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1. [Arch Surg.](#) 2010 Jan;145(1):28-33.

Prospective randomized trial of LC+LCBDE vs ERCP/S+LC for common bile duct stone disease.

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OBJECTIVE: To compare outcome parameters for good-risk patients with classic signs, symptoms, and laboratory and abdominal imaging features of cholecystolithiasis and choledocholithiasis randomized to either laparoscopic cholecystectomy plus laparoscopic common bile duct exploration (LC+LCBDE) or endoscopic retrograde cholangiopancreatography sphincterotomy plus laparoscopic cholecystectomy (ERCP/S+LC). **DESIGN:** Our study was a prospective trial conducted following written informed consent, with randomization by the serially numbered, opaque envelope technique. **SETTING:** Our institution is an academic teaching hospital and the central receiving and trauma center for the City and County of San Francisco, California. **PATIENTS:** We randomized 122 patients (American Society of Anesthesiologists grade 1 or 2) meeting entry criteria. Ten of these patients, excluded from outcome analysis, were protocol violators having signed out of the hospital against medical advice before 1 or both procedures were completed. **INTERVENTIONS:** Treatment was preoperative ERCP/S followed by LC, or LC+LCBDE. **MAIN OUTCOME MEASURES:** The primary outcome measure was efficacy of stone clearance from the common bile duct. Secondary end points were length of hospital stay, cost of index hospitalization, professional fees, hospital charges, morbidity and mortality, and patient acceptance and quality of life scores. **RESULTS:** The baseline characteristics of the 2 randomized groups were similar. Efficacy of stone clearance was likewise equivalent for both groups. The time from first procedure to discharge was significantly shorter for LC+LCBDE (mean [SD], 55 [45] hours vs 98 [83] hours; $P < .001$). Hospital service and total charges for index hospitalization were likewise lower for LC+LCBDE, but the differences were not statistically significant. The professional fee charges for LC+LCBDE were significantly lower than those for ERCP/S+LC (median [SD], \$4820 [1637] vs \$6139 [1583]; $P < .001$). Patient acceptance and quality of life scores were equivalent for both groups. **CONCLUSIONS:** Both ERCP/S+LC and LC+LCBDE were highly effective in detecting and removing common bile duct stones and were equivalent in overall cost and patient acceptance. However, the overall duration of hospitalization was shorter and physician fees lower for LC+LCBDE. **TRIAL**

REGISTRATION: clinicaltrials.gov Identifier: NCT00807729.

PMID: 20083751 [PubMed - indexed for MEDLINE]

2. [CA Cancer J Clin.](#) 2010 Jan-Feb;60(1):40-9. Epub 2009 Dec 18.

Developing a quality screening colonoscopy referral system in primary care practice: a report from the national colorectal cancer roundtable.

[Sifri R](#), [Wender R](#), [Lieberman D](#), [Potter M](#), [Peterson K](#), [Weber TK](#), [Smith R](#).

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The use of colonoscopy in colorectal cancer (CRC) screening has increased substantially in recent years. Media messages and changes in insurance reimbursement, as well as new screening guidelines from the American Cancer Society and the US Preventive Services Task Force, have contributed to this increase. Primary care providers (PCPs) are frequently responsible for making the recommendation and referral for screening. The process of successfully referring a patient for screening colonoscopy can be cumbersome and requires a coordinated effort between the PCP and the endoscopist. In recognition of the potential complexity of this process, the National Colorectal Cancer Roundtable has issued a report to describe the components of a quality screening colonoscopy referral system in primary care practice. The elements of a quality program include an optimal scheduling and referral system, the appropriate patient preparation information, consistent reporting and follow-up systems, and a detailed approach to dealing with special situations.

PMID: 20023050 [PubMed - indexed for MEDLINE]

3. [Ann Intern Med.](#) 2010 Jan 5;152(1):1-9. Epub 2009 Nov 30.

Continuation of low-dose aspirin therapy in peptic ulcer bleeding: a randomized trial.

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Comment in:

- [Ann Intern Med. 2010 Jan 5;152\(1\):52-3, W-12.](#)

Summary for patients in:

- [Ann Intern Med. 2010 Jan 5;152\(1\):1-20.](#)

BACKGROUND: It is uncertain whether aspirin therapy should be continued after endoscopic hemostatic therapy in patients who develop peptic ulcer bleeding while receiving low-dose aspirin. **OBJECTIVE:** To test that continuing aspirin therapy with proton-pump inhibitors after endoscopic control of ulcer bleeding was not inferior to stopping aspirin therapy, in terms of recurrent ulcer bleeding in adults with cardiovascular or cerebrovascular diseases. **DESIGN:** A parallel randomized, placebo-controlled noninferiority trial, in which both patients and clinicians were blinded to treatment assignment, was conducted from 2003 to 2006 by using computer-generated numbers in concealed envelopes. (ClinicalTrials.gov registration number: NCT00153725) **SETTING:** A tertiary endoscopy center. **PATIENTS:** Low-dose aspirin recipients with peptic ulcer

bleeding. INTERVENTION: 78 patients received aspirin, 80 mg/d, and 78 received placebo for 8 weeks immediately after endoscopic therapy. All patients received a 72-hour infusion of pantoprazole followed by oral pantoprazole. All patients completed follow-up.

MEASUREMENTS: The primary end point was recurrent ulcer bleeding within 30 days confirmed by endoscopy. Secondary end points were all-cause and specific-cause mortality in 8 weeks. RESULTS: 156 patients were included in an intention-to-treat analysis. Three patients withdrew from the trial before finishing follow-up. Recurrent ulcer bleeding within 30 days was 10.3% in the aspirin group and 5.4% in the placebo group (difference, 4.9 percentage points [95% CI, -3.6 to 13.4 percentage points]). Patients who received aspirin had lower all-cause mortality rates than patients who received placebo (1.3% vs. 12.9%; difference, 11.6 percentage points [CI, 3.7 to 19.5 percentage points]). Patients in the aspirin group had lower mortality rates attributable to cardiovascular, cerebrovascular, or gastrointestinal complications than patients in the placebo group (1.3% vs. 10.3%; difference, 9 percentage points [CI, 1.7 to 16.3 percentage points]).

LIMITATIONS: The sample size is relatively small, and only low-dose aspirin, 80 mg, was used. Two patients with recurrent bleeding in the placebo group did not have further endoscopy. CONCLUSION: Among low-dose aspirin recipients who had peptic ulcer bleeding, continuous aspirin therapy may increase the risk for recurrent bleeding but potentially reduces mortality rates. Larger trials are needed to confirm these findings.

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