreatic Carcinoma

Seventeen patients initially suspected to have pancreatic carcinoma were evaluated with clinical, serologic and radiologic findings, with a diagnosis of autoimmune pancreati-

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tis. The patients were predominantly elderly men who frequently presented with jaundice, but without features of acute pancreatitis. Elevation of serum gamma globulin and IgG, along with the presence of autoantibodies were usually evident, whereas serum tumor markers were elevated in 54 percent of the cases. Stenosis of the bile duct was detected in 94 percent of the cases. Diffuse enlargement of the pancreas and irregular narrowing of the main pancreatic duct were radiologically characteristic.

Segmental swelling and narrowing were detected in seven and two patients, respectively. In segmental cases, neither atrophy of the distal pancreas, nor marked upstream dilation of the pancreatic duct was observed. Angiographic abnormalities occurred in 54 percent of the cases. Serologic and radiologic abnormalities showed considerable improvement with steroid therapy.

It was concluded that stenosis of the bile duct, elevation of serum tumor markers, segmental pancreatic enlargement or narrowing of the main pancreatic duct and angiographic abnormalities can cause confusion in the differential diagnosis of autoimmune pancreatitis and pancreatic carcinoma. (Kamisawa T, Egawa N, Nakajima H, et al. “Clinical Difficulties in the Differentiation of Autoimmune Pancreatitis and Pancreatic Carcinoma.” Amer J Gastroenterol, 2003; 98, 2694-2699.)

**Treatment of Crohn's Ileal Anastomotic Disease With Infliximab**

Crohn’s disease that occurs in patients with ileal pouch anastomosis, results in severe morbidity. Medical records of 26 patients with same and Crohn’s disease related complications were reviewed. The median time between the surgery and the diagnosis of Crohn’s disease was 4-1/2 years. The main reasons for changing the original ulcerative colitis diagnosis to Crohn’s disease was complex perianal or pouch fistulizing disease in 14 patients (54 percent), prepouch ileitis in 5 (19 percent), and both prepouch ileitis and complex fistula in 7 (27 percent).

The patient has received 1 to 3 doses of Infliximab over 8 weeks as induction therapy and subsequently, received a variable number of maintenance infusions.

At short term follow-up, 16 of 26 patients had a complete response. Six of 26 had a partial response and 4 had no response. After a median follow-up of 21 months in 24 patients, 8 patients either had their pouches resected or had a persistent diverting ileostomy. The pouch was functional in 16 of 24 patients, with either good or acceptable clinical results in 14. Of those 14 patients, 11 were under long term on-demand or systematic maintenance therapy with Infliximab.

It was concluded that Infliximab is beneficial in both the short and long term treatment of patients with ileal pouch anastomosis performed for a presumed diagnosis of ulcerative colitis, who subsequently developed Crohn’s disease-related complications. Good pouch function requires long term treatment with Infliximab in most patients. (Colombel JF, Ricart E, Loftus E, Tremaine WJ, et al. “Management of Crohn’s Disease of the Ileal Pouch With Infliximab.” Amer J Gastroenterol, 2003; 98, 2239-2244.)

**Sertraline in Cholestatic Pruritus With PBC**

Pruritus was followed prospectively in 40 patients with PBC for a mean of 7.5 years. The data was then retrospectively examined to determine the effect of Sertraline on pruritus in all subjects who had received Sertraline some time during the study. In 28 of 32 patients with pruritus, itching was stable or fluctuated slightly over the follow-up period. No patient experienced rapid progression of pruritus. Four patients experienced a sustained resolution of their pruritus. Ten subjects started Sertraline and continued it long enough (greater than 6 months), to determine its lasting effect on pruritus. Three of these individuals did not have significant pruritus before or after Sertraline. Of the 7 patients with pruritus, 6 reported a significant reduction or resolution of the pruritus in their weekly diaries and also decreased or completely stopped other medications for pruritus.

It was concluded that Sertraline use is associated with an improvement in cholestatic pruritus. It was inferred that this novel observation implied that serotonergic fibers are important in regulating the perception of itch. (Browning J, Coombs B, Mayo MJ. “Long-Term Efficacy of Sertraline as a Treatment For Cholestatic Pruritus in Patients With Primary Biliary Cirrhosis.” Amer J Gastroenterol, 2003; 55, 2736-2741.)

Murray H. Cohen, D.O., editor of “From the Literature” is a member of the Editorial Board of Practical Gastroenterology.
**BOOK REVIEW**

**Inflammatory Bowel Disease Diagnosis and Therapeutics**
ISBN: 0-89603 -909-9; $99.50

This is the second book in the “Clinical Gastroenterology” series edited by George Y Wu. It brings together expertise from different fields—medicine, pediatrics, surgery, pathology, radiology and nursing to provide a holistic approach to the disease. An attempt has been made to address the entire spectrum of IBD—the book includes noteworthy chapters on ostomy care, nutritional support, gender specific issues and economics as related to IBD. This is a quick read, which is both comprehensive and concise. It is also amply illustrated, with numerous radiographs, pathological slides, and diagrams. New insights into the pathogenesis of IBD are discussed, as are newer directions in therapy. Despite doing all of this, the authors have managed to limit this to an attractive “handbook” size, easily lifted in the palm of one hand. An extensive list of references is provided at the end of each chapter, which may aid those who seek more specific information than is provided.

The preface by Dr. Cohen lays out many ambitious goals for this book—it satisfies all of them but one. He says, “The intent of many of the chapters is to provide resources on how to get more information on a particular topic, with web page addresses, phone numbers, and addresses of various sources.” While this was certainly done in the chapter on ostomy care, similar easy to find information for “lay readers” on other issues such as support groups or national organizations would have been a valuable addition to many of the other chapters.

Who should read this book? Patients, their friends and families, medical students, ancillary personnel, house staff, GI fellows and practitioners with a focus outside inflammatory bowel disease.

**Practical Nutrition Support Techniques**
Alan Buchman, MD, MSPH
Slack, Inc, 2003
ISBN: 1-55642-628-3; $37.95

“Practical Nutrition Support Techniques” is a very well written and easily understood manual of providing nutrition support. It is focused on allowing a clinician with limited knowledge in nutrition and nutrition support to understand the basic concepts and intricacies of assessing and providing nutritional therapy. This manual leads the audience through the basics of nutrition assessment and nutrition requirements and allows the reader to use these skills in the provision of nutritional therapy found in subsequent chapters on enteral nutrition, parenteral nutrition, and disease-specific nutritional support. It even has a chapter focusing on measuring the efficacy of nutrition therapy, often a difficult topic to understand.

The chapters on nutrition assessment and parenteral nutrition are especially well written. The diagrams and tables are an important addition to these chapters. More importantly, there is an abundant appendix that puts forth a great deal of information ranging from clinical signs of nutritional deficiency to the content of specialized infant enteral formulas. For the skilled physician in nutrition support, this appendix provides a ready reference for commonly used clinical tools.

I highly recommend this book to gastroenterologists. It provides a very readable reference for understanding nutritional therapy, an area of learning that is often lacking at many training programs.

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