Bayer Receives FDA Approval After Expedited Review For Hepatitis C Viral Load Assay, VERSANT® HCV RNA 3.0 Assay (bDNA)

The Diagnostics Division of Bayer HealthCare LLC, has received premarket approval after expedited review from the U.S. Food and Drug Administration (FDA) for its VERSANT® HCV RNA 3.0 Assay (bDNA) [1], a predictive test that directly measures hepatitis C virus RNA levels in serum or plasma. This is the first FDA-approved quantitative test to measure HCV viral load levels, and will aid physicians by guiding therapeutic decisions early in treatment.

“Current therapeutic recommendations rely on the accurate determination of HCV viral levels to assess a patient’s potential response to treatment. This is evidenced by a 2 log10 (100 fold or 99 percent) reduction in viral load at week twelve of therapy,” said Eugene R. Schiff, MD, Director, Center for Liver Diseases, University of Miami School of Medicine. “Since this viral measurement is essential to the clinical decision to continue or discontinue therapy, a reliable result as generated by the Bayer HCV bDNA assay affords great confidence in patient care.”

The VERSANT® HCV viral load assay is intended as an aid in the management of HCV-infected patients undergoing antiviral therapy.

The importance of quantitative assessment of HCV RNA levels in predicting patient response to antiviral therapy is reflected in the recent (2002) National Institutes of Health (NIH) Consensus Development Conference Final Statement on Management of Hepatitis C. The NIH Statement notes that “early viral response (EVR), defined as a minimum 2 log decrease in viral load during the first 12 weeks of treatment, is predictive of sustained viral response (SVR) and should be a routine part of monitoring patients with genotype 1. Patients who fail to achieve an EVR at week 12 of treatment have only a small chance of achieving an SVR even if therapy is continued for a

(continued on page 68)
full year. Treatment need not be extended beyond 12 weeks in these patients.”[1] Thus, the NIH recommends that testing for an EVR should be a routine part of patient monitoring.

References
[1] The VERSANT HCV RNA 3.0 Assay (bDNA) is intended for use as an aid in the management of HCV-infected patients undergoing anti-viral therapy. The assay measures HCV RNA levels at baseline and during treatment and is useful in predicting non-response to HCV therapy. For information on limitations of the procedure or information that may affect the interpretation of test results contact your clinical laboratory or Bayer HealthCare LLC, Diagnostics Division.


Boston Scientific Announces FDA Approval for ENTERYX® Technology

Endoscopic Injection Therapy Offers Alternative for GERD Sufferers
Boston Scientific Corporation has received approval from the U.S. Food and Drug Administration (FDA) to market the Enteryx® technology for the treatment of symptoms of gastroesophageal reflux disease (GERD) in patients responding to and requiring daily pharmacological therapy with proton pump inhibitors (PPI).

The Enteryx procedure involves injecting a patented liquid polymer into the lower esophageal sphincter (LES) that solidifies into sponge-like permanent implant. The implant helps to prevent or reduce reflux of gastric acid into the esophagus. The procedure employs existing endoscopic techniques and is performed under conscious sedation by therapeutic endoscopists on an outpatient basis. Unlike daily drug therapy that treats only the symptoms of GERD, the Enteryx procedure is designed to provide relief by changing the compliance of the gastroesophageal junction, thus addressing the underlying mechanical cause of the disease—LES dysfunction.

“Enteryx is an attractive alternative for both physicians and patients. The procedure builds on current GI physician skills and has produced significant improve-
Treating Gastroesophageal Reflux Disease
May Reduce Need For Asthma Medication
in Children

First Study to Assess New Acid Suppressing
Drugs in Children with Asthma

Children who suffer from both asthma and gastro-
esophageal reflux disease (GERD) may require fewer
asthma medications after receiving anti-GERD treat-
ment, according to a study published in the April issue of
CHEST. The study found that medically or surgically
treating GERD in children with asthma reduced the need
for total asthma medications by more than 50 percent.

“Many of our patients had never been off of any
asthma medication for a continuous three-month
period,” said lead researcher Vikram Khosho, MD,
PhD, Pediatric Gastroenterologist, West Jefferson
Medical Center, New Orleans, LA. “After being
treated for GERD, the majority of our patients reduced
their need for certain asthma medications and com-
pletely eliminated their need for others.”

The study, conducted at West Jefferson Medical
Center, is the first of its kind to evaluate the effect of
anti-GERD treatment using proton pump inhibitors
(PPIs) on the requirement for asthma medications in
older children with persistent moderate asthma.

Forty-six asthma patients, ages 5–11, were
selected for the study, based on predetermined criteria,
including the need for standard asthma medications
such as bronchodilators, leukotriene antagonists, and
corticosteroids. Upon evaluation, 27 patients showed
evidence of GERD and received either medical or sur-
gical anti-GERD treatment.

During 12 months of observation, all patients with
GERD receiving anti-GERD treatment showed a more
than 50 percent reduction in total asthma medications
used, and specifically, a more than 50 percent reduc-
tion in bronchodilator use. In addition, 89 percent of
patients with GERD required no treatment with
inhaled corticosteroids, and no patients required use of
leukotriene antagonists during the final six months of
observation. Patients receiving no anti-GERD treat-
ment showed no change in the use of total asthma
medications.

“Children with persistent asthma often take the
maximum amount of medications to maintain their
asthma, yet they still end up in the emergency room on
a regular basis,” said Dr. Khosho. “With anti-GERD
treatments such as PPIs, we may help to lighten our
patients’ asthma regimens and eventually reduce the
number of emergency room visits and school days
missed.”

Of the patients with GERD, 18 underwent medical
anti-GERD treatment for six months using PPIs and
lifestyle changes, and nine patients chose surgical
treatment. For patients without GERD, eight patients
opted to receive a therapeutic trial of anti-GERD treat-
ment, while the remaining 11 patients received no anti-
GERD treatment. Patients served as their own control
over asthma medications but were assessed by a physi-
cian for six months prior to anti-GERD treatment and
for 12 months posttreatment.

“Treating patients with persistent asthma can be
challenging,” said Udaya B. S. Prakash, MD, FCCP,
President of the American College of Chest Physi-
cians. “While we are still contemplating the relation-
ship between GERD and asthma, anti-GERD treat-
ment may prove to be an effective adjunct treatment
option for our young patients with asthma.”

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Treatment of Hepatitis B and C

Twenty-four patients with chronic hepatitis, seropositive for both hepatitis B surface antigen and antibody to HCV received ribavirin 1200mg daily for six months, together with 6,000,000 units of Interferon Alpha 2A, three times weekly for 12 weeks, and then 3,000,000 units for another 12 weeks. Serum HCV RNA was positive in 21 patients, negative in three patients. ALT and HBV DNA were monitored regularly for 12 months. Another 30 patients with chronic hepatitis C alone received the same regimen and served as controls. The serum HCV clearance rate in group one patients were comparable to those of controls, 24 weeks post treatment. The serum ALT normalization rate in group one and group two patients was 43 percent and 0 percent, respectively, 24 weeks post treatment.

After treatment, resurgence of HBV and HCV was encountered in 4 group one patients and 1 group two patients, respectively.

It was concluded that in hepatitis B and C dually infected patients, combination of Interferon with Ribavirin can achieve a sustained HCV clearance rate, comparable with hepatitis C alone. In dually infected patients, treatment may alter the dominant ruling hepatitis virus and additional therapy directed toward hepatitis B may be required. (Liu CJ, Lai MY, Kao JH, Jeng YM, Chen DS. “Ribavirin and Interferon is Effective for Hepatitis C Virus Clearance in Hepatitis B and C Dually Infected Patients.” Hepatology, 2003; Vol. 37, pp. 568-576.)

Aspirin To Prevent Colorectal Adenomas

A randomized, double-blind trial of aspirin as a chemo-preventive agent against colorectal adenomas was carried out, randomly assigning 1,121 patients with a recent history of histologically documented adenomas to receive placebo (372 patients), 81 mg of aspirin (377 patients), or 325 mg of aspirin (372 patients) daily. Follow-up colonoscopy performed three years after the qualifying endoscopy reported that study medications and avoidance of nonsteroidal antiinflammatory drugs was excellent. Follow-up colonoscopy was performed at least one year after randomization in 1,084 patients. The incidence of one or more adenomas was 47 percent in the placebo group, 38 percent in the group given 81 mg of aspirin and 45 percent in the group given 325 mg of aspirin per day.

The relative risks of any adenoma, compared with the placebo group was 0.81 in the 81 mg group and 0.96 in the 325 mg group for advanced neoplasms. The respective relative risks were 0.59 and 0.83.

It was concluded that low dose aspirin has a moderate chemo-preventive effect on adenomas in the large bowel. (Baron JA, Cole BF, Sandler RS, et al. “A Randomized Trial of Aspirin to Prevent Colorectal Adenomas.” N Engl J Med, 2003; Vol. 348, pp. 891-899.)

Aspirin and Colorectal Cancer

A randomized, double-blind trial was carried out on 635 patients with previous colorectal cancer to receive either 325mg of aspirin per day or placebo to determine the incidence of colorectal carcinoma under those circumstances. Determination was carried out of the proportion of patients with adenoma, the number of recurrent adenomas and the time to development of adenoma between randomization and subsequent colonoscopic examination. A total of 517 randomized patients had at least one colonoscopic examination at a median of 12.8 months after randomization. One or more adenomas were found in 17 percent of the patients in the aspirin group and 27 percent of patients in the placebo group.

The mean number of adenomas was lower in the aspirin group than the placebo group. The adjusted relative risk of any recurrent adenoma in the aspirin group, as compared with the placebo group, was 0.65. At times, the detection of the first adenoma was longer in the aspirin group than in the placebo group.

It was concluded that daily use of aspirin is associated with a significant reduction in the incidence of colorectal adenomas in patients with previous colorectal carcinoma. (Sandler RS, Halabi S, Baron JA, et al. “A Randomized Trial of Aspirin to Prevent Colorectal Adenomas in Patients With Previous Colorectal Cancer.” N Engl J Med, 2003; Vol. 348, pp. 883-890.)

(continued on page 72)
TIPS Vs. Paracentesis Plus Albumin For Ascites

Seventy patients with cirrhosis and refractory ascites were randomly assigned to TIPS (35 patients) or repeated paracentesis plus intravenous albumin (35 patients). The primary end point was survival without liver transplantation. Secondary end points were complications of cirrhosis and cost.

Twenty patients treated with TIPS and 10 treated with paracentesis died during the study, whereas 7 patients in each group underwent liver transplantation. The probability of survival without liver transplantation was 41 percent at one year and 26 percent at 2 years in the TIPS group as compared with 35 percent and 30 percent in the paracentesis group, respectively.

In a multivariate analysis, only baseline blood urea nitrogen levels and Child-Pugh score were independently associated with survival. Recurrence of ascites and development of hepatorenal syndrome were lower in the TIPS group, compared with the paracentesis group, whereas the frequency of severe hepatic encephalopathy was greater in the TIPS group. The calculated costs were higher in the TIPS group than in the paracentesis group.

It was concluded that in patients with refractory ascites, TIPS lowers the rate of ascites recurrence and the risk of developing hepatorenal syndrome. However, TIPS does not improve survival and is associated with increased frequency of severe encephalopathy and higher costs, compared with repeated paracentesis plus albumin. (Dines P, Uriz J, Calahorra B, et al for the International Study Group on Refractory Ascites and Cirrhosis. “Transjugular Intrahepatic Portosystemic Shunting Vs. Paracentesis Plus Albumin For Refractory Ascites and Cirrhosis.” *Gastroenterology*, 2003; Vol. 123, pp. 1839-1847.)

Entecavir Vs. Lamivudine in Hepatitis B

A 24 week, double-blind, randomized, multi-centered, phase II clinical trial was reported, comparing the safety and efficacy of Entecavir with Lamivudine in 169 patients chronically infected with hepatitis B, including hepatitis Be antigen positive and negative. Compared with Lamivudine, Entecavir reduced the HBV DNA significantly greater. A clear dose response relationship was observed for the Entecavir, with the higher doses showing significantly greater viral suppression. In patients treated with 0.5mg per day, 83.7 percent had an HBV DNA level below the limit of detection of the assay utilized, compared with 57.5 percent treated with 100mg per day of Lamivudine. In both treatment arms, very few patients achieved HBeAg loss and/or seroconversion by week 22.

More patients treated with the 0.1mg per day and 0.5mg per day doses of Entecavir had normalization of ALT levels at week 22, compared with Lamivudine. The Entecavir was well tolerated. Most of the adverse events were mild to moderate, comparable in all study arms.

It was concluded that Entecavir has potent antiviral activity against HBV at 0.1mg per day and 0.5mg per day doses, both of which were superior to Lamivudine in chronically infected HBV patients. (Lai CL, Rosemawati M, Lao J, et al. “Entecavir is Superior to Lamivudine in Reducing Hepatitis B Virus DNA in Patients With Chronic Hepatitis B Infection.” *Gastroenterology*, 2003; Vol 123, pp. 1831-1838.)

Endoscopic Implantation of Enteryx in GERD

In a prospective, multi-centered, single arm study of the safety and efficacy of endoscopic implantation of Enteryx, a biocompatible, nonbiodegradable liquid polymer for the treatment of GERD was evaluated. Eighty-five patients with heartburn symptoms responsive to proton pump inhibitors were enrolled. Inclusion requirements were HRQL (health-related quality of life) equal to or less than 11 on PPIs, and equal to or greater than 20 off of PPIs and the pH probe greater or equal to 5 percent with a total time at a pH of 4 or less. Patients with a hiatus hernia greater than 3 cm, grade III or IV esophagitis or an esophageal motility disorder were excluded. Using a 4mm needle-tipped catheter during standard endoscopy, implants were made in 3 to 4 quadrants, deep into the wall of the cardia.

At six months, PPI use was eliminated in 74 percent and reduced greater than 50 percent in 10 percent of patients. The median HRQL score improved from 24 preimplant, to four at 6 months. Mean total esophageal acid exposure time was 9.5 percent.
pretherapy and 6.7 percent at 6 months. The mean LES length increased from 2 cm at baseline to 3 cm post-therapy. There were no clinically serious adverse events. Transient mild to moderate chest pain commonly occurred after implantation.

It was concluded at six months that the endoscopic implantation of Enteryx is a safe and effective therapy for eliminating or decreasing the need for PPI medications, improving GERD symptoms and patient quality of life and decreasing esophageal exposure among patients suffering from GERD. (Johnson DA, Ganz R, Aisenberg J, et al. “Endoscopic Deep Mural Implantation of Enteryx For The Treatment of GERD: Six-Month Follow-up of a Multi-Center Trial.” Amer J Gastroenterol; Vol. 98, 2, pp. 250-258.)

**Two-Bite Forceps Technique**

Two hundred eighty-eight mucosal samples were obtained from 16 patients. Of these 192 were taken by using the two-bite technique. Thirty-five samples were missing when the two-bite technique was used, compared with only two when the single bite technique was used, irrespective of the location from which the first mucosal sample was taken. A significant number of first samples were lost (25 percent), compared with second samples (11.5 percent). The forceps without a spike were associated with significantly more missed samples than the spiked forceps.

At histopathologic evaluation, there were no significant differences between first and second samples, nor between samples taken with a two-bite and single bite techniques with regard to adequacy, integrity and depth. With regard to histopathologic evaluation, there were no differences among the three types of forceps used in the study.

Although the second mucosal sample obtained with a two-bite technique is adequate for histopathologic purposes, there is a significant risk of losing samples with this technique and thus, an increase in the probability of sampling error, and particularly with forceps without a spike. (Padda S, Shah I, Ramirez F. “Adequacy of Mucosal Sampling With a Two-Bite Forceps Technique: A Prospective, Randomized, Blinded Study.” Gastro Endo, 2003; Vol. 57, 2, pp. 170-173.)

**Cardiac Hepatopathy**

Eighty-eight patients from two tertiary referral centers were studied to evaluate clinical hemodynamic and histologic characteristics and correlations. Serum ALT levels were increased typically, particularly in the acute group. There was an elevated right atrial pressure and hepatic venous pressure. The hepatic venous pressure gradient was normal in most, and correlated moderately with the aminotransferase levels and associated with the presence of centrilobular necrosis and inflammation, periportal necrosis and stainable hepatic iron, but not with fibrosis.

Cardiac dilatation was associated with higher right atrial and free hepatic venous pressures. Cirrhosis was rare, but centrilobular fibrosis was common and not associated with any hemodynamic measurement.

It was concluded that cardiac hepatopathy has diverse clinical hemodynamic and histologic manifestations that vary with the temporal course of cardiac dysfunction. Hepatic fibrosis is common, but does not correlate with systemic or hepatic hemodynamics. (Myers RP, Cerini R, Sayegh P, et al. “Cardiac Hepatopathy: Clinical, Hemodynamic and Histologic Characteristics and Correlations.” Hepatology, 2003; Vol. 37, pp. 393-400.)

**Pancreatic Ascites**

An analysis of all case reports and case series of pancreatic ascites published between 1975 and 2000 was conducted, in which clinical data of every patient could be identified individually. A total of 139 cases were studied. Clinical characteristics, treatments administered, and response to therapy of every patient were registered. Conservative therapy included drainage of ascitic fluid, total parenteral nutrition and diet and somatostatin analogs. Interventional therapy was either endoscopic or surgical. After multivariate analysis, the only treatments related to success were surgery and transpapillary stent. It was concluded that conservative therapy is not advisable for pancreatic ascites because of the high proportion of failures. Interventional surgery or transpapillary stent has a positive effect in the clinical outcome. (Gomez-Cerizo J, Cano AB, Suarez I, et al. “Pancreatic Ascites: A Study
of Therapeutic Options By Analysis of Case Reports And Case Series Between The Years 1975 and 2000.”

Liver Biopsy in PBC

One hundred and ninety-eight patients that were AMA positive were evaluated and 42 patients were excluded because of unavailable laboratory data or liver biopsy specimens. Of that, only 156 patients were analyzed to determine which variables among patients with positive AMA, with and without histologic diagnosis of primary biliary cirrhosis indicate the need for liver biopsy. In 131 of 156 patients, a diagnosis of primary biliary cirrhosis was established by liver biopsy. The histologic diagnosis was associated with a cholecystatic biochemical profile, with an alkaline phosphatase greater than 1-1/2 times the upper limits of normal, an AST less than 5 times the upper limits of normal in 112 of 131. The combination of these two parameters yielded a 98 percent positive predicted value of primary biliary cirrhosis diagnosed on liver biopsy in AMA positive subjects.

It was concluded that this cholecystatic biochemical profile indicates the presence of primary biliary cirrhosis and rarely requires liver biopsy for confirmation.

(Zein CO, Angulo P, Lindor K. “When is Liver Biopsy Needed in the Diagnosis of Primary Biliary Cirrhosis?”
Clin Gastro Hepat, 2003; Vol.1, pp.89-95.)

Clonidine in IBS

Forty-four irritable bowel patients with predominant diarrhea were treated (with four dropouts), utilizing 0.1mg Clonidine, along with other doses b.i.d. Relief was sustained through four weeks of treatment and bowel function with firmer stools and easier stool passage. There was no significant alteration of gastrointestinal transit or gastric volumes. Drowsiness, dizziness and dry mouth were the most common adverse events. Severity of adverse effects subsided after the first week of treatment, and that dose of Clonidine seemed to relieve bowel dysfunction and appeared promising for the relief of diarrhea and irritable bowel syndrome, but without significant alterations in transit. (Camillari M, Kim DY, McKinnie S, et al. “A Randomized, Controlled Exploratory Study of Clonidine in Diarrhea-Predominant Irritable Bowel Syndrome.”
Clin Gastro Hemat, 2003; Vol. 1, pp. 111-121.)

Murray H. Cohen, D.O., editor of “From the Literature” is a member of the Editorial Board of Practical Gastroenterology.
**Child and Adolescent Obesity. Causes and Consequences, Prevention and Maintenance**
Burnat W, Cole T, Lissau I and Poskitt E, eds
Cambridge University Press, 2002
ISBN: 0521652375, $100

Childhood obesity is the most prevalent nutritional disorder in developed countries. It is believed 15% of children in the United States are obese. This new textbook brings together numerous national and international experts in the field of pediatric and adult nutrition and does a solid job of presenting a complete overview of the problem.

This clinically focused textbook is divided into 3 major sections; causes, consequences, and prevention and management. There is a concluding chapter outlining the future for childhood and adolescent obesity.

The authors do vary tremendously in their use of charts and graphs. A few of the chapters have no charts or graphs. Those charts and graphs that are used are to the point and easily interpretable, avoiding the pitfall of being too busy. There are no photographs. Each chapter is extensively referenced. The typeset is easily readable and the book itself very manageable in size. Thus, its 416 pages are well stocked with information regarding approaching this very important, worldwide disease.

Some of the more fascinating chapters are those explaining the molecular and biological factors of adipose tissue development, the psychosocial factors of obesity, and the prevention chapters. The management chapters including diet, exercise, drug therapy and surgical therapy were to the point, summarizing the results of numerous clinical trials.

I would highly recommend this textbook to any practicing clinician, including gastroenterologists, primary care physicians, and pediatricians. It also can serve as an invaluable reference for other members of the weight loss management team including dietitians, nurses, psychologists and exercise physiologist.

Mark H. DeLegge, MD
Associate Professor of Medicine
Digestive Disease Center
Medical University of South Carolina

**Percutaneous Endoscopic Gastrostomy (PEG)**
On DVD; Zephyr Medical Enterprises
(www.zephyrmedical.com); $35.00

The Percutaneous Endoscopic Gastrostomy DVD demonstrates commonly performed techniques of endoscopic gastrostomy tube placement. Joel Panish, former ASGE president, introduces the viewer to the general content of the DVD. The user friendly DVD menu allows choice of viewing either the introduction or one of three demonstrations of PEG placement. The DVD format provides flexibility to watch each case in its entirety or only the portions most pertinent to the viewer.

One may choose to observe PEG procedures by well known endoscopic specialists Drs. Jeffrey Ponsky, James DiSario, and Bennett Roth. Each physician discusses the indication for their particular case. Common features of the three cases include discussion of contraindications to PEG placement, the importance of proper insufflation, site location by finger indentation, and use of the safe track method. Drs. Ponsky and DiSario demonstrate the “pull” technique, while Dr. Roth performs the “push” technique. The unique styles of each endoscopist provide a varied experience from which one can learn.

A couple of changes in format may be beneficial to viewers. First, the menu does not specify which technique each physician is performing (e.g. “push” vs “pull”). A more specific listing would facilitate appropriate case selection. In addition, the “introducer” or “Russell” procedure was not demonstrated, and as it is less commonly performed, would have been a beneficial review for many practitioners.

The DVD, Percutaneous Endoscopic Gastrostomy, employs procedures in real time narrated by endoscopists, as its primary form of instruction. Such observational instruction, while lacking written teaching points and diagrams, can be useful for endoscopists of all experience levels. The trainee can benefit from the step by step narration, while the practicing gastroenterologist may fine tune their skills by witnessing the techniques of expert endoscopists.

Jason Umphress, MD
Gastroenterology Fellow
University of California, Davis
**Acute Gastrointestinal Bleeding: Diagnosis and Treatment**
Karen E Kim, Ed
Humana Press, 2003
ISBN: 1-58829-004-2; $99.50

Initial recognition and management of acute gastrointestinal bleeding is a responsibility shared by many different health care providers including gastroenterologists as well as primary care physicians, emergency physicians, resident housestaff, and medical students. This text is a comprehensive clinical information of acute GI bleeding management and diagnosis. Leading experts in the field of gastroenterology, surgery, and radiology contribute to the book with precise reviews of the pathophysiology, diagnosis, management, and treatment of acute disorders of the GI tract.

The authors break down acute bleeding into upper and lower GI sources with easy-to-follow algorithms emphasizing patient management, diagnostic measures, and treatment modalities. Although the book has more or less of a cookbook approach, it surprisingly has many interesting discussions outlining the many dilemmas faced by physicians in their evaluation of the patients, such as localization of the bleeding source (upper versus lower), the need and timing for emergency endoscopy, and the timing for radiologic intervention and/or surgery. More importantly for the gastroenterologists, these discussions are backed up by a number of different studies and thus more of evidence based practice. The pathophysiology of the diseases as well as the short pharmacologic details are refreshing and will be welcomed by medical students and physicians who want to refresh their memories. And for those who love to quote, trivial or not, percentages of incidences in each disease entity, you will find a plethora of such numbers in each chapter of this book. Overall, I feel that this book achieves its goal in being an excellent source of reference to be used easily by primary care physician in their approach to patient care as well as being a comprehensive, up-to-date overview for the gastroenterologist of this extremely common, and sometimes fatal, medical problem.

Caitlin Doan
GI Fellow
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**Atlas of Liver Transplantation**
E P Molmenti and Goran B Klintmalm, Eds
Saunders, Philadelphia, 2002
ISBN: 0-7216-9551-5; $165.00

Liver transplantation was first performed almost 40 years ago. Today, it is a common procedure whose outcome has dramatically improved as enhanced immunosuppression and surgical techniques have been developed. As a consequence, every practicing gastroenterologist must have a satisfactory working knowledge of the procedure including its technique and results to care for their patients with end-stage liver disease before and after liver transplantation. Unfortunately, every gastroenterology fellow does not have the opportunity to train in a center that also performs liver transplants and many gastroenterologists in practice have a limited understanding of the procedure and its outcomes. To that end, this atlas provides a basic understanding of the technique and of the complications that can ensue.

The book begins with a brief summary of indications and then devotes several chapters to the exacting operative technique of retrieving and implanting a donor liver from either a cadaver donor or from a living donor into a recipient. Utilizing detailed drawings, the authors take you through the multiple steps of the procedure documenting the craft of the transplant surgeon. While it cannot give you a complete understanding of the care and caution the surgeon utilizes, it certainly demonstrates the technical requirements needed to initially remove a recipient’s native and diseased liver and the multiple anastomoses needed to return function and viability to the new graft put in its place.

Two chapters are devoted to the congenital anatomic abnormalities of donor vasculature and to the potential of malpositioned recipient organ placement such as situs inversus that can add to an already exacting procedure. Twelve chapters are devoted to the problems of the post-operative patient. These complications are only briefly described, sometimes in a single paragraph. This was the section that left me wanting. For the primary gastroenterologist who provides the long-term care of the recipient, these are the problems that plague them and need personal attention. I
would like to have seen more detail to make the text a better reference.

The atlas finishes with a number of fine radiographs to illustrate post-transplant complications such as infections, bile duct and vascular problems, and CNS injuries to name a few. There is even a closing chapter of photomicrographs of liver histology during allograft rejection and of pre-transplant liver diseases. The latter seem a bit out of place in a surgical atlas.

However, the reason to buy this book is the superb illustrations of the donor and recipient operation. Understanding this procedure is key to discussions to adequately prepare your patient as they are being referred to a liver transplant center. Patients deserve to know as much about the techniques and complications of such a complicated procedure as they can. This book will enhance your knowledge for such discussions.

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The treatment sections are well done, with a welcomed special emphasis placed on evidence based medicine. In addition the evidence based medicine sections were well referenced.

Overall, this book is extremely well organized and concise, with an abundance of pertinent information. I found this book to be well written and I recommend it for first year Gastroenterology fellows, residents or primary practitioners.

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George W. Meyer, M.D., Book Editor, is on the Editorial Board of Practical Gastroenterology

PDxMD Gastroenterology
PDxMD, Elsevier Science, 2003
ISBN: 1932141049; $39.95

PDxMD Gastroenterology covers 24 of the most pertinent topics related to the field of gastroenterology, in a concise and organized manner. The 24 sections are broken down into “summary information,” “background,” “diagnosis,” “treatment,” “outcomes,” prevention and resources. The organization of the topics makes finding information easy and quick. In addition the concise nature of the material presented saves time when answering a specific question related to a disease process. The sections, although concise, do have an abundance of pertinent information. The “Key! Don’t Miss” points give attention to clinical pearls, which should not be overlooked, and I believe is a unique and invaluable section. I do find the laboratory sections within each section repetitive, and an appendix of normal values may be helpful. The differential diagnosis section is complete and well detailed. Other than just providing a list of possibilities, the section lists distinguishing features of the specific diseases in the differential.