

that is both more cosmetically acceptable and less prone to stenosis or leakage than a stoma.

**Original article** Yagmurlu A *et al.* (2006) Laparoscopic cecostomy button placement for the management of fecal incontinence in children with Hirschsprung's disease and anorectal anomalies. *Surg Endosc* 20: 624–627

## Regional anesthesia is successful for laparoscopic cholecystectomy

General anesthesia is usually used for laparoscopic cholecystectomy—as typically performed, pneumoperitoneum requires endotracheal intubation. Tzovaras *et al.* conducted a pilot study to see whether laparoscopic cholecystectomy can be successfully performed under regional anesthesia alone—regional anesthesia is associated with reduced postoperative risks, pain, and recovery time. The authors obviated the need for endotracheal intubation by using a nasogastric tube to decompress the stomach, thereby avoiding vomiting and aspiration of stomach contents. They limited any discomfort due to peritoneal irritation by using low-pressure CO<sub>2</sub> pneumoperitoneum and minimal, if any, tilting of the operating table.

Between May and July 2004, 15 patients (12 female), with a median age of 41 years (range 27–64 years), underwent laparoscopic cholecystectomy under spinal anesthesia. No major adverse events occurred during the procedures; however, two patients experienced severe shoulder pain requiring intravenous administration of fentanyl, and one patient experienced nausea, requiring administration of granisetron. Their operations were then completed uneventfully. Four patients experienced postprocedure nausea and/or vomiting, which was successfully treated with granisetron. At 2-week follow-up, 14 of the patients reported that they would recommend spinal anesthesia for laparoscopic cholecystectomy; the dissenting patient had experienced severe shoulder pain during and after the procedure, and had also developed urinary retention. No late complications were observed.

The authors conclude that regional anesthesia for laparoscopic cholecystectomy is safe and feasible. A prospective, randomized, controlled trial directly comparing general and spinal anesthesia for this procedure is currently underway.

**Original article** Tzovaras G *et al.* (2006) Laparoscopic cholecystectomy under spinal anesthesia. *Surg Endosc* 20: 580–582

## Bloating linked to abnormal abdominal-muscle activity

A team of Spanish investigators has conducted a prospective, controlled study of abdominal distention in patients with irritable bowel syndrome or functional bloating. They aimed to determine whether patients' perceived bloating was real, and, if so, whether abdominal-muscle activity was important, as the mechanisms underlying abdominal distension are unknown.

Colonic gaseous filling was performed in 12 patients and 12 healthy controls. Abdominal girth was measured and electromyographic activity was recorded at eight abdominal sites, both before and after the procedure. Patients' perception of bloating was recorded after the procedure. Colonic gaseous filling resulted in significantly greater perceived and actual abdominal distention, compared with controls ( $P < 0.05$  for both). Controls showed increased electromyographic activity in all but one abdominal muscle (internal oblique), but patients failed to show any significant increase in the activity of their lower rectus and external oblique muscles; furthermore, their internal oblique muscles showed decreased activity. The decrease in activity correlated with the increase in abdominal girth ( $r = 0.60$ ,  $P < 0.001$ ).

Although these results indicate that abdominal-muscle activity has a role in abdominal distention, the authors suggest that a combination of pathophysiologic mechanisms is probably responsible for bloating, and that these mechanisms might vary between individuals.

**Original article** Tremolaterra F *et al.* (2006) Impaired viscerosomatic reflexes and abdominal-wall dystonia associated with bloating. *Gastroenterology* 130: 1062–1068

## Stressful life events have no effect on IBD relapse rates

The effect that life events and their emotional impact have on the relapse of IBD remains unclear, but it has been hypothesized that stress exacerbates the disease. Previous studies investigating the effects of stress have been hampered by methodologic limitations, such as small sample size and recall bias. Vidal and colleagues have carried out a prospective study of patients with IBD to test this hypothesis and have overcome some of the methodologic problems encountered by previous studies.