

Omeprazole Stops Gastric Bleeding, Halves Endoscopic Treatment Rate

BY TIMOTHY F. KIRN
Sacramento Bureau

CHICAGO — Early high-dose omeprazole infusion speeds resolution of upper gastrointestinal bleeding and reduces the need for endoscopic treatment, according to preliminary results of a prospective trial from Hong Kong.

“Preemptive use of high-dose omeprazole has a hemostatic effect. It hastens resolution of active bleed-

ing, and, in fact, reduces the need for endoscopic therapy,” James Y. Lau, M.D., said at the annual Digestive Disease Week. “It potentially enables early discharge of patients and reduces hospital resource utilization.”

In Dr. Lau’s randomized, controlled trial, only 15% of 179 patients treated with omeprazole needed endoscopic therapy, compared with 31% of 190 patients who received placebo.

The study was conducted between February 2004 and November 2004; 648 individuals with upper gastrointestinal bleeding were considered for enrollment in the study. Patients

were excluded if they were chronic aspirin users, needed urgent endoscopic therapy, or were considered too unhealthy (such as those with cirrhosis), said Dr. Lau of Prince of Wales Hospital of the Chinese University of Hong Kong.

Infusion of the drug appears to help stop bleeding in the upper GI tract by bringing about a neutral pH, which facilitates platelet aggregation.

The treated patients received an 80-mg bolus of intravenous omeprazole, followed by an infusion of 8 mg per hour for 72 hours.

Endoscopy was conducted when it was scheduled in the endoscopy clinic, generally in the morning, after the drug or placebo was begun and the patient had been admitted to the hospital.

Endoscopic treatment was considered necessary when patients were found to still have actively bleeding ulcers or ulcers with non-bleeding but visible vessels, or when there was a clot found that could be

lifted to treat an oozing vessel underneath. Treatment consisted of epinephrine injection followed by heater-probe coagulation.

Overall, 220 of the patients were found on endoscopy to have, or to have had, a bleeding gastric ulcer. In that group, 17% of 110 omeprazole-treated patients needed endoscopic treatment, versus 35% of 112 placebo-treated patients. Moreover, only 3 omeprazole-treated patients with a gastric ulcer had active bleeding at the time of endoscopy, compared with 18 of the placebo patients.

Omeprazole appears to help stop bleeding in gastric ulcers because a neutral pH facilitates platelet aggregation, Dr. Lau said.

Dr. Lau’s group has previously reported that omeprazole treatment of patients who underwent endoscopic treatment for an upper gastrointestinal bleed significantly decreased the rate of rebleeding within 30 days, from a rate of 22% in a placebo group to 7% in a treated group (*N. Engl. J. Med.* 2000;343:310-6). ■

SSRIs May Be Tied To Lower and Upper GI Tract Bleeding

BY TIMOTHY F. KIRN
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CHICAGO — A preliminary analysis of hospital admissions suggests that selective serotonin reuptake inhibitors may be associated with a significant risk of gastrointestinal bleeding, Michael Jones, M.D., said at the annual Digestive Disease Week.

In a case-control study of all patients admitted with gastrointestinal bleeding to three hospitals over an 18-month period, 17% of the 417 patients with bleeding were using a selective serotonin reuptake inhibitor (SSRI) at the time. Of 500 age- and sex-matched controls—patients without bleeding who were admitted on the same date—12% used SSRIs. There was a significant association between SSRI use and bleeding risk.

“The true magnitude of the risk is yet to be determined,” Dr. Jones, of the division of gastroenterology at Northwestern University at Chicago, said at a press briefing.

Because the study was a retrospective investigation, it is not exactly clean, he allowed. The bleeding patients tended to be taking other medications associated with GI bleeding as well as the SSRI. For instance, 17% were taking an NSAID or a cyclooxygenase-2 inhibitor, 41% were taking aspirin or clopidogrel, and 24% were on Coumadin or enoxaparin. In addition, 34% were taking a proton-pump inhibitor or an H2 blocker. Those percentages were higher than the percentages in the control patients in the study, funded by Tap Pharmaceuticals.

SSRIs are widely used because they are perceived to be safe, not because they are necessarily more effective than tricyclic antidepressants, Dr. Jones said.

This study is not the first to note a bleeding risk for SSRIs, Dr. Jones noted. Studies from Europe and Canada have tended to report a higher risk than this study might indicate. Those studies reported that the risk of upper GI bleeding with an SSRI was three times normal.

The present study, funded by Tap Pharmaceutical Products Inc., differed from the previous reports also in that it found a risk of lower intestinal tract bleeding, as well as upper. The odds ratio that a patient in the study taking an SSRI would experience lower GI bleeding was 2.4 relative to those not on an SSRI.

The bleeding risk of the SSRIs probably is intrinsic to the properties that make them therapeutic. Platelets do not produce their own serotonin. They need to take it up from the circulation, and the drugs may be blocking the platelet receptors. Serotonin is necessary for platelet aggregation. ■

Early Colonoscopy Shortens Hospital Stays

BY KATHLEEN LOUDEN
Contributing Writer

CHICAGO — Patients with acute bleeding of the lower intestinal tract have a shorter hospitalization if they undergo colonoscopy on the first day of admission, according to a nationwide study by Harvard Medical School researchers.

Early colonoscopy also was associated with decreased hospital charges, Lisa Strate, M.D., reported at the annual Digestive Disease Week.

The study was based on a 20% sample of a nationally representative cohort called the Healthcare Cost and Utilization Project’s 2002 National Inpatient Sample. This database contains discharge data from 995 U.S. community hospitals in 35 states, according to its sponsor, the Agency for

Healthcare Research and Quality.

Among more than 255,000 discharged patients who had a principal diagnosis of acute lower intestinal bleeding, 28% had colonoscopy on hospital day 1, called early colonoscopy. Another 22% of the total cohort underwent colonoscopy after day 1.

Patients who underwent early colonoscopy had a mean stay of 5 days vs. 7 days for patients who did not have the procedure or had it after the first hospital day, Dr. Strate said.

Reduced stay did not appear to result from therapeutic interventions, because colonoscopy with endoscopic hemostasis was not associated with shorter length of stay, she reported. This finding confirmed the results of two single-institution studies (*Am. J. Gastroenterol.* 2003;98:317-22; *Gastrointest. Endosc.* 2003;58:841-6).

“We hypothesize that doing an early colonoscopy and finding no source of active or ongoing bleeding offered reassurance and led to an earlier discharge,” Dr. Strate said in an interview. “Patients with high-risk stigmata were observed for longer periods.”

In a separate presentation, Don Rockey, M.D., professor of gastroenterology at Duke University and an author of one of the previous studies (*Gastrointest. Endosc.* 2003;58:841-6), commented on early colonoscopy in this patient population. “Urgent colonoscopy translates to decreased hospital stay and costs,” he said.

Longer hospital stay for patients with acute lower intestinal bleeding is associated with higher mortality, Dr. Strate reported in another study at the meeting that used the National Inpatient Sample. ■

Bowel Sounds Did Not Flag Recovery From Abdominal Surgery

BY MITCHEL L. ZOLER
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PHILADELPHIA — The traditional markers used to identify patients who have recovered from major abdominal surgery were ineffective in a study with 124 patients.

“It’s unclear whether surrogate markers correlate with important clinical measures of recovery from abdominal surgery, such as

a patient’s tolerance of oral intake,” Marc Brozovich, M.D., said at the annual meeting of the American Society of Colon and Rectal Surgeons.

The ability of bowel sounds, flatus, and first bowel movement following surgery to flag patients who recovered from major abdominal surgery was tested in a prospective study with 124 patients who underwent procedures such as colorectal surgery,

exploratory laparotomy, and small-bowel resection at Western Pennsylvania Hospital in Pittsburgh.

Bowel sounds were monitored once per day by a third-year medical student who performed auscultation for 1 minute in the periumbilical area. Any sound heard during this examination was scored as a positive bowel sound. Patients were questioned daily to determine the time when

they recovered flatus and had their first bowel movement.

The median length of hospitalization was 6 days, and the mean duration spent in the hospital was 8 days.

All three markers tested showed no reliable correlation with patients’ tolerance of at least 1 L of oral fluid intake in a 24-hour period, Dr. Brozovich said.

On the basis of the new findings, “we recommend that as-

essment of postoperative ileus should not rely on bowel sounds, flatus, or bowel movement,” said Dr. Brozovich, a colorectal surgeon at Western Pennsylvania Hospital. “Better markers of recovery include tolerance of oral fluid intake, patients’ ability to hydrate themselves, whether patients get adequate pain control from oral medications, and their ability to care for themselves as outpatients.” ■