

Consensus Interferon Plus Ribavirin for Chronic Hepatitis C

According to the June issue of *Hepatology*, Bruce Bacon, MD, of St. Louis University in St. Louis, Missouri, and colleagues conducted a multicenter trial to assess the efficacy, tolerability, and safety of consensus interferon (CIFN) with ribavirin (RBV) in patients with failed initial pegylated interferon (PEG-IFN)/RBV therapy. Intent-to-treat analysis included 487 patients, among whom 245 patients took CIFN 9 µg daily plus RBV and 242 patients took CIFN 15 µg daily plus RBV. Advanced fibrosis was documented at baseline liver biopsy (stage F3 or F4) in 59.3% of patients. Most of the patients had hepatitis C virus genotype 1; 80% had not responded strongly to previous therapy; 68% had high baseline levels of the virus; 60% had advanced liver disease; and approximately 20% were African-American.

In the 9-µg arm, sustained virologic response (SVR) rates were 6.9% (17/245 patients), whereas they were 10.7% (26/242 patients) in the 15-µg arm. According to intent-to-treat analysis, SVR rates were higher in patients with a greater than 2- \log_{10} reduction in hepatitis C virus RNA levels during prior PEG-IFN/RBV therapy (11% [4/38 patients] in the 9-µg arm vs 23% [7/31 patients] in the 15-µg arm). As for patients with lower baseline fibrosis scores (F0–F3), SVR rates were found to be 7.8% (15/192 patients) in the 9-µg arm and 13.1% (23/175 patients) in the 15-µg arm. In these F0–F3 patients, achieving a greater than 2- \log_{10} reduction in hepatitis C virus RNA levels with prior PEG-IFN/RBV therapy resulted in an improvement of SVR rates to 10.7% and 31.6% in the 9-µg and 15-µg arms, respectively. Although adverse events were common, the authors noted that most of the patients did not discontinue their treatment. Common side effects included neutropenia, fatigue, leucopenia, depression, nausea, muscle pain, lymphopenia, and anemia. The authors concluded that re-treatment of PEG-IFN and RBV nonresponders with CIFN and RBV is safe, efficacious, and well tolerated and is a re-treatment option for patients who failed previous therapy with PEG-IFN/RBV, particularly interferon-sensitive patients with lower baseline fibrosis scores.

Obesity and Bowel Preparation for Colonoscopy

Researchers at the Washington University School of Medicine in St. Louis, Missouri evaluated the influence of increased body mass index (BMI) on bowel preparation quality for colonoscopy by assessing all colonoscopies

performed at a tertiary referral center during a 4-month period. Each bowel preparation was given a unique composite outcome score based on a subjective bowel preparation score, earlier recommendation for follow-up colonoscopy due to inadequate bowel preparation, and the endoscopist's confidence in adequate assessment of the colon. The researchers performed univariate and multivariate logistic regression analyses to evaluate the use of BMI as a predictor of inadequate bowel preparation. The results of this study were published in the June issue of *Clinical Gastroenterology & Hepatology*.

The inclusion criteria were fulfilled by 1,588 patients (59.1% women; mean age, 57.4±0.34 years). A BMI of at least 25 corresponded to an inadequate composite outcome score ($P=.002$). Multivariate logistic regression analyses demonstrated that both BMIs of at least 25 ($P=.04$) and at least 30 ($P=.006$) were independent predictors of inadequate bowel preparation. Each BMI unit increase improved the probability of having an inadequate composite outcome score by 2.1%, according to the authors. In addition, other independent predictors of inadequate bowel preparation exponentially improved the probability of having an inadequate composite outcome score: 7 other risk factors identified 97.5% of overweight patients with an inadequate composite outcome score.

Helicobacter pylori Eradication Regimens

In an informal talk at the 2009 Digestive Disease Week, held in Chicago, Illinois, William Chey, MD, of the University of Michigan Health System in Ann Arbor, Michigan, and Nimish Vakil, MD, of the University of Wisconsin Medical School in Madison, Wisconsin, discussed current recommendations for *Helicobacter pylori* eradication regimens. The speakers noted that the most common treatment for *H. pylori* in the United States is antimicrobial-based triple therapy with a proton pump inhibitor and two antibiotics, though bismuth-containing quadruple therapy is an equivalent first-line treatment based on efficacy and tolerability. They also noted that alternative treatments are becoming increasingly important given the increase in the prevalence of drug-resistant strains of *H. pylori*. Sequential therapy was also highlighted as promising, but it requires validation in different patient populations. Other mentioned treatment options included levofloxacin and rifabutin. The speakers also noted that clinicians should discuss the issues of adherence, resistance, and side effects with patients at the beginning of treatment in order to maximize adherence and increase the likelihood of attaining *H. pylori* eradication.