patients (mean age 56 years) NaP (3 tablets every 15 mins; total dose 40 tablets) or RF-NaP (3 or 4 tablets every 15 min; total dose 28, 32, or 40 tablets). Administration was started on the evening before colonoscopy and finished on the same evening or was split and finished the next morning, dependent on regimen.

The overall cleansing of colonic contents in patients who received a split dose of 40 RF-NaP tablets in doses of 4 every 15 mins was 100%. More than 90% overall cleansing (range 90–97%) was achieved with all RF-NaP regimens except the 28-tablet evening-only regimen, which produced 72% cleansing. The NaP regimen achieved 86% cleansing. Adverse events reported with RF-NaP were similar to those with NaP and included abdominal distension, nausea, and abdominal pain; however, 97% of all adverse events were mild or moderate.

The authors conclude that RF-NaP administered as a split dose is well tolerated and effective even with a total of 28 tablets. They suggest that use of RF-NaP will improve bowel preparation and reduce the need for repeat colonoscopies.

Original article Wruble L *et al.* (2007) Residue-free sodium phosphate tablets (OsmoPrep) versus Visicol for colon cleansing: a randomized, investigator-blinded trial. *Gastrointest Endosc* **65:** 660–670

Endoscopic stent placement for pain relief in patients with chronic pancreatitis

Surgery provides pain relief in 40–60% patients with chronic pancreatitis, pancreatic duct strictures and pancreatic duct stones; however, severe complications can occur. Endoscopic stent placement has been recommended as an alternative treatment for this condition.

Weber *et al.* evaluated the long-term benefits of endoscopic retrograde pancreatography (ERP) and stenting of the pancreatic duct in 19 patients with chronic pancreatitis and intermittent or continuous pain, ductal stenosis (with or without stones) and dilatation of the pancreatic duct. The stent was extracted or replaced depending on the findings during follow-up control ERPs; follow-up interviews enabled relapse rates 1 and 2 years after stent extraction to be considered.

Endoscopic stent placement (mean duration 5.6 months) reduced pain in 17 of 19 patients: cannulation and stent insertion could not be achieved in 2 patients. Increases in pain relative to that experienced after the initial stenting were reported in only 3 of 17 patients interviewed 1 year after stent extraction and in only 2 of 13 patients interviewed 2 years after stent extraction (1 patient was not available to be interviewed).

The authors acknowledge that the small patient cohort limited the scope of their study; however, they conclude that endoscopic stenting is safe and effective for relieving recurrent abdominal pain caused by chronic pancreatitis. As pain symptoms recurred in approximately 30% of patients within 2 years it has yet to be determined whether this procedure is preferable to surgery in the long-term.

Original article Weber A *et al.* (2007) Endoscopic stent therapy for patients with chronic pancreatitis – results from a prospective follow-up study. *Pancreas* **34:** 287–294

Granulocytapheresis for ulcerative colitis shows early promise in a pilot study

Bresci and colleagues compared the efficacy and tolerability of granulocytapheresis with corticosteroid therapy in patients with ulcerative colitis. Corticosteroids are often administered at high doses, and frequently cause adverse effects. Granulocytapheresis involves extracorporeal filtering of granulocytes and monocytes—cells involved in the pathogenesis of ulcerative colitis—out of blood.

This pilot study included 40 patients with ulcerative pancolitis, who had not previously taken steroids or immunosuppressive agents. Patients were randomly allocated to undergo granulocytapheresis once weekly for 5 weeks, or receive methylprednisolone 0.8–1.0 mg/kg per day (intravenous or intramuscular) for 5 weeks, with dose reduction after 2 weeks if clinical findings improved. Both groups received concomitant, delayed-release mesalamine (2.4 g per day) throughout. Disease activity was evaluated with the endoscopic index (EI, at baseline and at 6 weeks) and clinical activity index (CAI, at baseline, then weekly for 6 weeks).

After 6 weeks, a complete clinical response (defined as CAI<6, EI<4) was achieved in 70% and 60% of patients treated with granulocytapheresis and methylprednisolone,