Colon-cleansing efficacy of residue-free sodium phosphate tablets

Sodium phosphate tablets are the colon-cleansing agents preferred by patients in preparation for colonoscopy; however, the standard formulation includes microcrystalline cellulose, which forms a residue in the colon that could hinder the examination. Rex *et al.* compared the colon-cleansing efficacy of a new, residue-free (RF) sodium phosphate formulation with that of the standard formulation.

Participants ($n = 704$) were randomly allocated into three similar-sized groups: one group received 40 tablets (60 g) of the standard sodium phosphate formulation; the other two groups received either 40 tablets (60 g) or 32 tablets (48 g) of the new formulation (RF-40 and RF-32 groups). An 'excellent' cleansing rating was given for 76% of patients in the RF-32 group and for 73% of those in the RF-40 group, compared with 51% of patients in the standard-formulation group. Overall colon-cleansing scores were significantly better in the RF-32 and RF-40 groups than the standard-formulation group ($P < 0.0001$). For the ascending colon, overall cleansing response rates were 93.6% for the RF-32 and 95.7% for the RF-40 group, compared with 88.5% for the standard-formulation group ($P < 0.03$). Fewer patients who received the new formulation than those who received the standard formulation required irrigation to clear colonic material.

The authors conclude that the new sodium phosphate tablets provide superior cleansing compared with conventional tablets; they are also smaller and smoother, and consequently were considered easier to take by patients. As there was no difference in efficacy between the RF-32 and RF-40 regimens, the authors recommend the 32-tablet regimen.

Original article Rex DK *et al.* (2006) Safety and colon-cleansing efficacy of a new residue-free formulation of sodium phosphate tablets. *Am J Gastroenterol* **101:** 2594–2604

Minimally invasive treatment strategy for Budd–Chiari syndrome

Occlusion of the inferior vena cava or hepatic vein causes Budd–Chiari syndrome (BCS), which can lead to liver failure. BCS has a 1-year spontaneous mortality rate reported to approach 70%, and many treatments have been proposed for the condition. Plessier *et al.* report on their strategy of commencing therapy with the least-invasive treatment, followed by successively more-invasive procedures in patients who do not respond. Use of this strategy in 51 consecutive patients who presented with BCS produced overall 1-year, 3-year and 5-year survival rates of 96%, 89%, and 89%, respectively.

Anticoagulation therapy was the first-line treatment; a complete response was obtained in nine patients, and one patient died of hematologic disease. Recanalization was carried out in the 14 patients who had an adequately short stenosis; this procedure resulted in a complete response in 7 patients. Of the remaining 34 patients, 25 were suitable for transjugular intrahepatic portal shunt placement; this intervention was successful in 21 patients, although 1 required transplantation 4 months later. Two patients died from procedure-related complications. The remaining 11 patients underwent liver transplantation (median time from anticoagulation initiation, 12 months), 1 of whom died from sepsis. In total, 5 of the 51 patients who commenced treatment died.

The authors conclude that a strategy of increasing the invasiveness of treatment according to patient responses produces excellent medium-term survival rates. The liver-transplant success rate suggests that performing transplantation only when other interventions have failed does not compromise patient survival.

Original article Plessier A *et al.* (2006) Aiming at minimal invasiveness as a therapeutic strategy for Budd–Chiari syndrome. *Hepatology* **44:** 1308–1316

Sacral nerve stimulation is a cost-effective treatment for fecal incontinence

Several studies have demonstrated excellent results for sacral nerve stimulation (SNS) in the treatment of incapacitating fecal incontinence. The devices used for SNS are expensive, however, and no cost–benefit analyses were previously available.

Hetzer and colleagues prospectively assessed outcome parameters and real costs in 36 consecutive patients who underwent a two-stage procedure, which consisted of a 2–3 week trial of SNS followed by permanent neurostimulator

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