GI Bleeds Healed by Preemptive Omeprazole

BY KATHLEEN LOUDEN Contributing Writer

CHICAGO — Patients with bleeding peptic ulcers have quicker resolution of bleeding, lower transfusion needs and a shorter need for endoscopic therapy if they receive high-dose intravenous omeprazole before endoscopy, James Lau, M.D., reported at the annual Digestive Disease Week.

Dr. Lau, director of the endoscopy center at Prince of Wales Hospital in Hong Kong, presented the results of a double-blind, placebo-controlled trial of omeprazole in 369 patients with overt signs of upper GI bleeding who were scheduled for endoscopy. Between February and November 2004, Dr. Lau and his investigators randomized 179 of the patients to receive an 80-mg IV bolus of omeprazole and 8 mg/h before endoscopy (mean hours of infusion 14.9). The other 190 patients received a placebo before the procedure.

At endoscopy, a bleeding peptic ulcer was the most common cause of upper GI bleeding found. Bleeding ulcers were documented in 110 patients who had received high-dose omeprazole (61%) and 112 patients who had received placebo (59%) before endoscopy.

The primary outcome measured was the need for endoscopic treatment, which consisted of epinephrine injection and/or heater probe thermocoagulation for actively bleeding ulcers or ulcers with non-bleeding visible vessels or clots. Significantly fewer patients with bleeding ulcers in the omeprazole group needed endoscopic treatment, compared with the placebo group (19 of 110 patients vs. 40 of 112), he said.

In this subgroup, 92 (18%) of the 110 patients who received omeprazole had endoscopic stigmata of bleeding, whereas 41 (37%) of the 112 patients who received placebo had bleeding stigmas. The difference was statistically significant.

Preemptive use of high-dose omeprazole appears to have not only hemostatic effects but also healing effects, Dr. Lau said. Data showed significantly more clean-base ulcers at index endoscopy in patients assigned to the proton pump inhibitor than in those on placebo (74% vs. 50% respectively).

There were significantly more clean-base ulcers at index endoscopy in patients on omeprazole versus placebo.

Infliximab Seems Effective in Treating Active Ulcerative Colitis

BY KATHLEEN LOUDEN Contributing Writer

CHICAGO — Active ulcerative colitis responds to the drug infliximab, according to results of two multicenter phase III trials reported at the annual Digestive Disease Week.

Active Colitis Trial (ACT) 1 and ACT 2 each enrolled 364 patients with moderate or severe ulcerative colitis, refractory to at least one standard therapy.

Investigators randomized patients to receive infliximab at a 5 mg/kg dosage, a 10 mg/kg dosage, or placebo at baseline and at weeks 2 and 6, and then every 8 weeks through week 46.

After 8 weeks of infliximab therapy at either dosage, more than 60% of patients in each group demonstrated improvements in their symptoms vs. approximately 29% and 37% of placebo-treated patients in ACT 1 and 2, respectively, the authors reported. At 30 weeks, the clinical response was still significantly better in the infliximab groups.

Infliximab also effectively induced remission and led to mucosal healing in patients with active ulcerative colitis, both studies showed.

“This is very encouraging news for a patient population that has few treatment options,” said William Sandborn, M.D., principal investigator of ACT 2 and head of the Mayo Clinic College of Medicine’s irritable bowel disease interest group and clinical research unit. Both ACT 1 and 2 trials had similar results and patient populations, according to Dr. Sandborn, whose institution was one of 55 study centers. He described subjects as outpatients with relatively stable disease.

At enrollment, ACT 1 patients had not responded to treatment with corticosteroids and/or immunosuppressive therapy, whereas patients in ACT 2 had experienced treatment failure with 5-aminosalicylates, steroids, and/or immunomunosuppressives. The duration of ACT 1 was lost to follow-up at weeks 30 vs. 40.

Clinical response was defined as a decrease in the Mayo score of at least 30% and 3 or more points, plus either a reduction of 1 or more points in the rectal bleeding score or a score of 0 or 1 at week 8.

In addition to clinical response, both trials studied clinical remission—a Mayo score of 2 or less, with no individual sub-scores greater than 1—and mucosal healing, characterized as an endoscopy sub-score of 0 or 1.

Remission rates for the drug-treated patients were as high as 39% in ACT 1 (5 mg/kg) at week 8, compared with 15% for placebo. In ACT 1, the difference in the patients’ outcomes between the 10 mg/kg infliximab dosage (32%) and placebo was highly statistically significant, said that trial’s lead investigator, Paul Rutgeerts, M.D., from the University Hospital, Leuven, Belgium. Dr. Rutgeerts is a grant recipient of Centocor, the manufacturer of infliximab (Remicade).

Significant differences in remission rates between infliximab and placebo also were evident in ACT 2 and continued at 30 weeks in both trials.

Mucosal healing occurred at week 30 in a higher percentage of patients receiving 10 mg/kg of infliximab than in those with the smaller dosage (30% vs. 49% in ACT 1; 57% vs. 46% in ACT 2). Healing rates for both dosages were significantly higher than for placebo (25% in ACT 1; 30% in ACT 2).

In each study, the proportion of patients who were in remission and able to stop use of corticosteroids after 30 weeks of infliximab therapy was significantly greater for both dosages, compared with placebo.

Dr. Sandborn is also a grant recipient of Centocor.

BMI Linked to Surgical Infections

MIAMI — The incidence of surgical site infections after colorectal surgery could be reduced through greater awareness of risk factors, Harry van Goor, M.D., said at the joint annual meeting of the Surgical Infection Society and the Surgical Infection Society–Europe.

In a prospective, randomized, multi-center study of adults who elected colorectal resection for benign disease, 163 of the 1,701 patients (9.6%) had at least one surgical site infection (SSI), reported Dr. van Goor, a surgeon at the University Medical Center Nijmegen (the Netherlands). Of these, 46 (3.8%) were incisional infections, and 111 (6.5%) were organ/space infections. Approximately 50% of the infections in a group of 1,701 colorectal surgery patients occurred within 9 days after surgery, and 97% occurred within 24 days after surgery.

Significant independent risk factors for incisional infections included high body mass index (odds ratio of 2.6), bowel preparation with antibiotics (OR 0.5), preoperative hospitalization (OR 1.8), and wound classification (OR 2.8).

Significant independent risk factors for organ/space infections included age (OR 0.4), preexisting abscess or fistula (OR 19.1), diabetes (OR 2.4), perioperative steroid use (OR 2.1), preoperative hospitalization (OR 1.4), multiple procedures (OR 2.5), and wrapping of the anastomosis barrier around an anasto-motic leak (OR 3).

“Hospital stay increases by an average of 7 days if a surgical site infection occurs,” said Dr. van Goor. Furthermore, patients with SSIs are more likely to be re-admitted to the ICU than patients with- out infections.

—Heidi Splete