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Relieve dyspepsia, reduce health service costs ►

▲ **Meineche-Schmidt V**. Empiric treatment with high and standard dose of omeprazole in general practice: two-week randomized placebo-controlled trial and 12-month follow-up of health-care consumption. *Am J Gastroenterol* 2004;**99**:1050–8.

Empirical proton pump inhibitor (PPI) therapy has been recommended as an appropriate management strategy for uninvestigated dyspepsia. There is a relative paucity of randomised trial data on the optimum dose of PPI in this patient group and little information on long term health economic outcomes. Dr Meineche-Schmidt has addressed this in a trial where 103 general practitioners (GPs) randomised 829 dyspepsia patients to omeprazole 40 mg or 20 mg, or placebo for two weeks. Dyspepsia was defined as any upper gastrointestinal symptom and complete relief of the predominant symptom was achieved in 66%, 63%, and 35% of patients, respectively. There was no significant difference between the different doses of omeprazole but the PPI was superior to placebo with a number needed to treat of less than four. Patients had therapy discontinued after two weeks and were managed as normal by their GP. Those with successful treatment had similar dyspepsia relapse rates and gastrointestinal medication consumption over the next 12 months as those that did not achieve symptom cure. Patients with symptom cure however had less endoscopy, GP consultations, and specialist referrals. The ''PPI test'' may therefore be useful as patients are reassured that their symptoms are due to an acid related disorder and require less investigation.

(Bile) acid test of pregnancy ►

▲ **Glantz A**, Marschall H-U, Mattsson L-A. Intrahepatic cholestasis of pregnancy: relationships between bile acid levels and fetal complication rates. *Hepatology* 2004;**40**:467–74.

Intrahepatic cholestasis complicates pregnancy with a frequency ranging widely from 0.1% in the USA up to 27% in Chile. Presenting in the second half of pregnancy with itching, it has been associated with adverse fetal outcome. Glantz *et al* screened all 45 485 pregnant women in the population of the Vastra Gotaland region of Sweden between 1999 and 2002 to identify 937 with itching. Using fasting serum bile acid levels of $\geqslant$10 μmol/l as an additional criterion, 693 (1.5%) were diagnosed as having intrahepatic cholestasis of pregnancy (ICP). Of 937 women, 820 (87.5%) were prospectively followed with recording of all events and investigations throughout pregnancy and delivery. The majority (81%) of those with ICP had a mild form of the condition (bile acid 10–39 μmol/l) which was not associated with adverse outcome. Serum bile acid levels $\geqslant$40 μmol/l (severe ICP) were associated with fetal complications (spontaneous preterm delivery, asphyxial events, and meconium staining of amniotic fluid, placenta, and membranes) and the risk increased by 1–2% per additional μmol/l of serum bile acids. Higher incidence (4.1%) of intrauterine fetal death was reported in previous pregnancies in those with severe ICP (serum bile acid $\geqslant$40 μmol/l) when compared with 0.6% in those without ICP (serum bile acid $<$10 μmol/l). However, fetal death occurred in only 0.4% of the current pregnancies, indicating that the extra attention devoted to ICP in the study group and early intervention could have prevented fetal death.

This detailed study describes the frequency, associations, investigations, and outcome of ICP. Fasting serum bile acid levels could be used in the diagnosis of ICP as well as in identifying the subgroup with an increased risk of adverse fetal outcome and hence to guide the management of these patients.

A gatekeeper to hold back the tide? ►

▲ **Fockens P**, Bruno MJ, Gabbrielli A, *et al*. Endoscopic augmentation of the lower esophageal sphincter for the treatment of gastroesophageal reflux disease: multicenter study of the gatekeeper reflux repair system. *Endoscopy* 2004;**36**:682–9.

Endoscopic methods of augmenting antireflux mechanisms continue to gain interest with proponents of several devices and techniques but few trials have been reported. The authors report pooled data from two prospective but non-randomised multicentre European trials of the Gatekeeper system. This involved endoscopic implantation of an inert prosthesis into the submucosa at several sites around the oesophagogastric junction with endoscopic ultrasound confirmation of correct placement. Seventy seven procedures were performed in 68 eligible patients (proton pump inhibitor (PPI) responsive gastro-oesophageal reflux disease, normal motility, absence of long segment Barrett's, or large hiatus hernia) and patients were followed for six months with repeat endoscopy and oesophageal pH and manometry studies, and symptom and quality of life (QOL) scores were carefully collected. Two to six prostheses were inserted in procedures lasting approximately 30 minutes with one technical failure and two major adverse events (3%, one prolonged nausea and one pharyngeal perforation). A total of 93.1% of prostheses were successfully inserted and 70.4% of these were still in place at six months. Significant reductions were seen in QOL scores for heartburn and regurgitation compared with baseline off PPI therapy and at six months 53% remained off PPI therapy. Prevalence of oesophagitis fell from 58.2% to 32.1% at six months together with reductions in reflux episodes and acid exposure times. Little tissue reaction occurred and prostheses were easily removed endoscopically when needed. Therefore, here is another promising technique to join the list—with apparently similar efficacy and safety but perhaps with the advantages of simplicity and possibly reversibility. Yet again, however, incomplete data collection, short follow up, and lack of a control group weaken the conclusions we can draw and we must await the ongoing randomised, sham controlled study to inform clinical practice.

If you don't put your finger in it, will you put your foot in it? ►

▲ **Manimaran N**, Galland RB. Significance of routine digital rectal examination in adults presenting with abdominal pain. *Ann R Coll Surg Engl* 2004;**86**:292–5.

Traditional teaching encourages the use of routine digital rectal examination (DRE) in all patients presenting as an emergency with abdominal pain, although this practice is no longer used in children. This study evaluated the use of DRE in a group of 100 consecutive patients presenting with acute abdominal pain. The working diagnosis before DRE was acute appendicitis in 38% and upper gastrointestinal disease in 24%. The authors found that DRE did not alter the clinical diagnosis or initial management in any of the 100 patients studied, and neither did it identify any unrelated pathology. The need for the procedure was questioned by 93% of patients and 78% rated it as uncomfortable. If further bowel tests were to be performed, 54% requested that the DRE be performed at the same time as these tests rather than at the time of admission. The authors also highlighted the medicolegal implications of performing unnecessary internal examinations. Clearly DRE should be used selectively in those patients and should be confined to those with symptoms related to the large bowel.