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## Nice pictures, but so what? ►

▲ Chong AKH, Caddy GR, Desmond PV, *et al.* Prospective study of the clinical impact of EUS. *Gastrointest Endosc* 2005;62:399–405.

In an ideal world, we would use evidence from randomised controlled trials to inform our endoscopic practice. Such trials are however often impossible or prohibitively expensive to perform, yet outcomes research demands we demonstrate the benefits of new technologies. Endoscopic ultrasound (EUS) is a case in point, its niche in endoscopy seemingly already established. This study prospectively examined the impact of EUS with or without fine needle aspiration in a cohort of 330 consecutively referred patients. Using structured pre- and post-EUS questionnaires, referring clinicians were asked about diagnosis, further investigations, and management plans. Results were available for 233 patients (70%) across a broad range of conditions, including cancer staging, gastric wall abnormalities, mediastinal masses, and pancreaticobiliary disease. EUS, accurate in 88% of verified cases, led to a change in diagnosis in 26% of cases, examples being the nature of gastric submucosal lesions, suspected ampullary masses, or chronic pancreatitis and cytological confirmation of lung cancer. Overall, planned management was altered in 111 patients (48%) and examples included: upstaging of cancers, leading to non-surgical management; adoption of a conservative approach for lesions initially thought to be malignant or requiring surgery; and a change from surgery to endoscopic therapy. In 50% of patients it was possible to avoid further investigations on the basis of the EUS results, and overall 91% of referring clinicians found the procedure very or moderately useful.

This study provides objective evidence of how an endoscopic procedure impacts on daily practice but perhaps only “pro-EUS” clinicians referred patients for EUS and were therefore likely to find it useful? No economic data were presented, and unfortunately this is the aspect that may influence healthcare providers more than clinically important findings.

## Insights into chemoprevention of colorectal cancer from the Nurses Health Study ►

▲ Chan AT, Giovannucci EL, Meyerhardt JA, *et al.* Long-term use of aspirin and nonsteroidal anti-inflammatory drugs and risk of colorectal cancer. *JAMA* 2005;294:914–23.

Non-steroidal anti-inflammatory drugs have been associated with a reduced risk of colorectal cancer, and randomised controlled trials have suggested aspirin reduces the recurrence of colonic adenomas

in those undergoing colonoscopy surveillance. The dose of aspirin and duration of therapy required to reduce colorectal cancer risk is uncertain. Chan *et al* addressed this by evaluating aspirin use in 82 911 women from the Nurses Health Study that were followed up for 20 years. This prospective cohort study identified 962 colorectal cancers (CRC) in over 1.5 million patient years of follow up. The relative risk (RR) of CRC was reduced in women taking aspirin compared with those that did not take aspirin regularly (RR 0.77 (95% CI 0.67–0.88)). The effect was only statistically significant in those taking aspirin for more than 10 years (multivariate adjusted RR 1.04 (95% CI 0.88–1.24) in those using aspirin for 1–5 years; RR 0.67 (95% CI 0.54–0.84) in those taking aspirin for 11–20 years). There was also a dose-response, with the greatest relative risk reduction in those taking more than fourteen 325 mg aspirin tablets per week.

The study noted that the risk of hospitalisation for gastrointestinal bleed increased from 0.77 per 1000 person years in those not taking aspirin to 1.57 per 1000 person years in those taking more than 14 aspirin per week. Higher doses of aspirin may be required for many years to reduce the incidence of CRC and any benefit may be offset by an increase in gastrointestinal bleeding.

## Changing times for hilar tumours ►

▲ Read DJ, Heimbach JK, Rosen CB, *et al.* Liver transplantation with neoadjuvant chemoradiation is more effective than resection for hilar cholangiocarcinoma. *Ann Surg* 2005;242:451–61.

Hilar cholangiocarcinoma is a devastating disease with little chance of cure, even after resectional surgery, which is only possible in a small proportion of patients. Bilateral liver involvement, vascular encasement, and extensive hilar invasion are usually contraindications to resection. The early results of liver transplantation for this disease were disappointing but preliminary results following neoadjuvant chemotherapy and radiotherapy, reported by these authors, were very encouraging. This latest report compares patient survival after transplantation and neoadjuvant therapy of unresectable cases versus surgical excision of resectable cases. Prior to transplantation, a staging operation was done and abnormal lymph nodes were biopsied. Extrahepatic metastases, lymph node metastases, and local extension of disease to adjacent organs or tissues precluded transplantation. Those patients with concomitant primary sclerosing cholangitis were transplanted. Survival for the 38 patients who underwent liver transplant was 92%, 82%, and 82% at one, three, and five years, respectively, significantly higher than after potentially curative resection (82%, 48%, and 21% respectively).

The authors acknowledge the difficulties in comparing results between resection and transplant groups. Nevertheless, this multimodality approach has resulted in a significant survival advantage in this very difficult group of patients in whom transplantation has been previously contraindicated. Further experience by other groups of clinicians will be eagerly awaited. Will the rules for liver transplantation in this and other malignancies be rewritten?