whether findings on repeat CE precipitated a change in management of the patient.

Jones *et al.* investigated the records of 24 patients with OGIB, who had undergone a repeat CE procedure between August 2001 and October 2003 during the establishment of a diagnosis for their condition. They discovered that the major reasons behind the undertaking of the repeat procedure were recurrent gastrointestinal bleeding and limited visualization during the initial CE. The authors also revealed that in 18 of these patients (~75%), the repeat CE resulted in additional findings such as arteriovenous malformations, gastropathy, and erosions. In 15 patients with repeated CEs (63%), these additional findings did in fact lead to changes in their management such as the undertaking of an intraoperative endoscopy, or push enteroscopy.

The authors conclude that repeat CE should be considered in patients who suffer with persistent OGIB and in whom the initial CE proved inconclusive or negative, since repetition of the test can result in a high yield of additional findings that frequently lead to changes in patient management.

Original article Jones BH *et al.* (2005) Yield of repeat wireless video capsule endoscopy in patients with obscure gastrointestinal bleeding. *Am J Gastroenterol* **100:** 1058–1064

Sargramostim activity in Crohn's disease

It has been suggested that Crohn's disease might be the result of an inherent defect of the intestinal immune system, and thus stimulation, rather than suppression, could be an alternative therapeutic option. Sargramostim, a yeast-derived granulocyte-macrophage colony-stimulating factor, may help to maintain and enhance the intestinal innate immune system and thus decrease inflammation.

A randomized, placebo-controlled trial was carried out in adults with moderate-to-severe Crohn's disease, defined as a Crohn's Disease Activity Index score of 220–475. A total of 124 patients were randomly allocated in a 2:1 ratio to receive sargramostim (6 μg/kg body weight) or placebo, administered daily by subcutaneous injection, for 56 days. The primary endpoint of the study was a decrease of at least 70 points from baseline in the Crohn's Disease Activity Index score; secondary endpoints included a decrease of 100 points, remission, and an increase in health-related quality of life.

There was no significant difference between the two groups in terms of primary outcome; however, significantly more patients in the sargramostim group had reached the secondary endpoints of a decrease of 100 points or remission by day 57 compared with placebo. In addition, at 30 days post-treatment, sargramostim patients had higher response and remission rates, and significantly greater improvements in health-related quality of life at all evaluation points of the study.

Korzenik and colleagues conclude that, despite a negative finding with regard to the primary endpoint, secondary endpoints suggest a beneficial role for sargramostim in Crohn's disease in terms of severity of symptoms and quality of life, and propose that "…a treatment designed to modulate intestinal innate immune defense may have a role in patients with Crohn's disease". However, they stress that the role of granulocyte-macrophage colony-stimulating factors in Crohn's disease remains to be defined.

Original article Korzenik JR *et al.* (2005) Sargramostim for active Crohn's disease. *N Engl J Med* **352:** 2193–2201

Statin use and risk of colorectal cancer

Statins inhibit 3-hydroxy-3-methylglutaryl coenzyme A reductase, an enzyme involved in cholesterol synthesis and growth control, and are used to control hypercholesterolemia; however, a role in the chemoprevention of cancer has also been proposed. In order to clarify the association between statins and colorectal cancer, Poynter and colleagues have evaluated data from the Molecular Epidemiology of Colorectal Cancer study.

This population-based, case-control study included 1,953 colorectal cancer patients from northern Israel, diagnosed between May 1998 and March 2004. In addition, 2,015 controls were identified from the same population and were individually matched to patients according to year of birth, gender, clinic location and ethnic group. Standardized interviews were used to obtain demographic data and a dietary questionnaire was completed. Medications used over the last 5 years were recorded, from which statin intakes were determined and their