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1. [Am J Kidney Dis](#). 2010 Feb;55(2):A35-7.

[Quiz page. Severe hypocalcemia caused by intravascular calcium phosphate precipitation after sodium phosphate-containing bowel preparation.](#)

[Piccoli GB](#), [Vigotti FN](#), [Consiglio V](#), [Deagostini MC](#).

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2. [Med Care](#). 2010 Feb;48(2):101-9.

[The effect of nonmedical factors on variations in the performance of colonoscopy among different health care settings.](#)

[Lamiraud K](#), [Holly A](#), [Burnand B](#), [Juillerat P](#), [Wietlisbach V](#), [Froehlich F](#), [Gonvers JJ](#), [Vader JP](#).

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BACKGROUND: Previous published studies have shown significant variations in colonoscopy performance, even when medical factors are taken into account. This study aimed to examine the role of nonmedical factors (ie, embodied in health care system design) as possible contributors to variations in colonoscopy performance. METHODS: Patient data from a multicenter observational study conducted between 2000 and 2002 in 21 centers in 11 western countries were used. Variability was captured through 2 performance outcomes (diagnostic yield and colonoscopy withdrawal time), jointly studied as dependent variables, using a multilevel 2-equation system. RESULTS: Results showed that open-access systems and high-volume colonoscopy centers were independently associated with a higher likelihood of detecting significant lesions and longer withdrawal durations. Fee for service (FFS) payment was associated with shorter withdrawal durations, and so had an indirect negative impact on the diagnostic yield. Teaching centers exhibited lower detection rates and longer withdrawal times. CONCLUSIONS: Our results suggest that gatekeeping colonoscopy is likely to miss patients with significant lesions and that developing specialized colonoscopy units is important to improve performance. Results also suggest that FFS may result in a lower quality of care in colonoscopy practice and highlight the fact that longer withdrawal times do not necessarily indicate higher quality in teaching centers.

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3. [Am J Gastroenterol](#). 2010 Jan;105(1):235-6.

Balloon enteroscopy for diagnosis and treatment of cytomegalovirus-induced small bowel gastrointestinal bleeding after whole-organ pancreas transplantation.

[Genzini AC](#), [Dib R](#), [Takahashi W](#), [Almeida PS](#), [de Miranda MP](#), [Genzini T](#), [Ilanhez LE](#).

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4. [Am J Gastroenterol](#). 2010 Jan;105(1):229-30.

Proctocolitis caused by coffee enemas.

[Keum B](#), [Jeen YT](#), [Park SC](#), [Seo YS](#), [Kim YS](#), [Chun HJ](#), [Um SH](#), [Kim CD](#), [Ryu HS](#).

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5. [Am J Gastroenterol](#). 2010 Jan;105(1):227-8.

"Blessed are those who have not seen and yet have believed".

[Giannini EG](#), [Savarino V](#).

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- [Am J Gastroenterol](#). 2009 May;104(5):1112-8.

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6. [Am J Gastroenterol](#). 2010 Jan;105(1):225-6; author reply 226.

Acid exposure within the dilated end-stage esophagus.

[Riegler FM](#).

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7. [Am J Gastroenterol.](#) 2010 Jan;105(1):90-2.

[Editorial: Upper GI bleeding-associated mortality: challenges to improving a resistant outcome.](#)

[Lanas A.](#)

Comment on:

- [Am J Gastroenterol.](#) 2010 Jan;105(1):84-9.

Although the incidence of peptic ulcer bleeding (PUB) has decreased, mortality has remained constant despite the advances in endoscopic and pharmacological therapies. Recent data indicate that most PUB-linked deaths are not direct sequelae of the bleeding ulcer itself. Instead, mortality derives from multi-organ failure, cardiopulmonary conditions, or terminal malignancy, suggesting that improving treatments for the bleeding ulcer may impact mortality by very little. Recognizing this possibility is paramount for the implementation of strategies that provide supportive care and prevent complications and key-organ failure, as well as treat the ulcer. Identifying non-gastrointestinal (GI) risk factors for poor outcomes and a multidisciplinary approach for high-risk patients should help to affect this hard outcome.

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