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Brief summaries of the latest clinical findings

Gastrointestinal Ulcers

Peptic Ulcer Bleeding

Peptic ulcer disease, the most common cause of upper gastrointestinal (GI) bleeding, is usually due to *Helicobacter pylori* (*H pylori*) infection or to nonsteroidal antiinflammatories (NSAIDs). Does the etiology make a difference in outcome? Researchers from the University of Texas Southwestern Medical Center and Parkland Memorial Hospital, both in Dallas, and the Medical University of South Carolina in Charleston hypothesized that the answer would be yes.

In their retrospective analysis, the researchers divided 2,242 patients with upper GI bleeding into 4 groups: *H pylori* negative/NSAID negative (also idiopathic); *H pylori* negative/NSAID positive; *H pylori* positive/NSAID negative; and *H pylori* positive/NSAID positive.

About 25% of patients with upper GI bleeding had ulcer disease. Of those with appropriate diagnostic testing, about half had evidence of *H pylori* infection, half did not. Of those positive for *H pylori*, 55% reported using NSAIDs. Of those who were *H pylori* negative, 66% used NSAIDs.

Patients without *H pylori* infection were significantly more likely to have comorbid conditions and higher comorbidity scores. They also were more likely to have more severe bleeding, be admitted to the intensive care unit, and have significantly longer hospital stays. Those who also did not take NSAIDs had the longest hospital stay (7 days). Rebleeding was also more common among patients who were *H pylori* negative.

Mortality at 30 days was similar for all 4 groups. The most common cause of death was multiorgan dysfunction syndrome and respiratory/cardiac failure. However, 2 of 3 patients who died of GI bleeding were *H pylori* negative.

The findings suggest that *H pylori* infection status may be more important than NSAID use for predicting poorer outcomes, the researchers say. They advise early and aggressive testing for *H pylori* in all ulcer disease patients, including starting them on triple antibiotic therapy.

Source: Chason RD, Reisch JS, Rockey DC. *Am J Med.* 2013;126(9):811-818.
doi: 10.1016/j.amjmed.2013.02.025.

Metabolic Syndrome

PTSD and Metabolic Syndrome

People with posttraumatic stress disorder (PTSD) are more likely than is the general population to have dyslipidemia, hypertension, diabetes, and obesity. They also tend to engage in behaviors that raise the risk of metabolic syndrome, such as drinking too much, smoking, not getting enough physical activity, and not eating well. But no research has definitively linked PTSD and metabolic syndrome.

Researchers from the University of Milano-Bicocca in Milan and San Gerardo Hospital in Monza, both in Italy; and the University College London in the United Kingdom, decided to do a meta-analysis to examine the risk of metabolic syndrome in people with PTSD, but in looking at the literature they found only 6 studies that had all the data needed for a pooled estimation. The 6 studies involved 528 people with PTSD (most often veterans), and 846 people from comparison samples.

To their knowledge, the researchers say, this is the first meta-analysis that systematically synthesizes data from studies comparing the risk of metabolic syndrome between individuals with and without PTSD. They found that PTSD did indeed have a strong bearing on the chances of also having metabolic syndrome, and the result was confirmed by the sensitivity analysis. Overall, the odds ratio was 1.37; in 3 studies, the risk of metabolic syndrome in patients with PTSD was 43% vs 36%, 30% vs 24%, and 48% vs 31%.

The result is consistent with other reviews that showed high rates of metabolic syndrome among individuals experiencing severe mental illnesses, such as bipolar disorder and depression.

It wasn't possible to clarify which components of metabolic syndrome were the most significant, the researchers say, because no studies had enough data for supplementary analyses.

Three factors might help explain or mediate the association, the researchers say. One is off-label use of antipsychotics, which are related to weight gain, hyperglycemia, and dyslipidemia. A second factor is comorbidities; some research suggests that people with PTSD and, for example, depressive disorder, have a greater risk of metabolic syndrome. And, third, metabolic syndrome may be a consequence of neuroendocrinal adaptation to chronic stress, which has been linked to insulin resistance, obesity, and dyslipidemia, among other health problems.

The authors recommend making regular assessment of lifestyle habits, weight, blood pressure, lipids, and glucose part of routine monitoring for patients with PTSD.

Source: Bartoli F, Carrà G, Crocamo C, Carretta D, Clerici M. *Metab Syndr Relat Disord.* 2013;11(5):301-308.
doi: 10.1089/met.2013.0010.

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