

Guidelines on Endoscopic Treatment of Dyspepsia

The American Society for Gastrointestinal Endoscopy (ASGE) recently issued guidelines regarding the role of endoscopy in the treatment of dyspepsia. Prepared by the ASGE Standards of Practice Committee, these guidelines were published in the December issue of *Gastrointestinal Endoscopy* and included the following recommendations:

- Patients with dyspepsia who are older than 50 years of age and/or those with alarm features should undergo endoscopic evaluation. Alarm features are defined as new onset of symptoms in a patient over 50 years of age, family history of upper gastrointestinal malignancy, unintended weight loss, gastrointestinal bleeding or iron deficiency anemia, progressive trouble swallowing, pain with swallowing, persistent vomiting, palpable mass or lymphadenopathy, and jaundice.
- Patients with dyspepsia who are less than 50 years of age and do not experience alarm features may undergo an initial test-and-treat approach for *Helicobacter pylori* infection, as there is growing evidence that patients who are managed with this approach have similar outcomes compared to those who undergo initial endoscopy. The test-and-treat approach has also been shown to be more cost-effective.
- Patients who are less than 50 years of age and are *H. pylori*-negative can be given an initial endoscopy or a short trial of proton pump inhibitor (PPI) acid suppression.
- Patients with dyspepsia who do not respond to empiric PPI therapy or have recurrent symptoms after an adequate trial should undergo endoscopy.

Body Mass Index and Liver Transplantation

To determine how body mass index (BMI) influences the survival benefits from liver transplantation, researchers led by Shawn J. Pelletier, MD, of the University of Michigan Medical School, conducted a retrospective study of 25,647 adult patients listed for liver transplantation in the United States between September 2001 and December 2004. The results were published in the December issue of *Liver Transplantation*. Patients were classified as underweight (BMI <20); nonobese (BMI 20 – <25); overweight (BMI 25 – <30); obese (BMI 30 – <35); severely obese (BMI 35 – <40); or morbidly obese (BMI >40). The researchers compared outcomes for patients within these groups after adjusting for age, gender, race, ascites status, diagnosis, and Model for End-Stage Liver Disease score. Adjusted Cox regression models were used to evaluate the association between BMI and liver transplant survival benefit (posttransplan-

tation vs waiting list mortality). Of the 25,647 wait-listed patients, 4,488 (17%) underwent liver transplantation during the study period. At wait-listing and transplantation, similar proportions were morbidly obese (3.8% vs 3.4%) and underweight (4.5% vs 4.0%).

Underweight patients were found to experience a significantly higher covariate-adjusted risk of death on the waiting list (hazard ratio [HR]= 1.61; $P<.0001$) compared to nonobese patients. However, underweight recipients reported a similar risk of post-transplantation death (HR=1.28; $P=.15$) compared to nonobese patients. The authors concluded that all subgroups of liver transplant recipients demonstrated a significant ($P<.0001$) survival benefit, including morbidly obese and underweight recipients, compared to patients on the waiting list with a similar BMI. The authors thus concluded that high or low recipient BMI should not be a contraindication for liver transplantation.

Telbivudine Versus Lamivudine in Chronic Hepatitis B

According to an article in the December *New England Journal of Medicine*, in a double-blind phase III trial, researchers at the Queen Mary Hospital in Hong Kong, China, randomly assigned 1,370 patients with chronic hepatitis B to 600 mg of telbivudine (Tyzeka, Idenix/Novartis) or 100 mg of lamivudine (EpiVir, GlaxoSmithKline) once daily. The primary efficacy endpoint was noninferiority for therapeutic response (ie, a reduction in serum hepatitis B virus [HBV] DNA levels to $<5 \log_{10}$ copies/mL, along with loss of hepatitis B e antigen [HBeAg] or normalization of alanine aminotransferase [ALT] levels). Secondary efficacy measures consisted of histologic response, changes in serum HBV DNA levels, and HBeAg responses.

Researchers reported that at Week 52, a significantly higher proportion of HBeAg+ patients receiving telbivudine than patients receiving lamivudine experienced therapeutic response (75.3% vs 67.0%, $P=.005$) or histologic response (64.7% vs 56.3%, $P=.01$). In addition, telbivudine was not inferior to lamivudine for these endpoints in HBeAg- patients. In HBeAg+ and HBeAg- patients, telbivudine was superior to lamivudine in terms of the mean reduction in HBV DNA copies from baseline, the proportion of patients with a reduction in HBV DNA to levels undetectable by polymerase chain reaction assay, and the development of drug resistance. Elevated creatine kinase levels were more common in patients receiving telbivudine, whereas elevated ALT and aspartate aminotransferase levels were more common in patients receiving lamivudine.