Bleeding Peptic Ulcer—Celecoxib Vs. Diclofenac and Omeprazole

Two hundred and eighty-seven patients were studied in the intention-to-treat analysis. 144 received Celecoxib and 143 received Diclofenac plus omeprazole. All patients had used NSAIDs for arthritis and presented with ulcer bleeding, and after their ulcers had healed, the study was carried out. Recurrent ulcer bleeding occurred in 7 patients receiving Celecoxib and 9 receiving Diclofenac plus omeprazole.

The probability of recurrent bleeding during the six month period was 4.9 percent for Celecoxib and 6.4 percent for the combination. Renal adverse effects, including hypertension, peripheral edema and renal failure occurred in 24.3 percent of the patients receiving Celecoxib and 30.8 percent of the patients receiving Diclofenac plus omeprazole.

It was concluded that in patients with a recent history of ulcer bleeding treatment with Celecoxib was as effective in the prevention of recurrent bleeding as Diclofenac plus omeprazole, and that renal toxic effects are common in high risk patients receiving both. Ed. Note; A significant incidence of recurrent bleeding is noted with both regimens in patients treated for arthritis. (Chan FK, Hong LCT, Swen BY, at al. “Celecoxib Vs. Diclofenac and Omeprazole in Reducing the Risk of Recurrent Ulcer Bleeding in Patients With Arthritis.” N Eng J Med, 2002; Vol. 347, pp. 2104-2110.)

Appendicitis and Imaging

On the basis of clinical findings, 350 consecutive patients with clinical suspicion of acute appendicitis were prospectively divided into three groups as follows: Low, intermediate and high probability of having appendicitis. All patients then underwent diagnostic ultrasonography. The clinical likelihood of appendicitis and the ultrasonographic results were correlated with definite diagnoses.

In the patient with clinically low probability of having appendicitis, appendicitis was present in 10 percent (11 of 109 patients), and in those with intermediate probability, appendicitis was present in only four percent (23 of 97 patients). Patients with a clinically high probability of having appendicitis had appendicitis in 65 percent (94 of 144 patients), and alternative diagnosis in 18 percent and no specific definitive diagnosis in 17 percent. Ultrasonography diagnosed appendicitis in the differential diagnosis with a sensitivity of 98 percent and 97 percent, specificity in 98 percent and 100 percent, positive predictive value of 96 percent and 99 percent, negative predictive values of 99 percent and 99 percent and accuracy of 98 and 99 percent, respectively.

It was concluded that even in patients with clinically high probability of acute appendicitis, diagnostic imaging should be performed because it accurately depicts a high percentage of normal appendices and differential diagnoses. (Rettenbacher T, Hollerweger A, Gritzmann N, et al. “Appendicitis: Should Diagnostic Imaging be Performed if the Clinical Presentation is Highly Suggestive of a Disease?” Gastroenterology, 2002; Vol. 123, pp. 992-998.)

Celiac Disease in Auto-Immune Cholestasis

Two hundred and fifty-five patients with primary biliary cirrhosis, auto-immune cholangitis and primary sclerosing cholangitis were evaluated by serologic screening for celiac disease (CD) to define the prevalence of an association between CD and the other disorders and to evaluate the impact of gluten withdrawal on liver disease, associated with gluten-sensitive enteropathy.

Immunoglobulin A endomysial and human tissue transglutaminase antibodies were positive in nine patients (7 with PBC, one with autoimmune cholangitis and one with primary sclerosing cholangitis) with duodenal biopsy results showing villous atrophy consistent with CD.

Two of the patients had a malabsorption syndrome and one had iron deficiency anemia. Clinical and biochemical signs of cholestasis did not improve after gluten withdrawal in three patients with severe liver disease.

Findings of CD in 3.5 percent in autoimmune cholestasis suggests that serologic studies for CD should be routinely performed in those patients by immunoglobulin A, endomysial or transglutaminase antibodies. (Volta AU, Rodrigo L, Grinito A, et al. “Celiac Disease in Auto-Immune Cholestatic Liver Disorders.” Amer J Gastroenterology, 2002; Vol. 97, pp. 2609-2613.)

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