**Advanced Digestive Endoscopy:**
*Comprehensive Atlas of High Resolution Endoscopy and Narrowband Imaging*
Cohen J, Editor, 318 pp.
Blackwell Publishing, 2007
(www.blackwellgastroenterology.com)
ISBN 978-1-4051-58886-2; $194.95

*Advanced Digestive Endoscopy* is a comprehensive textbook authored by fifty-two world renowned experts in this field. It serves as an excellent visual reference guide to endoscopists interested in learning high resolution endoscopy and narrow band imaging.

The book is nicely organized into three sections: Part I: The basics of NBI; Part II: Potential applications of NBI and early supportive data (Section I: Pharynx and esophagus; Section II: Stomach and duodenum; Section III: Colon); Part III: Atlas of Images and histopathologic correlates. And there is a companion DVD with video clips, searchable database of images from the book, and complete text with a full text search.

The thing I liked best about the book is quality of pictures—excellent pictures. Over 80% of the book is filled with beautiful pictures that will help anyone interested in learning about high resolution imaging and narrow band imaging. Dr. Cohen and his colleagues should be congratulated for putting together an excellent reference guide. In addition, I found initial chapters very useful in understanding the technology. The accompanying DVD contains the entire book, images and videos. The audio accompanying the majority of the videos is very useful to the viewer.

As endoscopic technology is progressing to higher resolution imaging, it is critical for gastroenterologists to recognize patterns of disease seen with these new endoscopes. This need can be met by reading this excellent book—a treat to the eyes. Having this book (with the DVD) for a quick reference in every endoscopy laboratory with high resolution endoscopes (or planning to procure them) will be extremely valuable.

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**Clinical Nutrition in Gastrointestinal Disease**
Buchman A, Editor
SLACK, Incorporated, 2006
ISBN: 1-55642-697-6; $134.95

Most Gastroenterology training programs devote minimal time to nutrition course work, yet nutritional therapy is relevant to every facet of digestive disease. This comprehensive text, the effort of seventy experts in nutrition, is very appropriate for the trainee, as well as for all health care professionals seeking an update in clinical nutrition. The text includes chapters on nutritional assessment, general nutrition, and chapters devoted to specific disease processes including celiac disease, cystic fibrosis, inflammatory bowel disease, diabetes, hyperlipidemia, acute and chronic pancreatitis, chronic liver disease, and alcoholism. Special nutritional needs in critically ill and perioperative patients are also discussed, including detailed information on total parenteral nutrition, and enteral feeding.

I am impressed with the methodical approach of each chapter, beginning with a brief review of current knowledge of pathophysiology, followed by specific recommendations for correcting nutritional deficiencies common to the disease. Each chapter contains well organized tables that summarize key points, making this text a valuable resource for the busy clinician. Excellent chapters on the management of obesity, childhood obesity, and nutritional needs following bariatric surgery provide up-to-date information useful to all gastroenterologists given the emerging epidemic of obesity. I found the chapters on probiotics, and herbal nutritional supplements to be balanced and informative. I highly recommend this textbook for both trainees, and physicians in practice.

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George W. Meyer, M.D., Book Editor, is on the Editorial Board of Practical Gastroenterology.
IBD and Ursodeoxycholic Acid Impact on Small-Duct PSC

A longitudinal cohort study was performed to characterize the clinical features of patients with small-duct primary sclerosing cholangitis (PSC), occurring with and without IBD and to determine the influence of IBD and to determine the effects of UDCA therapy on the course of liver disease.

Forty-two patients were followed for up to 24.9 years. At presentation, prevalence of the signs of liver disease (none versus 35%), gastroesophageal reflux disease (5 versus 30%) and stage III/IV disease (9 versus 45%) were lower in those with IBD versus those without IBD.

During follow-up, six patients underwent liver transplantation and another died of cirrhosis. Using the Cox Proportional Hazard Analysis, concomitant IBD was not associated with liver death or transplant, whereas the revised Mayo Risk Score for PSC was the only prognostic factor associated with liver-related outcomes (relative risk 6.47, 1.75–137.5). UDCA 13 to 15 mg/kg/day therapy for an average of 40 months showed biochemical improvement on those treated patients, while no significant change occurred in untreated patients. UDCA therapy had no effect on delaying progression of disease (relative risk 0.95).

It was concluded that small bowel PSC often is recognized at an early age in patients with IBD; however, IBD has no impact on long-term prognosis. Although UDCA therapy improves liver biochemistries, it may not delay disease progression during the short period of treatment. (Charatcharoenwitthay AP, Angulo P, Enders F, Lindor K. “Impact of Inflammatory Bowel Disease and Ursodeoxycholic Acid Therapy on Small-Duct Primary Sclerosing Cholangitis.” Hepatology, 2008; Vol. 47, pp. 133-142.)

Platelet Count as a Predictor of Gastroesophageal Varices in Cirrhosis

Current guidelines recommend EGD in patients with cirrhosis to screen for gastroesophageal varices (GEV). Thrombocytopenia has been proposed as a noninvasive test to predict the presence of GEV. There has been no agreement regarding a specific platelet count (PLC) that can reliably predict the presence of GEV.

In order to study this circumstance, a longitudinal study was carried out, (1) to further investigate the relationship between varices and PLC at the time of endoscopy, (2) investigate whether change in the PLC from the baseline over time can predict the development of GEV, and (3) investigate whether change in the PLC correlate with hepatic venous pressure gradient (HVPG).

A secondary analysis was conducted for 213 subjects with compensated cirrhosis and portal hypertension, but without GEV, enrolled in a randomized, placebo-controlled, double blind trial of a nonselective beta-blocker used to prevent GEV. PLTs were obtained every 3 months and HVPG measurements and EGD were done annually. The PLTs were compared between subjects who did and did not develop GEV.

In a median follow-up of 54.9 months, 84 patients developed GEV. PLT was greater than 150,000 in 15% of patients after development of GEV. A receiver-operating curve did not show any PLT with high sensitivity or specificity for the presence of GEV. Subjects with clinically insignificant portal hypertension (HVPG less than 10 mmHg), whose PLT remained greater than 100,000 had a two-fold reduction in the occurrence of GEV. A significant correlation was found between HVPG and PLT at the baseline, year one and year five.

It was concluded that cross-sectional or longitudinal evaluation of PLTs are inadequate noninvasive markers for GEV. Patients with mild portal hypertension whose PLT remains greater than 100,000 have significantly less risk of GEV. Although HVPG correlates somewhat with PLT, changes in PLT cannot be used as a surrogate for HVPG changes. (Qumar A, Grace N, Groszmann R, et al for the Portal Hypertension Collaborative Group. “Platelet Count is Not a Predictor of the Presence or Development of Gastroesophageal Varices in Cirrhosis.” Hepatology, 2008; Vol. 47, pp. 153-159.)

Hepatic Nodules 2 cm or Smaller in Cirrhosis: Validation of Noninvasive Diagnostic Criteria for HCC

In order to prospectively evaluate the accuracy of contrast-enhanced ultrasound (CEUS) and dynamic MRI for the diagnosis of nodules 20 mm or smaller detected during ultrasound (US) surveillance, 89 patients with (continued on page 52)
cirrhosis, without prior hepatocellular carcinoma (HCC) in whom US detected a small solitary nodule were studied. Hepatic MRI, CEUS, and fine-needle biopsy (FNB) were performed at baseline. Non-HCC cases were followed for a median of 23 months by CEUS/3 months, MRI/6 months. FNB was repeated up to three times and on detection of change in aspect/size.

Intense arterial contrast uptake followed by washout in the delayed venous phase was registered as conclusive for HCC. Final diagnoses were HCC (N = 60), cholangiocarcinoma (N = 1), and benign lesions - regenerative dysplastic nodule, hemangioma, focal nodular hyperplasia (N = 28). Sex, cirrhosis cause, liver function and AFP levels were similar between HCC and non-HCC groups. HCC patients were older and their nodules significantly larger. First biopsy was positive in 42 of 60 HCC patients. Sensitivity, specificity and positive and negative predictive values of conclusive profile were 61.7%, 96.6%, 97.4% and 54.9% for MRI, 51.7%, 93.1%, 93.9% and 50.9% for CEUS. Values for coincidental, conclusive findings in both techniques were 33.3%, 100%, 100% and 42%.

The diagnosis of HCC 20mm or smaller as concluded can be established without a positive biopsy if both CEUS and MRI are conclusive. However, sensitivity of these noninvasive criteria is 33%, and as occurred with biopsy, absence of a conclusive pattern does not rule out malignancy. These results were interpreted to validate the AASLD Guidelines. (Forner A, Vilana R, Ayuso C, et al. “Diagnosis of Hepatic Nodules 20mm or Smaller in Cirrhosis: Prospective Validation of the Non-invasive Diagnostic Criteria for Hepatocellular Carcinoma.” Hepatology, 2008; Vol. 47, pp. 97-104.)

**Efficacy of Radiofrequency Ablation of Early Hepatocellular Carcinoma in Cirrhosis**

If liver transplantation is not feasible, partial resection has been considered the treatment of choice for HCC in patients with cirrhosis. To evaluate the approach of using first line treatment for small single, operable HCC with radiofrequency ablation (RFA), 218 patients with single HCC 2 cm or less (very early or T1 stage), underwent RFA. Two primary end points were assessed that could be easily compared with those reported for resective surgery: (1) The rate of sustained, local, complete response and (2) The rate of treatment-related complications.

The secondary end point was five-year survival in the 100 patients whose tumors had been considered potentially operable. After a median follow-up of 31 months, sustained complete response was observed in 216 patients (97.2%). In the remaining six, percutaneous ethanol injection, selective intra-arterial chemoembolization, or resection were used as salvage therapy.

Perioperative mortality, major complication and five-year survival rate were zero percent, 1.8% and 68.5%, respectively.

It was concluded that compared with resection, RFA is less invasive and associated with lower complication rate and lower cost, and was just as effective for ensuring local control of stage T1 HCC and is associated with similar survival rates as demonstrated by two randomized trials.

It was interpreted that RFA can be considered the treatment of choice for patients with single HCC 2 cm or less in size, even when surgical resection is possible. Other approaches can be used as salvage therapy for the few cases in which RFA is unsuccessful or unfeasible. (Livraghi T, Meloni F, DiStasi M, Rolle E, et al. “Sustained Complete Response and Complications Rates After Radiofrequency Ablation of Very Early Hepatocellular Carcinoma in Cirrhosis: Is Resection Still the Treatment of Choice?” Hepatology, 2008, Vol. 47, pp. 82-89.)

**Individualized Treatment for HCV Genotype 1 Patients**

To evaluate the hypothesis that in HCV genotype patients, variable treatment duration individualized by first undetectable HCV RNA is as effective as standard 48 week treatment, 696 patients received PEG Interferon Alfa-2A, 180 mg/week or PEG Interferon Alfa-2B 1.5 mg/kg/week, plus Ribavirin 1000 to 1200 mg/day for 48 weeks (N = 237) as standard, or for 24, 48 or 72 weeks if HCV RNA negative at weeks 4, 8 or 12, respectively (variable N = 459).

SVR was achieved in 45.1% of the patients of the standard group and 48.8% of the patients in the variable group. The percentages of patients who first
achieved undetectable HCV RNA at weeks 4, 8 or 12 were 26.7%, 27.8% and 11.3%, respectively. In the standard treatment group, 87.1%, 70.3% and 38.1% of patients who first achieved undetectable HCV RNA at 4, 8 or 12 weeks attained SVRs, respectively. In the variable group, corresponding SVR rates were 77%, 71.9%, and 63.5%.

Low viremia levels and young age were independent predictors of response at week 4 for rapid virological response (RVR). RVR patients with baseline viremia 400,000 i.u./ml or less achieved higher SVR rates when treated for 48 weeks, rather than 24 weeks (86.8% vs. 73.1%). The only predictive factor of SVR in RVR patients was advanced fibrosis.

It was concluded that variable treatment duration ensures SVR rates similar to those of standard treatment duration, sparing unnecessary side effects and costs. (Mangia A, Minerva N, Bacca D, et al. “Individualized Treatment Duration for Hepatitis C, Genotype I Patients: A Randomized Control Trial.” Hepatology, 2008; Vol. 47, pp. 43-50.)

Fourteen Week vs. Twenty-Four Week Treatment for HCV Genotype II or III

To assess the concept that HCV patients with genotype 2/3 and rapid virological response (RVR) may have a 90% SVR rate after 14 weeks of treatment, 428 treatment-naïve HCV RNA-positive patients with genotype 2 or 3 were enrolled. Patients with RVR were randomized to 14 (Group A) or 24 (Group B) weeks of treatment. The patients were treated with PEG-Interferon Alfa-2B (1.5 mcg/kg) subcutaneously weekly, and Ribavirin (800mg to 1400 mg orally daily).

The noninferiority margin was 7 to 10% between the two groups with a one-sided 2.5% significance level. RVR was obtained in 302 of 428 (71%), and 290 of these were randomized to Group A (N = 148), or Group B (N = 150).

In the intention to treat analysis, SVR rates were 120 of 148 (81.1% in Group A) and 136 of 150 (90.7% in Group B) with a difference of 9.6%. Among patients with an HCV RNA test 24 weeks after the end of treatment, 120 of 139 (86.3%) in Group A achieved SVR, compared with 136 of 146 (93.2% in Group B), difference 6.9%.

It was concluded that 14 weeks of treatment cannot be formally claimed as noninferior to 24 weeks of treatment. However, the SVR rate after 14 weeks of treatment is high, although longer treatment may give slightly better SVR, it was interpreted that economical savings and fewer side effects make it rational to treat patients with genotype 2 or 3 and RVR for only 14 weeks. (Delgard O, Bjoro K, Ring-Larsen H, et al and the North-Sea Group. “Pegylated Interferon Alfa and Ribavirin For 14 Vs. 24 Weeks in Patients With Hepatitis C Virus Genotype 2 or 3 and Rapid Virological Response.” Hepatology, 2008; Vol. 47, pp. 34-43.)

Terminal Ileum Biopsies—Diagnostic Value

Four hundred fourteen consecutive patients with terminal ileal biopsies were retrospectively reviewed. Histologic parameters evaluated were primarily those changes diagnostic of chronic inflammation or its sequelae. Histologic findings were then compared with the indications and endoscopic findings.

The terminal ileum was histologically normal in 82 percent and endoscopically normal in 81 percent, with most endoscopic abnormalities having “ileitis” (13 percent). Known or strongly suspected inflammatory bowel disease was the most common indication (38 percent), with Crohn’s disease accounting for 20 percent and ulcerative colitis 16 percent, followed by diarrhea (33 percent) and anemia/hematochezia (15 percent), abdominal pain (6 percent) and abnormal imaging (5 percent).

Diagnostic yields vary with indication and endoscopic findings being highest with known suspected Crohn’s disease (40 percent), abnormal imaging (32 percent), and with endoscopic “ileitis” (84 percent) or ulcers/erosions (69 percent).

The diagnostic yield of terminal ileum biopsy varied with the indication and endoscopic findings. This study indicated that biopsy is of greatest value in patients undergoing endoscopy for known or strongly suspected Crohn’s disease, or with an abnormal imaging study of the terminal ileum. Biopsy of endoscopically normal mucosa is unlikely to yield diagnostically useful information, and is not encouraged as routine. However, when “ileitis,” ulcers or erosions are identified, biopsies can be very helpful. (McHugh JB, (continued on page 56)
MRI and Acute Pancreatitis

CT scan, especially contrast-enhanced (CECT), provides important information on the severity and prognosis of acute pancreatitis (AP). Magnetic resonance imaging (MRI) has become a useful tool as an alternative to CT in the assessment of AP. In order to determine the diagnostic value of nonenhanced MRI (NEMRI) to assess the severity and predict outcome in patients with AP from the third to the fifth day after admission, findings were correlated with CT and biochemical parameters.

One hundred one patients with a diagnosis of AP between 1/1/04 and 6/30/05 were included with criteria consisting of a combination of clinical features, a typical case history, elevation of serum pancreatic enzymes, and diagnosis confirmed by imaging studies. CECT was performed in all patients from the third to fifth day after admission, and Balthazar grade and CT severity index were calculated.

All patients underwent NEMRI and MR severity index (MRSI) was calculated. MRCP was performed in all patients to detect bile duct lithiasis.

Significant correlation between CECT and NEMRI was found for the Balthazar grade and the assessment of pancreatic necrosis, as well as between the combined severity indices. MRSI correlated with Ranson score, C-reactive protein, appearance of systemic complications and length of hospital stay. Considering the Atlanta criteria as a gold standard and the Ranson score, no difference in sensitivity, specificity, positive predictive value, negative predicted value and accuracy of the two measures were observed. Comparing the group of patients with presumed acute pancreatic hemorrhage, with a group of patients with severe AP, we found a significantly higher Apache II score on the first day, that the development of systemic complications was more frequent, and that the hospital stay, and ICU management of patients with MRI signs of pancreatic hemorrhage tended to be longer.

It was concluded that NEMRI is comparable to CECT in the early assessment of the severity of AP, and both methods are equally efficient in predicting local and systemic complications of AP. MRI has a potential advantage over CT in detecting bile duct lithiasis and pancreatic hemorrhage. (Stimac D, Miletic D, Radic M, et al. “The Role of Nonenhanced Magnetic Resonance Imaging in the Early Assessment of Acute Pancreatitis.” Am J Gastroenterol, 2007; Vol. 102: 997-1004.)

Double-Balloon Enteroscopy in Refractory Sprue

In patients with refractory celiac disease in developed enteropathy-associated T-cell lymphoma (EATL), or ulcerative jejunitis, double-balloon enteroscopy allows examination of the small bowel to prospectively assess the value of this technique in patients with refractory celiac disease. Small bowel enteroscopy was performed in twenty-one consecutive patients for lesion like ulcerations (high-risk). Biopsy specimens were taken for such lesions and from examined small bowel at three different levels of scope insertion depth.

Tissue specimens were evaluated for the modified Marsh classification and for the presence of EATL. Twenty-four procedures were successfully performed without complications. EATL was found in five patients (24 percent), as circumferential, discrete or fluent ulcerations. In three of them, Marsh III was found, while in the other two patients with EATL, Marsh I was found. Another two patients (9 percent), had ulcerative jejunitis in the absence of EATL. The histology was compatible with Marsh III.

In the remaining 14 patients (54 percent), no high-risk lesions were found. Double-balloon enteroscopy could exclude the presence of EATL in four patients, as was suggested by abdominal computerized tomography.

It was concluded that complications of refractory celiac disease like ulcerative jejunitis or EATL could efficiently be detected or excluded by double-balloon enteroscopy. This technique should be reserved for patients with refractory celiac disease or patients with a past history of EATL. (Hadichi M, Al-Toma A, Oudejan SJ, et al. “The Value of Double-Balloon Enteroscopy in Patients with Refractory Celiac Disease.” Am J Gastroenterol, 2007; Vol. 102: 987-996.)
World’s Largest Diet-Cancer Study Confirms Current Advice on Alcohol

Experts at the American Institute for Cancer Research (AICR) welcomed the latest results from the world’s largest study on diet and cancer. The new results, published online at the *International Journal of Cancer*, link excessive alcohol consumption to an increased risk of colon cancer.

According to the study, those participants who reported consuming three or more alcoholic drinks per day had a 26 percent higher lifetime risk of colon cancers than non-drinkers.

These results support AICR’s long-standing advice to limit alcohol consumption. The AICR guideline on alcohol reads: If alcohol is consumed at all, men should consume no more than two drinks per day and women no more than one.

To those members of the public concerned about how these results relate to studies showing that moderate consumption of alcohol benefits heart health, AICR offered some perspective.

“The key word is moderate,” said Karen Collins, MS, RD. “The heart benefits that have been associated with alcohol occur at relatively low levels of consumption—the levels specified in the AICR guidelines.

“When it comes to alcohol and overall health we know one thing for sure—more is not better,” Collins said.

The EPIC Study

The new results come from the largest study of diet and cancer ever undertaken. Called the European Prospective Investigation into Cancer and Nutrition, or EPIC, this ongoing cohort study is currently tracking the diets and disease rates of an unprecedented 521,483 individuals in 10 different European countries.

Behind the Alcohol—Cancer Link

Alcohol has been linked to cancers of the colon and rectum for years, as well as several other cancers including those of the mouth and throat. Smokers who drink increase their risk of lung cancer significantly. Years of drinking can give rise to liver damage that leads to liver cancer. Alcohol has also been designated a probable cause for breast cancer.

The reason for these links, experts say, has to do with the behavior of alcohol in the body. Alcohol is a pro-inflammatory, pro-oxidant substance. Sensitive tissues that are repeatedly exposed to it can get damaged in ways that spark the cancer process.

The breast cancer link seems to be a special case, however. Unlike other cancers associated with alcohol consumption, the cells of the breast are only indirectly exposed to alcohol. Yet the association keeps showing up, in study after study.

“The breast cancer link is particularly troubling and consistent, but its precise nature remains unclear,” said Collins. “We do know that a man’s body has more muscle and less fat than a woman’s, so it’s easier for him to dilute and metabolize the alcohol he drinks. Alcohol stays in a woman’s bloodstream longer, and that may be one reason that women who consume even one drink a day have a slightly higher risk of breast cancer compared to non-drinkers.”

Survey Shows Gender Differences are a Factor When Surgeons in Training Choose a Subspecialty

Many factors may influence whether a general surgery resident pursues a subspecialty as a career choice, but women think about lifestyle more than men.

A gender difference exists among surgeons who choose a surgical subspecialty, particularly when they evaluate the factors that may influence their career choice, according to results of a new survey published in the November issue of the *Journal of the American College of Surgeons*. The survey revealed that a significantly higher percentage of women than men were influenced by their perception of the lifestyle associated with their career choice. These findings suggest that general surgical residency programs might improve efforts to recruit women for subspecialty training by addressing the perception of the lifestyle associated with choosing a subspecialty surgical career.

“Typically, surgery has been viewed as having an uncontrollable lifestyle with higher work hour demands. However, it is becoming evident through similar types of surveys that both men and women are placing a higher priority on personal and family time.
and seeking ways to shape their careers to accommodate these desires,” said Jaime H. McCord, MD, general surgery resident at the University of Wisconsin, Madison.

Over the past 20 years, the number of women has increased across many medical fields, including general surgery. Yet despite these advances, of the approximately 26,300 practicing general surgeons in the US, only 12 percent are women.

“The field of surgery and the majority of surgical residencies have been implementing changes to improve the “lifestyles” of surgeons. That’s why it is important for surgeons, both male and female, to model a balanced lifestyle to medical students and promote it in surgical residents if we are to continue to recruit high caliber women, as well as men, into surgery, and especially subspecialty fields,” McCord added.

The University of Wisconsin general surgery residency program developed and distributed via email a 32-item Web based survey to 99 graduates (74 respondents) between the years 1985 and 2006. The survey contained matrix questions, contingency questions, scaled responses and open questions designed to evaluate the factors that most influenced a resident’s decision to pursue fellowship or subspecialty training. Of the 74 respondents, 58 were men and 16 were women.

The mean age of the respondents was 40 years (range 31 to 52 years), and 95 percent were married or partnered, with an average of 1.9 children.

There was a significant difference between genders in those practicing general surgery versus subspecialties, with 69 percent of women and 36 percent of men responding that general surgery was their current field (p = 0.02) and the rest currently practicing in a specialized area of surgery.

More than 70 percent of respondents indicated that the following factors were either important or very important when choosing future subspecialty training: interest in the field, intellectual appeal of field, an influential mentor, and clinical opportunities in that field. Among all possible factors queried, only lifestyle was significantly more important to women versus men graduates when choosing their future career (69 percent [11 of 16] versus 43 percent [25 of 58], respectively; p = 0.03).

Other results for women and men respondents focused on research exposure during residency (basic science, 38 percent versus 40 percent; clinical, 56 percent versus 61 percent, respectively; p > 0.05); fellowship training (38 percent versus 69 percent, respectively; p = 0.04); and academic practice setting (27 percent versus 46 percent, respectively; p = 0.2).

For the majority of factors there was no significant difference in the response rates for men and women.

bioLytical Laboratories: INSTI™ HIV-1 Rapid Antibody Test to be Used in Research Study Conducted by McGill University AIDS Centre and Funded by CIHR

bioLytical Laboratories is pleased to announce the use of its 60-second rapid HIV test, INSTI™, in a research study entitled “Pro-active intervention to limit HIV transmission among MSM populations.” The study is being conducted by the McGill University AIDS Centre, directed by Dr. Mark Wainberg and funded by the Canadian Institute of Health Research (CIHR).

bioLytical Laboratories will provide 5,000 INSTI™ kits to conduct the testing for this study. The study proposes to test individuals who are in vulnerable situations with significant risk of HIV infection. The public health benefits of this type of point-of-care (POC) HIV test delivery can be substantial, based on the potential to identify individuals who are unaware they are HIV infected and the opportunity to deliver effective prevention measures. The study will include visits to commercial bathhouses and other party venues in Montreal, at which transmission of HIV is often likely to occur.

“We hope that the use of this rapid test will enable us to identify newly infected people more quickly and will ultimately lead to the modification of high risk behaviour and therefore reduce the transmission rate of HIV,” commented, Dr. Mark Wainberg, Director of Research, Jewish General Hospital and Professor/Director, McGill University AIDS Centre. “Enormous progress has been made in HIV treatment. The use of INSTI is the best method to now make advances in HIV prevention.”

The announcement was made earlier today onsite at bioLytical’s mobile testing trailer on the Boulevard St. Laurent. The INSTI-trailer is part of bioLytical’s
Test Your Commitment (TYC) public awareness and mobile testing campaign that provides the public with access to live demonstrations of INSTI™. TYC offers an open forum to discuss issues regarding HIV and AIDS and provides the public with access to new testing information.

The campaign is presented by bioLytical Laboratories with the support of Virgin Mobile Canada and the endorsement of UNICEF Canada. Together, bioLytical, Virgin Mobile Canada and UNICEF Canada have a shared goal of bringing needed attention to the growing HIV and AIDS crisis at home and abroad.

Ontario was the first provincial government in Canada to launch an HIV testing program and more than 50 of their Anonymous Testing sites now carry INSTI™. In September, Manitoba also increased accessibility to HIV testing for its residents.

“Simple, unobstructed access to rapid HIV testing is a critical first step in reducing the spread of HIV,” commented Matthew Clayton, Executive Vice President, bioLytical. “TYC is the first of its kind in Canada, offering the public at large the opportunity to see first hand just how quick and easy it is to be tested for HIV. It is our hope this campaign will continue to raise public awareness encouraging other provinces to recognize the importance of expanding their HIV testing programs making it more accessible to everyone.”

bioLytical, Virgin Mobile and UNICEF in association with Test Your Commitment held two education days in Toronto, Ontario at Dundas Square, December 6 and 7.

About INSTI(TM) HIV-1 Rapid Antibody Test
The INSTI(TM) HIV-1 Rapid Antibody Test is a rapid, in-vitro, qualitative test for the detection of antibodies to Human Immunodeficiency Virus Type 1 in human whole blood, serum or plasma. The test is capable of providing results in 60-seconds and is intended for use as a screening assay by trained personnel in medical facilities, clinical laboratories, emergency care situations, and physicians’ offices.

Study Data Show Asacol® (Mesalamine) is Effective in Treating All Extents of Ulcerative Colitis Including Isolated Proctitis
Findings Reinforce the Benefits of Asacol for Ulcerative Colitis Patients
Data from two Phase III clinical trials support that Asacol, an oral, non-steroidal medication that belongs to the class of agents known as 5-aminosalicylic acids (5-ASAs), is an effective and well-tolerated treatment for patients with all extents of ulcerative colitis (UC), including isolated proctitis. The results showed that patients with isolated proctitis who took Asacol, dosed at 2.4 g/day for six weeks, experienced significant improvement as early as three weeks, and sustained improvement at six weeks, of UC symptoms. At six weeks 83 percent of patients had improvement in rectal bleeding, 75 percent had mucosal healing and 57 percent had reduced stool frequency. These data were presented at the Crohn’s & Colitis Foundation of America’s (CCFA) National Research and Clinical Conference/Sixth Annual Advances in the Inflammatory Bowel Diseases (IBD) Meeting.

Treatment of UC patients is impacted by the fact that most patients would choose oral therapy over other routes of delivery, such as rectal therapy(1). However, approximately 30 percent of UC patients have isolated proctitis (2), a condition that is thought to be a challenge to treat with oral medication alone.

“A common misperception among physicians is that all oral 5-ASA studies have included proctitis patients; however, this is not the case,” says Dr. Seymour Katz, Clinical Professor of Medicine at the New York University School of Medicine. “The positive findings from these Asacol studies reassure physicians that Asacol is one treatment that has been proven effective throughout the entire colon, even the most distal portions, and should help guide physicians how to effectively treat their UC patients.”

Nationwide Survey Reveals Differing Physician and Patient Perceptions Regarding Impact of Ulcerative Colitis on Patients’ Lives

Authors Conclude Communication and Compliance Important for Addressing Challenges Uncovered in Survey

Nearly three out of four patients with ulcerative colitis (UC) consider feeling unwell to be a normal part of life, while gastroenterologists estimate this to be true for only 37 percent of their UC patients, according to results from a nationwide series of surveys presented at the 2007 Crohn’s & Colitis Foundation’s 6th Annual Advances in the Inflammatory Bowel Diseases conference.

The series of surveys, titled “UC: NORMAL (New Observations on Remission Management and Lifestyle),” were sponsored by Shire Pharmaceuticals, a specialty biopharmaceutical company, which markets once-daily Lialda™ and Pentasa® (mesalamines) for UC.

“Before these surveys, patient and physician views on UC’s impact had not been compared and the ‘real-life’ impact of UC had not been explored to this extent,” says lead author David Rubin, MD, a gastroenterologist and associate professor of medicine at the University of Chicago Medical Center who helped design the surveys. “This series of surveys brings to light some challenges for the UC community: patients accept a high level of disruption from UC on their lives; physician and patient views regarding the impact of UC are not in alignment; and compliance with medications requiring multiple daily dosing is a challenge.”

The UC: NORMAL surveys were fielded online between February and March 2007. For the physician survey, doctors were recruited by fax from a complete list of U.S. board-certified gastroenterologists. Gastroenterologists who spent less than half their time in direct patient care were excluded from the study.

At the time the surveys were fielded (prior to the availability of a once-daily mesalamine), patients reported they found it difficult to adhere to medication dosing schedules. Forty-six percent of patients (n = 451) reported they had not taken all of their medication in the past week and 41 percent of gastroenterologists (n = 300) believed their patients were not adhering to their medications.
Hypnotherapy for Abdominal Pain in Children

Most functional gastrointestinal disorders in children are characterized as irritable bowel syndrome (IBS) and functional abdominal pain (FAP). Although these disorders are common in children, minimal data regarding therapy is available and gut-directed hypnotherapy is a possible option. This prospective study from the Netherlands evaluated 53 children with IBS or FAP. Patients who underwent hypnotherapy received six sessions (50 minutes each) over three months in which relaxation and control of abdominal pain was attempted by various techniques including mental visualization of a normal gastrointestinal system. This study group was compared to a control group which received IBS/FAP education, dietary instruction, fiber, and pain medication or proton pump inhibitor therapy, if necessary. Both groups were evaluated at baseline and throughout the study as well as six and 12 months after therapy with seven-day pain diaries. Headache frequency also was measured.

Although both groups had a significant decrease in pain during and after treatment, the group receiving hypnotherapy had significantly decreased pain compared to subjects receiving standard medical therapy (P<0.002). There was no significant change in headache frequency in either study group. Interestingly, the hypnotherapy group had a significantly higher rate of remission (85%) at 12 months compared to the standard medical therapy group (25%) regardless if the child had FAP or IBS. Gender also did not influence outcome although children younger than 14 years of age showed a significantly better response to therapy. This study demonstrates that hypnotherapy is a valuable, non-pharmacologic therapy for functional pediatric gastrointestinal disorders. Obviously, it remains to be determined if insurance carriers will provide coverage for such prolonged therapy. (Vlieger A, Menko-Frankenhuis C, Wolfkamp S, Tromp E, Benninga M. "Hypnotherapy for children with functional abdominal pain or irritable bowel syndrome: a randomized controlled trial. Gastroenterology, 2007; Vol. 133: 1430-1436).

Body Positioning and Gastroesophageal Reflux in Premature Infants

Gastroesophageal reflux (GER) is extremely common in premature infants, and it can be associated with serious clinical consequences. Previous studies have suggested that placement of infants in the prone and left lateral position may decrease the incidence of GER. However, positioning has not been clarified in premature infants, and this study used both esophageal pH and impedance monitoring to measure the effect of body positioning in premature infants with symptomatic GER.

A total of 22 symptomatic premature infants from Italy with a mean gestational age of 31 weeks were studied, and all infants had frequent vomiting associated with oxygen desaturation. The infants were placed in the prone, supine, right lateral, and left lateral position for 6 hours each, for a total of 24 hours. The infants also were fed twice in each position. Throughout the study period, pH and impedance monitoring was performed.

Liquid reflux as well as esophageal acid exposure time was significantly decreased in the prone and left lateral position. Also, the left lateral position was associated with less acid exposure in the early postprandial period (first 75 minutes after a meal) while the prone position was associated with less acid exposure in the late postprandial period (75 minutes after the first 75 minute period). This study is valuable in demonstrating that simple positioning decreases GER in premature infants, but it does not address the effect of positioning on symptoms and does not replace the recommendation of using the supine position to decrease SIDS risk in infants at home. However, placing premature infants in the prone or left lateral position in a monitored situation, such as a neonatal intensive care unit, may be effective for decreasing symptomatic GER. (Corvagua L, Rotatori R, Ferlini M, Aceti A, Ancora G, Faldella G. "The effect of body positioning on gastroesophageal reflux in premature infants: evaluation by combined impedance and pH monitoring. J Pediatrics, 2007; Vol.151: 591-596).