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## Guilt by association ►

▲ **Rezende G**, Roque-Afonso AM, Samuel D, *et al.* Viral and clinical factors associated with the fulminant course of hepatitis A infection. *Hepatology* 2003;38:613–18.

Increased risk of paracetamol induced liver injury in those with chronic alcohol abuse has been well recognised. But the concept of “therapeutic misadventure” with paracetamol has remained controversial. In a study involving 50 patients with acute hepatitis A infection, Rezende *et al* found female gender, low hepatitis A viral load, genotype other than 1A, and paracetamol intake to be associated with a fulminant course. Only subjects in whom accurate drug history was available were included in the analysis and daily paracetamol intake was well within the recommended dose (1–3 g) in all subjects. On univariate analysis, paracetamol intake was significantly associated with the risk of encephalopathy as well as high bilirubin levels, and the latter in turn independently predicted death or transplantation. These findings rekindle the debate as to whether paracetamol in therapeutic doses could contribute to the development of hepatic failure. Recent reports of the detection of paracetamol adducts in the sera of a significant proportion of patients with seronegative acute hepatic failure would support such an argument (Davern *et al.* *Hepatology* 2003;38[suppl 1]: 538A–9). The current study also adds to the evolving evidence for an increased risk of drug induced hepatotoxicity in those with pre-existing viral liver disease.

## Antibiotic resistance after *Helicobacter pylori* eradication ►

▲ **Sjölund M**, Wreiber K, Andersson DI, *et al.* Long-term persistence of resistant enterococcus species after antibiotics to eradicate *Helicobacter pylori*. *Ann Intern Med* 2003;139:483–7.

*Helicobacter pylori* test and treat is recommended in the management of uninvestigated dyspepsia. This increased use of antibiotics may promote resistance in other bacteria. There are few data on the impact of antibiotic use on microbial resistance in general and no information specifically relating to *H pylori* therapy. Sjölund *et al* report a cohort study of 10 patients followed up for three years. Five duodenal ulcer patients were given omeprazole 20 mg, clarithromycin 250 mg, and metronidazole 400 mg, all twice daily, for one week. Five *H pylori* positive patients with normal endoscopy were not given any antibiotics but were followed up in the same manner as the cases. Enterococci clarithromycin resistance was evaluated by the E test and the presence of the erm(B) gene in faecal samples. At baseline, no clarithromycin resistant strains were isolated. Immediately after treatment, clarithromycin resistance was identified in all patients given eradication therapy compared with one in the control group. Clarithromycin resistance persisted for three years in 1/5 (20%) patients (95% confidence interval 4–62%) given eradication therapy and none of the control group. This is an interesting preliminary study but the numbers studied are very small.

Nevertheless, this paper warns us that there are long term risks as well as benefits to *H pylori* eradication.

## EUS: what difference does it make? ►

▲ **Preston SR**, Clark GWB, Martin IG, *et al.* Effect of endoscopic ultrasonography on the management of 100 consecutive patients with oesophageal and junctional carcinoma. *Br J Surg* 2003;90:1220–4.

Much has been written about the accuracy of endoscopic ultrasound (EUS) in the staging of oesophagogastric cancer yet little is known of its impact on therapeutic decision making. The authors studied this using proformas containing clinical details, comorbidities, and staging information. Excluding EUS data, these were blinded, coded, and randomised for assessment by three upper gastrointestinal surgeons who were asked to choose among four management strategies for each case. The data were then presented again with the EUS findings and agreement among the consultants was studied. The three surgeons deemed EUS to be useful in 87%, 65%, and 63% of cases. Agreement on management was lowest without EUS and the number of concordant treatment plans rose from 53% to 62% following addition of EUS information, mostly the result of more decisions to opt for non-surgical palliation (4–7% increase). The impact of EUS applied not only to intended management plans but also held true for the actual treatment ultimately received by the patients. The impact, a 3–9% increase in concordant management plans, may seem small but given the mortality and morbidity of oesophagectomy and the long lasting major impact it has on quality of life, it is essential that patients are correctly selected for surgery. This study could not measure whether adding EUS may have assisted the decision making process without actually changing it nor did it study quality of life, but it does belong to a very small number of endoscopic studies which demonstrate an impact of diagnostic procedures on disease management.

## Does laparoscopic antireflux surgery reduce cancer risk? ►

▲ **Oelschlager BK**, Barreca M, Chang L, *et al.* Clinical and pathologic response of Barrett's oesophagus to laparoscopic antireflux surgery. *Ann Surg* 2003;238:458–66.

Once Barrett's oesophagus has developed in a patient with reflux oesophagitis, surveillance of the patient endoscopically becomes necessary to identify the presence of dysplasia or carcinoma. The role of laparoscopic antireflux surgery in reducing the risk of dysplasia or metaplasia is unknown. These authors have evaluated 106 consecutive patients with Barrett's oesophagus who had undergone laparoscopic antireflux surgery during a six year period. Median clinical follow up was 40 months. Symptoms improved in over 80% of patients. Following surgery, complete regression of intestinal metaplasia (suggesting regression of Barrett's oesophagus) occurred in 55% of patients with short segment Barrett's oesophagus. Of those with complete regression, 89% tested by pH monitoring had normal oesophageal acid exposure. The authors therefore claim that laparoscopic antireflux surgery, as well as providing excellent control of symptoms and acid exposure, also causes regression of intestinal metaplasia in the majority of patients with short segment Barrett's. Further studies will be necessary to determine whether antireflux surgery does indeed reduce cancer risk.