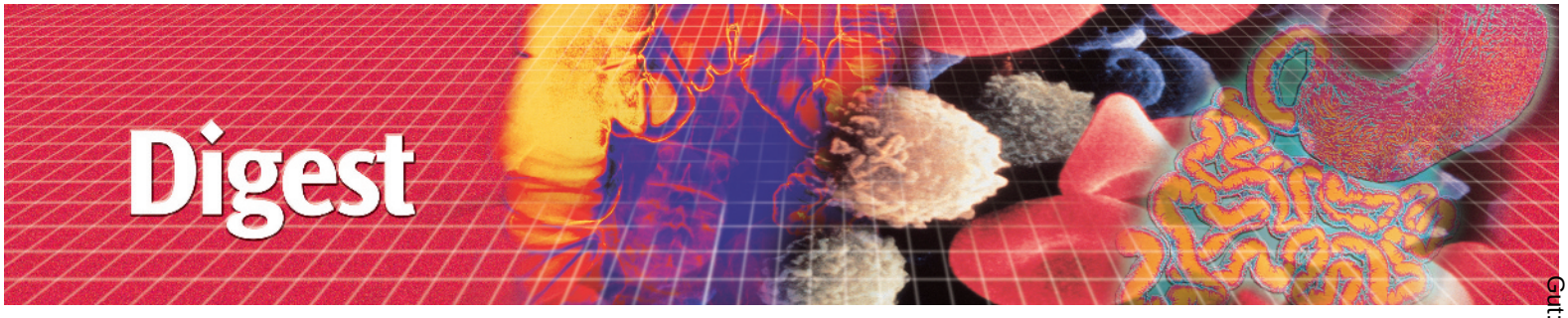
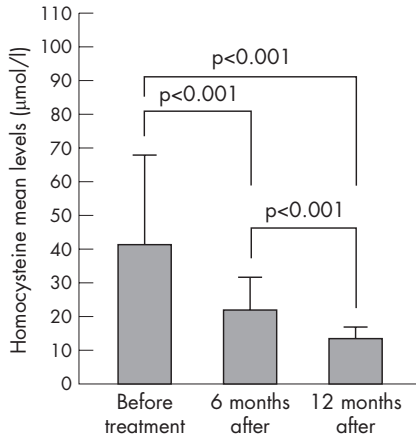


Robin Spiller and Emad El-Omar, *Editor and Deputy Editor*



Plasma homocysteine mean levels in patients with cobalamin deficiency before and 6 and 12 months after *H pylori* eradication.

LONG-TERM EFFECT OF *HELICOBACTER PYLORI* ERADICATION ON PLASMA HOMOCYSTEINE IN ELDERLY PATIENTS WITH COBALAMIN DEFICIENCY

Cobalamin (B_{12}) deficiency is common in the elderly and this may be associated with hyperhomocysteinaemia, a recognised risk factor for cardiovascular and cerebrovascular diseases. *H pylori* may be implicated in cobalamin deficiency but the published data are confusing. The authors prospectively evaluated 62 elderly patients with cobalamin deficiency before and after *H pylori* eradication. They measured homocysteine and cobalamin concentrations before and 6 and 12 months after *H pylori* eradication. The initial homocysteine mean (SD) levels decreased from 41.0 (27.1) to 21.6 (10.1) mmol/l at the 6 month follow-up ($p<0.001$) and 13.1 (3.8) mmol/l 12 months after *H pylori* eradication ($p<0.001$) (see figure). Conversely, the initial cobalamin mean levels increased from 145.5 (48.7) pmol/l to 209.8 (87.1) pmol/l and to 271.2 (140.8) pmol/l, 6 and 12 months after the treatment, respectively ($p<0.001$ for both). The data suggest that elderly patients with *H pylori* and cobalamin deficiency may benefit from eradicating the infection.

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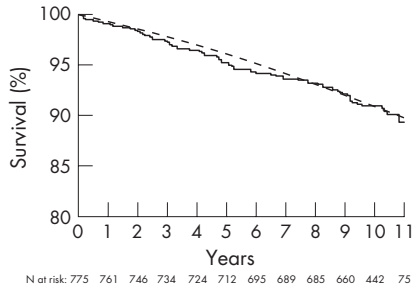

Total observed survival of the entire cohort (—) compared with expected survival (---) based on aggregated mortality statistics of all participating countries.

ULCERATIVE COLITIS: NO RISE IN MORTALITY IN A EUROPEAN-WIDE POPULATION-BASED COHORT 10 YEARS AFTER DIAGNOSIS

Estimates of mortality rates associated with ulcerative colitis (UC) are dated and cover populations from limited geographical areas. Höie *et al* assessed overall mortality in a European cohort of patients with UC, 10 years after diagnosis. This prospective European-wide population-based cohort of patients with UC was recruited from nine centres in seven European countries in 1991–1993. Expected and standardised mortality ratios (SMR) were calculated. At follow-up, 661 of 775 patients were alive with a median follow-up duration of 123 months. A total of 73 deaths (median follow-up time 61 months) occurred compared with an expected 67. The overall mortality risk was no higher: SMR 1.09 (95% CI 0.86 to 1.37). There was a slightly higher risk in older age groups and a higher SMR for pulmonary disease. Mortality by European region was SMR 1.19 (95% CI 0.91 to 1.53) for the north and SMR 0.82 (95% CI 0.45 to 1.37) for the south. The authors conclude that patients with UC do not have a higher mortality 10 years after disease onset.

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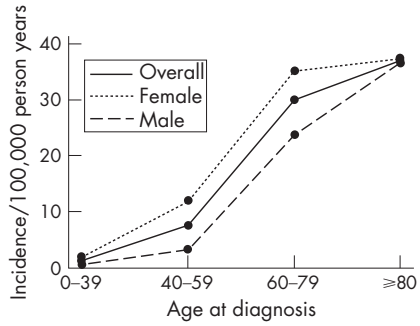

Age and sex specific incidence of microscopic colitis.

RISING INCIDENCE OF MICROSCOPIC COLITIS IN OLMSTED COUNTY

Clinicians are diagnosing microscopic colitis more frequently; however, a true assessment of the incidence and prevalence requires an epidemiological approach. The Rochester Epidemiological Project covers 124 000 residents and provides one of the most comprehensive descriptions of a community's health. Pathologists at the Mayo Clinic identified 130 cases of microscopic colitis from 1985 to 2001. There was a strong age effect, with the incidence rising from around 1 per 10^5 person-years in those <40 years to around 38 per 10^5 person-years in those >80 years (see figure). Males had a significantly lower incidence of collagenous colitis but a similar incidence of lymphocytic colitis compared with females. The rise in diagnosis parallels the rise in colonoscopy usage so the increase may be more apparent than real. Interestingly, 5 out of the 130 also had coeliac disease. The yield of microscopic colitis in those undergoing colonoscopic biopsy for unexplained diarrhoea was 14%. The authors conclude by recommending colonic biopsy for unexplained diarrhoea, particularly in those >40 years together with screening for coeliac disease.

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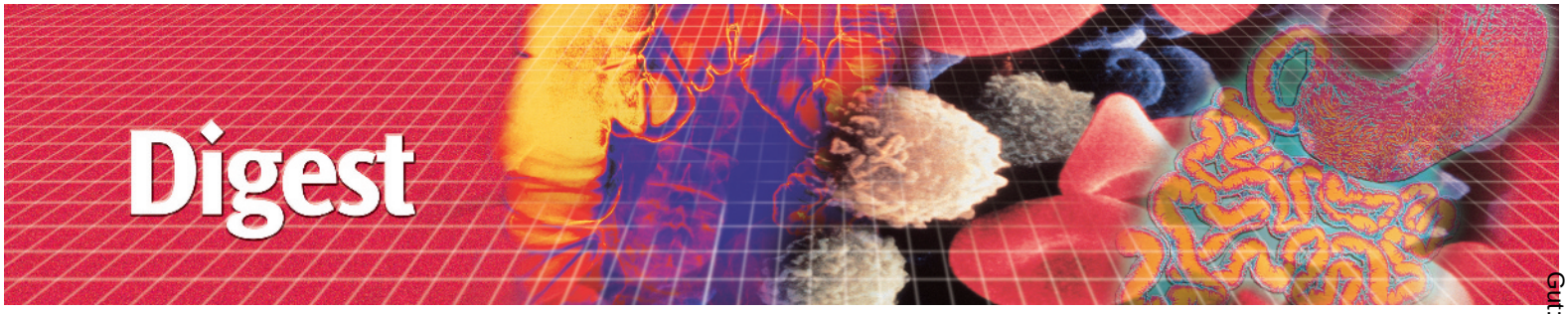

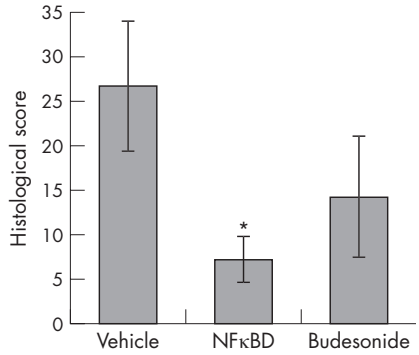

Quantification of histological colitis scores in the oxazolone model.

NON-VIRAL DELIVERY OF NF-κB DECOY AMELIORATES MURINE INFLAMMATORY BOWEL DISEASE AND RESTORES TISSUE HOMEOSTASIS

Nuclear factor-κB (NF-κB) is a key transcriptional regulator in many inflammatory conditions including inflammatory bowel disease (IBD). It is an ideal target for anti-inflammatory therapeutic strategies. De Very *et al* investigated the therapeutic potential of a locally administered non-viral NF-κB decoy (NFκBD) in three models of murine IBD: trinitrobenzene sulphonic acid, oxazolone and dextran sodium models. Intracolonic administration of NFκBD results in the delivery of NFκBD to inflammatory cells and a reduction of NF-κB heterodimers. The authors showed that NFκBD was efficacious in T helper cell 1 and T helper cell 2 mediated colitis. NFκBD treatment reduced the level of NF-kB and decreased the expression of pro-inflammatory cytokines. It also promoted healing of colonic tissue and restoration of goblet cell function. Finally, NFκBD treatment showed efficacy comparable with the steroid budesonide (see figure). The data suggest that non-viral NFκBD may be as or more effective with fewer side effects than current therapeutics in treating IBD.

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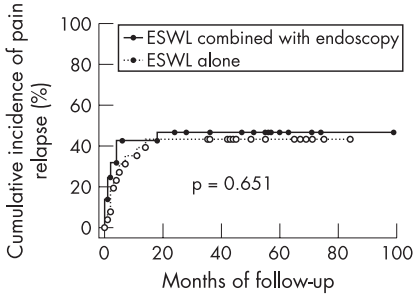

Kaplan-Meier cumulative event curves for pain relapse for the two treatments.

SHOCK WAVE LITHOTRIPSY IN PAINFUL CALCIFIED CHRONIC PANCREATITIS: NO NEED FOR ENDOSCOPIC RETRIEVAL OF STONE FRAGMENTS.

Extra corporal shockwave lithotripsy (ESWL) combined with endoscopic drainage of the pancreatic duct has been increasingly used to treat patients with painful calcified chronic pancreatitis but it is unclear whether subsequent endoscopic removal of calculi fragments is needed. This randomised controlled trial in 55 patients compared ESWL alone with ESWL combined with endoscopic drainage via endoscopic retrograde cholangiopancreatography. Stones were broken by lithotripsy into fragments <2 mm which were then extracted in those randomised to endoscopy, with the insertion of a pancreatic stent which was exchanged every 6 months and removed after 12–24 months. Both initial treatments were successful and pain resolved to <2 on a 10-point scale in all subjects. Two years after treatment, 38% of patients in the ESWL alone group experienced pain relapse (pain score >2), compared with 45% in the ESWL combined with endoscopy group (see figure, difference not significant). Both groups appear to do well compared with previous experience of untreated patients, with more than half being free of pain during follow-up (median 4 years). Given the striking increase in costs associated with the endoscopic procedures this can no longer be recommended.

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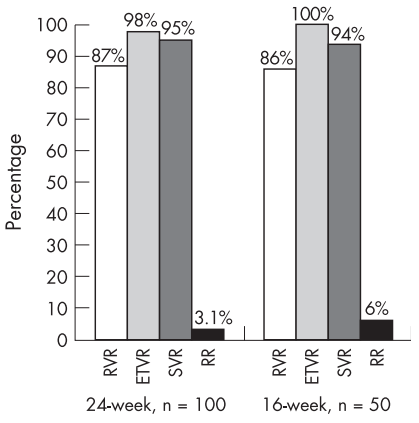

Percentage of patients achieving endpoints in the two treatment groups. ETVR end-of-treatment virological response, RR = relapse rate.

NO LOSS OF EFFICACY WITH SHORTER COURSES OF PEGYLATED INTERFERON AND RIBAVIRIN

This treatment for hepatitis C virus (HCV) genotype 2 is highly effective but frequent side effects often lead to premature termination of treatment. Shorter courses of treatment are associated with better compliance and recent studies have suggested that in those who have a rapid virological response (RVR) at 4 weeks, shorter treatments are as effective as longer ones. The current study randomised 150 Taiwanese patients with chronic HCV infection to 16 or 24 weeks' treatment. As expected, there was a tendency for compliance (taking >80% of drug) to be higher (86%) with the shorter course than the longer one (75%). Six months after treatment discontinuation there was no difference in the sustained viral response (SVR), which was seen in 94% and 95% of those in the 16 and 24 week treatment groups, respectively (see figure). As others have reported, those who had a RVR at 4 weeks were more likely to have a SVR, which was achieved in 98% and 100% of those having 24 and 16 weeks treatment, respectively. Those without sustained rapid viral response at week 4 need more than 16 weeks' and possibly more than 24 weeks' treatment. The lower body weight of Taiwanese patients means that the 800 mg dose of ribavirin gives a 15 mg/kg daily dose, significantly higher than in European studies, which may explain the better results reported here. These studies clearly indicate that tailoring doses to the patients' weight, age and initial response to treatment is vital for optimising outcomes.

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