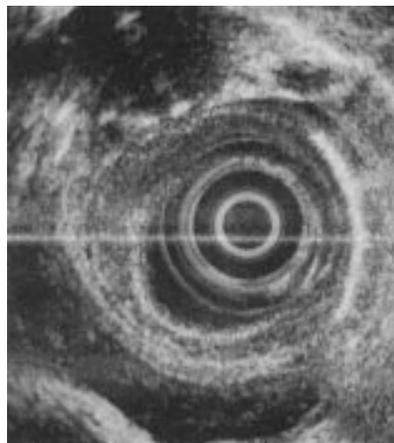


## VIEW ON USE OF EUS

Endoscopic ultrasound (EUS) is not the first advance in imaging to be elevated to a diagnostic pedestal by pioneering enthusiasts. Nor will it be the last whose

position has been assailed by subsequent scrutiny. Videos of EUS to stage patients with upper g-i cancers were retrospectively evaluated either with or without additional diagnostic test results. EUS was more accurate in staging when additional information was available. Despite the authors' scepticism, it's not yet time to hang up your EUS scope (if you have one!) for good just yet.

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An oesophageal carcinoma in histopathological stage T<sup>2</sup> but with endosonographic visualisation of transmural tumour growth, falsely suggesting stage T<sup>3</sup> on endoscopic ultrasonography (pp 599–603)

## S.O.D.'S LAW

It's not only the sphincter of Oddi (SO) that can behave dysfunctionally in patients with hard-to-explain right-sided upper abdominal pain. Patients are tricky to assess when the initial evaluation is negative and their physicians may come up with an interesting variety of diagnostic possibilities and therapeutic alternatives. Additional non-invasive tests are always welcome if SO dysfunction is suspected. Cicala and colleagues evaluated quantitative choledochoscintigraphy in 30 patients with suspected SO dysfunction. Delayed transit compared favourably with SO manometry and reliably predicted response to sphincterotomy. This might be useful in reducing the need for more hazardous tests—especially if an unnecessary and risky treatment can be avoided.

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## CLEARING UP AFTER HCV

Clearance of hepatitis C virus (HCV) occurs in up to 25% of acutely infected patients. Subsequent spontaneous clearance in chronically infected individuals does occur but the frequency with which this happens in the general population is unclear. Kondili and colleagues studied anti-HCV prevalence in a random population of Italians. Population prevalence of anti-HCV was 2.4%. After seven years, 19% showed spontaneous HCV clearance. It would be very good to know what markers will predict those who spontaneously clear the virus.

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## TRAINING IN EUROPE: VIVE LA DIFFERENCE (OR NOT!)

Whether you are a Euro-ophile, -sceptic or -phobe, the integration of specialists across the continent into a common register is a reality. It seems highly desirable to harmonise specialist training in the various countries so as to set a common standard for trainees and ensure the quality and competence of fully trained gastroenterologists. Bisschops and colleagues sent a questionnaire to 34 training centres in 10 European countries. Major international differences emerged with respect to workload and training—especially when endoscopy training was below the accepted threshold of experience for trainees. This needs to be addressed. The data on salaries were interesting: trainees might be curious to know how much/little they earn in comparison with colleagues elsewhere.

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## COLORECTAL CANCER—A GROWING PROBLEM

There is a much interest in a potential link between trophic factors and bowel cancer. In vitro studies suggest a possible role for insulin-like growth factor (IGF-I) in colon carcinogenesis. A study of IGF-I in plasma of patients with colorectal cancer and controls has shown increased IGF-I levels are directly proportional to colon cancer risk but inversely proportional to rectal cancer risk. Now here's a study that really does raise more questions than it answers.

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## TUFTSIN: VENTING THE SPLEEN

Tuftsins are small molecules—just 4 amino acids—with a big role in stimulating phagocytosis by neutrophils. The tetrapeptide is doubly cleaved, firstly within the spleen, and secondly on its neutrophil receptor. As might be expected, tuftsins deficiency may accompany splenic disease and leads to susceptibility to bacterial infections. Trevisani and colleagues found reduced tuftsins activity in cirrhotic patients associated with deficient phagocytic activity. Although deficient patients have more infections, their survival was uninfluenced by tuftsins levels.

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