endpoint. Primary safety endpoints were hematologic, biochemical and clinical adverse events at day 56, compared with placebo.

Significantly more patients treated with 200 mg or 300 mg RDP58 achieved treatment success than did patients in the placebo group ($P = 0.016$). The 100 mg dose was not effective. Adverse events were similar between patients treated with placebo and those treated with 100–300 mg RDP58. This lack of hematologic, biochemical and other toxicities is consistent with the topical action of RDP58 on colonic epithelial cells. The authors state that RDP58 cannot be detected systemically at the current limits of sensitivity.

Travis *et al.* conclude that RDP58 at doses of 200 mg or 300 mg given for 28 days is a promising and safe treatment for patients with ulcerative colitis. Further studies are needed to determine the optimal dose of RDP58, and to confirm its mechanism of action.

Rebecca Ireland

Original article Travis S *et al.* (2005) RDP58 is a novel and potentially effective oral therapy for ulcerative colitis. *Inflamm Bowel Dis* **11:** 713–719

Single-stage diagnosis and resection of submucosal colorectal lesions

High-frequency endoscopic ultrasound (HFUS) using a miniprobe accurately diagnoses and stages T1 mucosal and submucosal colorectal tumors. Hurlstone *et al.* have now shown that this technique can be a safe and effective guide for endoscopic mucosal resection (EMR) of these lesions, which means that patients could potentially be treated with a single-stage HFUS/EMR procedure. This finding represents a substantial improvement on conventional management, in which patients are typically offered either surgical resection or endoscopic observation, often without histologic diagnosis.

After an index colonoscopy to confirm the presence of a single mucosal or submucosal lesion <20 mm in diameter, 30 of 33 eligible patients had lesions that met the inclusion criteria and subsequently underwent HFUS-guided EMR. In three cases the lesion could not be detached from the muscularis propria and was surgically resected. The remaining 27 lesions were successfully excised by EMR, and histologic analysis showed that all 27 had negative resection margins. Only one patient suffered minor bleeding at the time of surgery; this low rate might be attributable to the use of an adrenaline-containing submucosal injection solution. No local recurrence was detected in any of the 27 cases at endoscopic follow-up (range 4–18 months). One limitation of the study, however, was that the EMR technique used was not suitable for lesions >20 mm.

While the results are encouraging, it is worth remembering that HFUS-guided EMR is currently recommended only for highly demarcated hypoechoic lesions without umbilication—those most likely to become malignant.

Caroline Barranco

Original article Hurlstone DP *et al.* (2005) 20-MHz high-frequency endoscopic ultrasound-assisted endoscopic mucosal resection for colorectal submucosal lesions: a prospective analysis. *J Clin Gastroenterol* **39:** 596–599

GLOSSARY

ENDOLUMINAL GASTROPLICATION
The suturing of folds in the gastroesophageal junction to reduce its circumference by using an instrument passed through the esophagus

New endoscopic antireflux device has poor long-term efficacy

Endoscopic treatment of gastroesophageal reflux disease offers the potential benefit of allowing patients to avoid long-term use of antisecretory medication and the risks associated with laparoscopic surgery. One endoscopic technique, ENDOLUMINAL GASTROPLICATION using the EndoCinch™ device (BARD Endoscopic Technologies, Billerica, MA), has demonstrated little long-term efficacy owing to suture loss or inadequate plication. In this German, single-center study, Schiefke *et al.* investigated the efficacy and safety of the newer ESD® endoluminal suturing device (Wilson-Cook Medical, Winston-Salem, NC) in 20 patients with >2 years chronic reflux who had relapsed after EndoCinch™ treatment.

The authors used the ESD® to perform endoluminal gastroplication at no less than three points at the gastroesophageal junction. They measured clinical status (by endoscopy, 24 h pH monitoring, use of acid-suppressive medication and esophageal manometry), reflux symptoms and subjective quality of life, before and 6 months after plication.

The ESD® procedure was successfully completed in all patients. Six months after surgery, however, only one patient had all sutures present; three patients had no sutures