suspected Crohn's disease ($n = 20$); those with polyposis involving the colon ($n = 6$); and those with obscure gastrointestinal bleeding ($n = 4$). In each case, the results of the capsule study were compared with those of the corresponding conventional imaging technique.

In the Crohn's disease group, lesions were identified by capsule endoscopy in 60% of patients and by conventional techniques in only 25% of patients. For the detection of polyposis, the diagnostic yield was 83% for both the capsule endoscopy and the conventional imaging techniques, but 50% more polyps were identified by capsule endoscopy. In the group with obscure gastrointestinal bleeding, capsule endoscopy diagnosed 75% of patients, whereas conventional techniques diagnosed 25% of patients.

Capsule endoscopy was well tolerated by all patients; furthermore, it is entirely noninvasive and radiation-free. The authors predict that the high diagnostic accuracy and safety of wireless capsule endoscopy will make it the standard investigation for an increasing number of small-bowel disorders in both children and adults.

Original article Guilhon de Araujo Sant'Anna AM *et al.* (2005) Wireless capsule endoscopy for obscure small-bowel disorders: final results of the first pediatric controlled trial. *Clin Gastroenterol Hepatol* **3:** 264–270

Prevention of variceal rebleeding with ligation plus nadolol

Patients suffering from portal hypertension are at high risk of repeated episodes of variceal bleeding. Current therapeutic options for preventing secondary episodes of hemorrhage of esophageal varices include β-blockers and endoscopic treatment by endoscopic variceal ligation (EVL). Although studies have shown that EVL is efficient at diminishing variceal rebleeding, variceal episodes recur at a rate of 29–50% within the first year.

de la Peña *et al.* investigated the efficacy of combination therapy with EVL and the β-blocker nadolol compared with EVL alone in patients at risk of variceal rebleeding. Cirrhotic patients aged 18–75 years with acute variceal bleeding were randomly assigned to receive EVL sessions and 40 mg nadolol daily (increasing doses until a 25% decrease in heart rate was achieved) or EVL sessions alone. After a median follow-up period of 16 months, variceal rebleeding was observed in 14% of patients receiving EVL and nadolol, compared with 38% of patients receiving EVL alone ($P = 0.006$). Analyses showed that the probability of variceal rebleeding within the first year of follow-up was also lower in the patient group treated with nadolol plus EVL, compared with EVL alone (54% vs 77%, $P = 0.06$). Mortality rates were comparable between the two groups of patients, as were the numbers of EVL sessions necessary to eradicate esophageal varices. Adverse events were observed in 11% of patients receiving nadolol and EVL.

The authors conclude that nadolol plus EVL is efficient in reducing variceal rebleeding.

Original article de la Peña J *et al.* (2005) Variceal ligation plus nadolol compared with ligation for prophylaxis of variceal rebleeding: a multicenter trial. *Hepatology* **41:** 572–578

Do thiazide diuretics increase the risk of gallbladder disease?

Following reports linking thiazide diuretics with increased biliary cholesterol saturation, it has been postulated that these drugs increase the risk of gallstone development. Leitzmann and colleagues have investigated this in their recent study in the US.

A total of 81,351 women aged 30–55 years were enrolled in this 20-year study. Use of thiazide diuretics was reported by 8% of the participants at baseline; these women maintained "fairly consistent" use of these drugs during follow-up. Cholecystectomy, used as a surrogate for symptomatic cholelithiasis, was reported by 8,607 women during the study period.

By comparing the incidence of cholecystectomy among users of thiazide diuretics and those who did not use these drugs, the authors found a positive association between the use of thiazide diuretics and the risk of cholecystectomy. The multivariate relative risk of cholecystectomy for women currently using thiazide diuretics, compared with 'never users', was 1.39 (95% CI 1.29–1.50). The corresponding risk for those who had used thiazide diuretics in the past was 1.16 (95% CI 1.08–1.24).

Leitzmann *et al.* acknowledge that these results might have been influenced by the