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What's the score? All new, easy to use, endoscopic scoring system for Crohn's! ►

▲ Daperno M, D'Haens G, Van Assche G, *et al.* Development and validation of a new, simplified endoscopic activity score for Crohn's disease: the SES-CD. *Gastrointest Endosc* 2004;60:505–12.

Interest in objective endoscopic activity scores for Crohn's waned in recent years because they were cumbersome, suffered from interobserver variation, and healing correlated poorly with clinical response. Newer biological therapies can induce mucosal healing, and this may correlate with longer remissions, rekindling interest in such endoscopic scoring systems. The authors developed the previous Crohn's disease endoscopic index of severity (CDEIS) which was reproducible but complicated and impractical for routine use. They have now developed a simplified score by selecting the most reproducible variables in an interobserver study, developing an easy to use scoring system with them, and validating the score in a different patient cohort. Lastly, reliability of the new simplified endoscopic activity score for Crohn's disease (SES-CD) was assessed in all patients and correlated with clinical and biochemical parameters.

The four variables used were presence of deep ulcers, proportion of the surface affected by ulcers, proportion affected by any other lesions, and stenoses, with a possible score of 0–3 for each. These were recorded for each of five segments of the ileum and colon. The new tool correlated highly with the previous CDEIS but was significantly easier to use and also correlated reasonably well with C reactive protein levels and Crohn's disease activity index but not with albumin, body mass index, or inflammatory bowel disease questionnaire scores. This score cannot take fistulas or proximal small intestinal disease into consideration and needs to be externally validated but seems practical and user friendly, at a time when endoscopic assessment of mucosal healing is regaining clinical importance.

The heart of the matter ►

▲ Gangi S, Saidi F, Patel K, *et al.* Cardiovascular complications after GI endoscopy: occurrence and risks in a large hospital system. *Gastrointest Endosc* 2004;60:679–85.

More about complications of endoscopy. Those that occur during procedures are usually easily spotted but we know little of complications occurring after patients leave the endoscopy suite. Previous questionnaire studies suffer from recall bias and underestimate the true frequency of such events. The authors used a novel methodology to examine cardiovascular complications—all inpatients and outpatients undergoing endoscopic procedures in nine

hospitals over a two year period were tracked. Any patient incurring charges for any cardiac investigations or therapy (for example, cardiac enzymes, ECG, prescription of cardiac drugs) on the day of or after their procedure was considered at risk of having had a cardiac event and the case notes of 25% of these were reviewed. Cardiac events such as chest pain, arrhythmia, hypotension, and myocardial infarction were assessed and clinical risk factors reviewed. Of 31 039 procedures, 2133 were thought to be at risk. Of the 513 case notes sampled and reviewed, cardiac events were confirmed in 23, giving an overall complication rate of 308 per 100 000 procedures (95% confidence interval 197–457)—or 1 per 325 procedures. There was no association with any particular type of procedure and multivariate analysis revealed only older age, male sex, high Goldman score (cardiac risk stratification), and the use of propofol as predictive. Overall, this cardiovascular complication rate is 2–70 times higher than previously thought and deserving of further study as we endeavour to undertake increasingly invasive procedures in ever older and comorbid patients.

Tips on timing TIPS ►

▲ Monescillo A, Martinez-Lagares F, Ruiz-del-Arbol L, *et al.* Influence of portal hypertension and its early decompression by TIPS placement on the outcome of variceal bleeding. *Hepatology* 2004;40:793–801.

Transjugular intrahepatic portosystemic shunt (TIPS) insertion has been well established as a treatment for acute variceal bleeding. Although TIPS insertion based on clinical criteria (such as failure to achieve sustained haemostasis after two endoscopic therapy) controls bleeding, it does not improve survival in these patients. This is because of the fact that high mortality (30–40%) in this group is due to progressive liver failure and its complications. Monescillo *et al* measured the hepatic venous pressure gradient (HVPG) in 116 patients with acute variceal bleeding immediately after one session of sclerotherapy. Fifty two patients with HVPG >19 mm Hg (considered high risk for rebleed) were randomised to TIPS insertion (n=26) within 24 hours of admission. TIPS was inserted in the low risk group (HVPG <20 mm Hg, n=64) and high risk non-TIPS group (n=26) only when medical and endoscopic therapy failed. Patients in the high risk non-TIPS group had significantly more treatment failures (50% v 12%), transfusions (3.7 v 2.2 units), need of intensive care (16% v 3%), and worse probability of survival compared with the low risk group. Early TIPS insertion in the high risk group significantly reduced inpatient mortality (11% v 38%) and one year mortality (31% v 65%) compared with the high risk non-TIPS group.

The authors emphasise that the sample size for the study was calculated to find differences in treatment failures and not in survival. Despite this, one should consider the improved survival in the high risk group of patients (with higher baseline serum bilirubin levels) as significant. Identifying those with a high risk of treatment failure and timing TIPS insertion early in the course may prevent the cascade of complications following acute variceal bleeding and improve survival in these patients. This could however lead to an overuse of TIPS.