**Ulcerative Colitis: The Complete Guide to Medical Management**

Editor: Gary Lichtenstein  
Associate Editor: Ellen J. Scherl  
Slack, Inc.  
Hard cover, 480 Pages  
$99.95

Ulcerative Colitis: The Complete Guide to Medical Management is a comprehensive review of the medical management of patients with ulcerative colitis (UC). The book includes a prologue and 39 chapters and is organized into three major sections: General, Medications, and Specific Clinical Presentations. The majority of the book focuses on medical therapy, including an overview of disease assessment prior to treatment and general treatment principles for both mild to moderate outpatients as well as steroid refractory or steroid dependent inpatients or outpatients. Detailed chapters are presented that discuss aminosalicylates and steroids, both in oral and topical forms as well as infliximab and immune suppressants. However, this review is noteworthy for including dedicated chapters on medications used infrequently or that are in development for the treatment of UC. Specifically, the use of antibiotics, methotrexate, calcineurin inhibitors, other anti-TNF agents, and novel biologic and non-biologic agents are discussed in detail. The book also covers complementary or adjunctive medical therapy including nicotine, pre- and probiotics, enteral and parenteral nutrition, and dietary manipulation.

The other sections of the review focus on the natural history of the disease, the current role of animal models in inflammatory bowel disease (IBD) research, pediatrics, management of pouchitis, and medication adherence. As above, noteworthy chapters for the IBD clinician include a section on placebo response in clinical trials, fertility and pregnancy, extraintestinal manifestations, and pseudointractability in IBD. The editors also have included a prologue which provides a nice historical perspective of UC.

In general, the book is organized well with an excellent layout. The majority of chapters are extremely detailed and comprehensive. However, the chapters are all divided into subsections to help organize the reader, and the chapters contain plenty of figures/algorithms, tables, and photos to help reinforce and at times simplify the text. The strengths of this review include the comprehensive coverage of the disease state by acknowledged thought leaders in the field, many of whom have contributed to the science in their respective chapters. This review would be useful to gastroenterology fellows interested in IBD as well as general gastroenterologists and IBD providers. The only weaknesses are that some of the chapters are repetitive, particularly the ulcerative proctitis and left-sided colitis chapters. In addition, as this book is a review of medical management, surgery is only touched on briefly.

In summary, *Ulcerative Colitis: The Complete Guide to Medical Management* is a comprehensive review that will be of interest to gastroenterology fellows, gastroenterologists, and IBD providers. The information included in the review on medical management covers the major issues encountered in the care of patients with UC and should be a must-have reference for providers as questions often arise in clinical practice.

Raymond Cross, MD, MS  
Associate Professor of Medicine  
Director of the IBD Program  
University of Maryland, Baltimore  
Co-Director, Digestive Health Center  
University of Maryland Medical Center

**Gastroparesis: Pathophysiology, Presentation and Treatment**

Editors: Henry P. Parkman and Richard W. McCallum  
Humana Press  
ISBN 978-1-60767-551-4  
422 Pages  
$219.00

The editors brought together a group of experienced clinicians and researchers to provide an update on gastroparesis, an important and often frustrating challenge for patients and physicians alike. The book is as much a summary of our current understanding as it is a call for action, highlighting the many gaps in our knowledge. Should you read it? My answer is “yes”, if you see and treat patients with gastroparesis or functional dyspepsia.

Starting with a historical retrospective and ending with a futuristic perspective, the editors designed an excellent framework that touches the many different

(continued on page 64)
(continued from page 62)

facets of gastroparesis. The chapters typically read like well-researched reviews with a distinct focus. While this structure allows the reader to pick and choose topics of interests, it creates some redundancy with the frequently repeated and at times partially contradictory basic facts. Several central themes emerge throughout the book. While delay in gastric emptying defines the illness, it does not explain the manifestation and should not be the only target of treatment. Much of our routine therapy from dietary interventions to pharmacotherapy or even surgery is based on beliefs, circumstantial evidence or reasoning by analogy. For example, the majority of patients receive antiemetics or acid suppressive therapy; while intuitively appropriate in a disease characterized by nausea and vomiting, no study ever systematically examines their effects in patients with gastroparesis as Dr. Hasler points out in his chapter. Interestingly, even if evidence becomes available, some of the authors and many physicians seem to have problems parting with their beliefs, as several chapters list botulinum toxin injection into the pylorus as treatment option despite two negative randomized controlled trials. Such hopes or beliefs may have contributed to the fact that the only topic given two separate chapters is gastric electrical stimulation, which is described as promising based on open-label trials but shows, at best, minor improvement in one symptom domain when tested against sham interventions (a critical fact only one of the chapters pointed out at the end).

Several outstanding summaries should be interesting for practicing gastroenterologists. Dr. Ordog describes the pathophysiology of the disease and its potential implication for future therapies. The discussion on diabetic gastroparesis and its potential implication for future therapies. The detailed discussion on dietary management should be a “must read” for all of us seeing patients with this disorder.

What did I miss as reader? Several chapters emphasize the correlation between severity of gastroparesis and depressive symptoms, a fact highlighted by recent results from a large multicenter study in the United States. The chapters on psychiatric aspects and antidepressants (mislabeled as sensory neuromodulators) unfortunately provide little more than global summaries of psychiatry or practice patterns loosely based on meta-analyses of treatment effects in other functional disorders. Overall, there is much to read, much to learn in this book and even more to investigate in this difficult to treat disease.

Klaus Bielefeldt, MD, PhD
Associate Professor of Medicine
Director, Neurogastroenterology and Motility Center
University of Pittsburgh Medical Center
Pittsburgh, Pennsylvania

John Pohl, M.D., Book Editor, is on the Editorial Board of Practical Gastroenterology.

Answers to this month’s crossword puzzle:

ETIOLOGY  ROUXEN
US DR PS RO
SICKLE CELL BAND
HOAYE
PSEUDOCYSTS EMS
EMOCMEND
UNIDRY AMP MO
SAGXE SPL
TMBED DRAINAGE
OMSISONI
WHIPPLE SN SCAN
PTREK PER
HAMoudI RESECT
RNBNIGHTAI
SESSILE OASGE

Interactive Crossword and Answers can also be found on our website: www.practicalgastro.com

REPRINTS
Special rates are available for quantities of 100 or more.
For further details visit our website:
www.practicalgastro.com
High-Fiber Diet and Asymptomatic Diverticulosis

To determine whether low-fiber or high-fat diets, diets that include large quantities of red meat, constipation or physical activity increase risk for asymptomatic diverticulosis, a cross-sectional study of 2104 participants 30 to 80 years old who underwent outpatient colonoscopy from 1998 to 2010 was carried out. Diet and physical activity were assessed in interviews using validated instruments.

The prevalence of diverticulosis increased with age. High intake of fiber did not reduce the prevalence of diverticulosis. Instead, the quartile with the highest fiber intake had a greater prevalence of diverticulosis than the lowest (prevalence ratio = 1.3), risk increased based on calculated intake of total fiber, fiber from grains, soluble fiber, and insoluble fiber. Constipation was not a risk factor.

Compared to individuals with less than 7 bowel movements per week, individuals with greater than 15 bowel movements per week had a 70% greater risk for diverticulosis (prevalence ratio = 1.7). Neither physical activity nor intake of fat or red meat was associated with diverticulosis.

It was concluded that a high-fiber diet and increased frequency of bowel movements are associated with greater, rather than lower prevalence of diverticulosis. Hypotheses regarding risk factors for asymptomatic diverticulosis should be reconsidered.

Ed. Note: Discussion included the fact that dietary adjustment would affect symptom relationship to diverticulosis and possibly complications of same.


Adalimumab in Ulcerative Colitis

ULTRA-2 was a randomized, double-blind, placebo-controlled trial to evaluate the efficacy of adalimumab in induction and maintenance of clinical remission in 494 patients with moderate to severe ulcerative colitis, who received concurrent treatment with oral corticosteroids or immunosuppressants.

Patients were stratified based on prior exposure to TNF-a antagonists and randomly assigned to groups, given the drug 160 mg at week zero, 80 mg at week 2, and then 40 mg every other week or placebo. Primary end points were remission at weeks 8 and 52.

Overall rates of clinical remission at week 8 were 16.5% on adalimumab and 9.3% on placebo; corresponding values for week 52 were 17.3% and 8.5%. Among anti-TNF alpha-naive patients, rate of remission at week 8 were 21.3% on the drug and 11% on placebo; corresponding values for week 52 were 22% and 12%.

Among patients who had previously received anti-TNF agents, rates of remission at week 8 were 9.2% on adalimumab and 6.9% on placebo; corresponding values for week 52 were 10.2% and 3%.

Serious events occurred in 12% of patients given the drug, all placebo. Serious infections developed in 1.6% of patients with the drug and 1.9% given placebo. In the group given the drug, one patient developed squamous cell carcinoma and one developed gastric cancer.

It was concluded that adalimumab was safe and more effective than placebo in inducing and maintaining clinical remission in patients with moderate to severe ulcerative colitis who do not have an adequate response to conventional therapy with steroids or immunosuppressants.


Murray H. Cohen, D.O., “From the Literature” Editor, is on the Editorial Board of Practical Gastroenterology.
Chef Spike Mendelsohn Dishes on How to Turn Down the Heat on Acid Reflux Disease

Mendelsohn and Takeda Launch Don’t Let it Burn National Campaign and Contest to Educate Consumers on Acid Reflux Disease Management and Treatment

Deerfield, Ill. Celebrity chef Spike Mendelsohn knows all too well the effects of a busy and hectic lifestyle – especially for a person with acid reflux disease (ARD). But while he’s used to firing up the grill, Chef Spike has also had to learn how to turn down the heat on his heartburn associated with ARD. To raise awareness and understanding about the importance of managing heartburn symptoms of ARD, including through lifestyle modifications, Chef Spike is cooking up an exciting recipe with Takeda Pharmaceuticals U.S.A., Inc. (Takeda), makers of the prescription medication DEXILANT (dexlansoprazole), through the educational campaign and contest, Don’t Let it Burn (Don’tLetitBurn.com).

“Food is not only one of my passions, it’s my life and as a chef, I know all about long days and nights. And, for me, certain foods and stress can aggravate my symptoms,” Chef Spike shared. “But as the saying goes, if I can’t take the heat, I should get out of the kitchen. So I’ve worked with my doctor to come up with a treatment plan that, for me, includes taking DEXILANT, which helps me to manage my acid reflux disease.”

Also known as gastroesophageal reflux disease (GERD), acid reflux disease is often a chronic condition affecting nearly 19 million Americans, and is characterized by persistent heartburn that occurs two or more days a week despite treatment and diet changes. Acid reflux disease should be managed with lifestyle changes and by working closely with a physician, not only to help relieve the uncomfortable and sometimes painful symptoms, but to heal damage (erosions) in the esophagus, a condition known as erosive esophagitis (EE).

“In the 40 years I’ve spent in clinical practice, I have seen many patients like Spike who have busy schedules, and who are concerned with their condition. For many people, symptoms can recur despite adjustments made to one’s diet, lifestyle and treatment,” said David A. Peura, M.D., Professor of Medicine, University of Virginia Health Sciences Center, Charlottesville, VA. “A helpful treatment option is the proton pump inhibitor (PPI) DEXILANT, which can provide up to 24 hours of heartburn relief for acid reflux disease. DEXILANT has a Dual Delayed Release formulation, which means that it provides two separate releases of medication in one pill.”

Contest: How Do You Turn Down the Flame on Heartburn Associated with ARD?

“Those who know me from reality television shows, have eaten in my restaurants or are familiar with my cookbook, know I love food – and also know how things can get heated in the kitchen,” said Chef Spike. “Visit Don’tLetitBurn.com to learn more about my story and to find out how to enter the “Don’t Let it Burn” Contest for the chance to win an opportunity to cook dinner with me. When you are on the site, you can also share your recipes for not triggering the burn.”

To enter the “Don’t Let it Burn” Contest*, visit Don’tLetitBurn.com to submit a favorite recipe that shouldn’t impact your heartburn related to ARD. All contest rules and details are available on Don’tLetitBurn.com.

Help Put Out the Fire of Acid Reflux Disease

Heartburn occurs when stomach acid repeatedly flows back into the esophagus, which can happen when the valve between the stomach and esophagus is not working properly. Affecting both men and women, persistent heartburn two or more days a week, despite treatment and diet changes could be a sign of ARD. The esophagus may become irritated and possibly damaged with continued exposure to stomach acid, a condition known as erosive esophagitis. ARD affects people differently, so it is important to talk to a doctor about symptoms.

“For more than 15 years, Takeda has been committed to supporting patients with digestive diseases,” said Heather Dean, Senior Director Marketing, Takeda. “We truly believe Don’t Let it Burn will further encourage individuals to help take control of their acid reflux disease and to work with their health care professional,

(continued on page 70)
May 10, 2012
Ohio Viral Hepatitis Summit
Columbus, OH. Join us at the Quest Conference Center for this “must attend” event for anyone working with those who are infected with or affected by viral hepatitis. Continuing education credits for physicians assistants, nurses, social workers, and addictions professionals are available. For reservations, call Pat Snyder at (614) 841-9100 and mention group code “Hepatitis Foundation” www.hepatitisfoundation.org

May 18-23, 2012
SGNA 39th Annual Course
Phoenix, AZ. The Society of Gastroenterology Nurses and Associates 39th Annual Course is a chance for you to join and collaborate with your fellow GI/endoscopy professionals, resulting in professional growth and development. Learn more about the following opportunities you can take advantage of: Unique networking opportunities, Exciting general sessions, Business meetings and ABCGN certification. SGNA is a professional organization of nurses and associates dedicated to the safe and effective practice of gastroenterology and endoscopy nursing. SGNA carries out its mission by advancing the science and practice of gastroenterology and endoscopy nursing through education, research, advocacy, and collaboration, and by promoting the professional development of its members in an atmosphere of mutual support. For more information visit: www.sgna.org

May 19-22, 2012
Digestive Disease Week
San Diego Convention Center, San Diego, CA. DDW is the largest international gathering of physicians, researchers and academics in the fields of gastroenterology, hepatology, endoscopy and gastrointestinal surgery. An average of 15,000 medical professionals attend the meeting each year. Jointly sponsored by the American Association for the Study of Liver Diseases (AASLD), the American Gastroenterological Association (AGA), the American Society for Gastrointestinal Endoscopy (ASGE) and the Society for Surgery of the Alimentary Tract (SSAT), DDW showcases thousands of abstracts and hundreds of lectures on the latest advances in GI research, medicine and technology. For more information visit: www.ddw.org

July 27-29, 2012
7th Postgraduate Course on Gastrointestinal Motility and Neurogastroenterology in Clinical Practice (Live Demonstrations and Interactive Meeting with the Experts) & Young Investigator Forum (Abstract deadline April 4, 2012)
Hyatt Regency, Chicago, IL. American Neurogastroenterology and Motility Society. For more information visit: www.motilitysociety.org
PRactical Gastroenterology Crossword puzzle

By Myles Mellor

(Answers on Page 64)

ACROSS
1. Cause of disease
5. _____ Y cystojejunostomy
9. Hospital professional, abbr.
11. Pigmented gallstones are the result of chronic hemolysis of the _____ disease (2 words)
13. Range of frequencies
14. Pancreatic _____ spontaneously resolve in 40% to 50% of patients treated expectantly with observation alone
17. Emergency medical team
18. Conclusion
19. _____ locular
20. Remove moisture from
21. Electrical power measurement
22. Atomic number 42
24. Symbol of an inert gas
27. Symbol for thulium
28. Hospital unit
29. Percutaneous or endoscopic?
33. Relative
34. Pancreaticoduodenectomy
37. Tin symbol
38. Examine closely
39. Journey
40. Proportionately
41. Solid pseudopapillary tumor
43. Remove part of an organ
45. Note well, abbr.
46. Kind of nurse
47. Referring to a polyp that lacks a stalk
48. American Society for Gastrointestinal Endoscopy

DOWN
1. Endoscopic ultrasound, for short
2. Localized anemia in a body part
3. The “bad” cholesterol
4. Metal in rocks
6. Symbol for osmium
7. Took a picture of
8. Sources of lymph
10. Red blood cells are suspended in it
12. It’s at the end of the vertebral column
14. Surgical procedure for chronic pancreatitis
15. Sidestep
16. Presence of toxic bacteria causing infection
23. Liquid part of fat
25. Magazine manager, for short
26. Important gland
28. Common file type, abbr.
30. Potential liability
31. Entrances to respiratory tracts
32. Amino acid
35. Premalignant lesions
36. Inc., in Europe
40. Use of a computerized radiographic technique to examine the metabolic activity in various tissues
41. Time segment, for short
42. Branch of medicine relating to childbirth, abbr.
43. Small guanosine triphosphate
44. Link

(Answers on Page 64)