Apheresis and Pediatric IBD

Apheresis of granulocyte and monocyte cell lines is a new therapeutic option for inflammatory bowel disease (IBD), and pediatric data is almost exclusively limited to case reports. The authors of this European study evaluated 37 children who underwent granulocyte-monocyte adsorptive apheresis (GMA) using a retrospective review. Pooled data from three countries (Denmark, Finland, and Sweden) found 37 children who had undergone GMA. In total, 22 children had ulcerative colitis, 13 had Crohn’s disease, and two had indeterminate colitis. The average patient age was 13.2 years, and the average disease duration of 2.25 years. Steroid dependency was present in 55% of patients; steroid resistance was present in 24% of patients.

GMA was applied weekly for five weeks, and extra treatments were provided if needed. All patients were re-evaluated three months after their last GMA. The patient group with ulcerative colitis had a significant decrease in the Pediatric Ulcerative Colitis Activity Index, but patients with Crohn’s disease had no significant decrease in the Pediatric Crohn’s Disease Activity Index (although five of these patients had individual decreases in activity). At the three month follow-up period, 9% of the ulcerative colitis patients and 22% of the Crohn’s disease patients had symptom relapse. Fewer patients were on corticosteroid therapy after GMA, and a significant decrease in corticosteroid dose was noted in patients after therapy. Side effects of GMA were few and minimal.

This study demonstrates that GMA is a safe treatment for pediatric IBD, but the authors note that prospective studies are needed to confirm these findings. (Ruuska T, Wewer V, Lindgren F, Malmborg P, Lindquist M, Marthens L, Browaldh L, Casswall T, Kalliomaki M, Gronlund D. “Granulocyte-monocyte adsorptive apheresis in pediatric inflammatory bowel disease: results, practical issues, safety, and future perspectives.” Inflamm Bowel Dis, 2009;15: 1049-1054).

Is Impedance Monitoring Feasible in Infants?

Multiple intraluminal impedance (MII) monitoring for gastroesophageal reflux (GER) is becoming a common diagnostic modality in adults. Minimal studies are available in children, and MII may be more difficult to perform in infants as GER and prolonged esophageal bolus formation is a normal, physiologic process in this age group. The authors of this study attempted to describe GER associated with changes in esophageal pH and impedance in infants.

This retrospective study evaluated MII studies in 80 preterm and 39 term infants. A reflux event detected by pH but not by MII was characterized as a change in impedance less than or equal to 50% of baseline in one channel, decrease in impedance in two or more channels but remaining more than 50% of baseline, technical artifact, air bolus with appropriate impedance change, or no change in impedance. In total, 2,572 acid GER events were noted from these infant studies, but only 1,057 events met impedance criteria as well. Significantly more preterm infants had pH-only reflux without impedance changes compared to term infants.

The majority (64%) of missed impedance events associated with a change in pH was due to no detectable impedance change during monitoring. Other causes of missed impedance events included not meeting scoring criteria, positive deflection (air bolus), or technical artifact. When the group of missed impedance events with a decrease of esophageal pH was evaluated separately, the majority of these events (44%) had baseline impedance levels less than 1,300W, possibly consistent with prolonged presence of nonacidic fluid in the esophagus.

The authors conclude that it is difficult to use MII to accurately detect GER in infants. Lack of motility neuronal maturation of preterm infants, problematic MII catheter design for infants, and slow accumulation of nonacidic fluid in the esophagus may be potential causes of these findings and deserve further study. (Di Fiore J, Arko M, Churbock K, Hibbs A, Martin R. “Technical limitations in detection of gastroesophageal reflux in neonates.” J Ped Gastroenterol Nutrit, 2009;49:177-182).
Curbside Consultation in Endoscopy: 49 Clinical Questions
Editors: Joseph Leung and Simon Lo
Series editor: Francis A. Farraye
Published by Slack incorporated, 2009
ISBN 978-1-55642-817-3; $79.95

Curbside Consultation in Endoscopy offers quick answers to a variety of questions that arise not only in basic endoscopy but also in the expanding fields of endoscopic ultrasound (EUS) and capsule enteroscopy. The book is comprised of six sections: upper endoscopy, lower endoscopy, ERCP, EUS, capsule enteroscopy, and a final section that deals with miscellaneous topics such as evaluation of abdominal pain after bariatric surgery. Each chapter in the book is in the form of questions and answers that cover a broad range of topics from management of foreign bodies and Barrett’s esophagus to obscure gastrointestinal bleeding. It addresses dilemmas that gastroenterologists face in day-to-day clinical practice, is user-friendly, and serves as a quick guide.

The first section is on upper endoscopy, and common conditions including the treatment of GERD and its complications are explored. The reader learns about newer therapeutic modalities for treatment of Barrett’s esophagus such as radiofrequency ablation, recommendations for surveillance, and improved techniques to detect Barrett’s esophagus. Treatment of duodenal adenomas is often challenging and Dr Kozarek explains the various endoscopic techniques used to treat this. There are several color images in the book as well which serve as useful visual aids.

The second section on colonoscopy is interesting and the endoscopic management of flat, large polyps and bowel preparation are discussed. The last three sections focus on advanced procedures. For example, determinations of the appropriate length of stents to be used in bile duct strictures, techniques to prevent stent migration, and tricks to performing a difficult papillotomy are discussed. Pancreatic cysts which are frequently encountered with more sophisticated imaging often leave physicians in a quandary, and the appropriate management of pancreatic cystic lesions is highlighted in the section on EUS. This book also provides a quick primer on the use of capsule enteroscopy and its applications in the management of small bowel bleeding.

In summary, this book offers excellent and succinct answers to various problems in GI endoscopy and is very useful for GI fellows, practicing gastroenterologists and all physicians with an interest in GI endoscopy. It is reasonably priced and provides quick answers to clinical questions that are difficult to find in traditional text books.

Thangam Venkatesan, M.D.
Assistant Professor of Medicine
Division of Gastroenterology and Hepatology
Department of Internal Medicine
Medical College of Wisconsin
Milwaukee, Wisconsin

John Pohl, M.D., Book Editor, is on the Editorial Board of Practical Gastroenterology.
ASGE Recognizes 10 Endoscopy Units for Quality and Safety as Part of Its Endoscopy Unit Recognition Program

The American Society for Gastrointestinal Endoscopy (ASGE) has recognized 10 endoscopy units as part of its program specifically dedicated to promoting quality in endoscopy, in all settings where it is practiced in the United States. The ASGE Endoscopy Unit Recognition Program honors endoscopy units that follow the ASGE guidelines on privileging, quality assurance, endoscopy reprocessing and CDC infection control guidelines. To date, 134 endoscopy units have been recognized by ASGE.

New ASGE Endoscopy Unit Recognition Program Honorees

- Midwest Physician Surgery Center, Lees Summit, MO
- Franklin Endoscopy Center, Franklin, TN
- Lebanon Endoscopy Center, LLC, Lebanon, TN
- Strand GI Endoscopy Center, Myrtle Beach, SC
- Tacoma Digestive Disease Center/Tacoma Endoscopy Center, Tacoma, WA
- Endoscopy Center Of Southwest Virginia, Roanoke, VA
- Middlesex Endoscopy Center, Middletown, CT
- Stanford Endoscopy Unit, Stanford, CA
- Kettering Medical Center, Miamisburg, OH
- Digestive Health Center, Wake Forest, Winston Salem, NC

Salix Receives FDA Marketing Approval for METOZOLV™ ODT (Orally Disintegrating Tablets) for Relief of Diabetic Gastroparesis and Symptomatic Documented GERD

The First Available Orally Disintegrating Metoclopramide Tablet Designed to Offer Improved Convenience

Salix Pharmaceuticals, Ltd. announced the U.S. Food and Drug Administration (FDA) has granted marketing approval for METOZOLV™ ODT (metoclopramide HCl) 5 mg and 10 mg orally disintegrating tablets. METOZOLV ODT is indicated for the relief of symptoms in adults associated with acute and recurrent diabetic gastroparesis and for the treatment of short-term therapy (4–12 weeks) for adults with symptomatic documented gastroesophageal reflux disease (GERD) who fail to respond to conventional therapy.

“METOZOLV ODT is the first available treatment for both diabetic gastroparesis and symptomatic documented GERD that offers physicians and patients the similar safety and efficacy of metoclopramide with the added convenience of an orally disintegrating tablet formulation,” said Ronnie Fass, MD, FACP, FACG and Professor of Internal Medicine at the University of Arizona. “Patients with diabetic gastroparesis and symptomatic documented GERD may have trouble adhering to treatment because of difficulty swallowing, the need for treatment when they do not have water available, or the need for a portable way to take medication. METOZOLV ODT, which rapidly melts on the tongue, gives these patients a new choice that may be more convenient than traditional metoclopramide tablets.”

PRACTICAL GASTROENTEROLOGY

REPRINTS

Practical Gastroenterology reprints are valuable, authoritative, and informative. Special rates are available for quantities of 100 or more.

For further details on rates or to place an order:
Practical Gastroenterology
Shugar Publishing
99B Main Street
Westhampton Beach, NY 11978
Phone: 631-288-4404  Fax: 631-288-4435
Or visit our Web site at:
www.practicalgastro.com