greater weight loss than those in the placebo group. Patients treated with the higher dose of the drug fared significantly better than the placebo group in terms of insulin resistance and prevalence of the metabolic syndrome, and also showed significantly greater reductions in waist circumference. In addition, rimonabant was associated with significant improvements in HDL-cholesterol and triglycerides, which could not be attributed solely to the observed weight loss.

Noting that the drug was generally well tolerated, the investigators conclude that this strategy shows promise in the treatment of obesity and its associated cardiovascular risk factors.

Original article Van Gaal LF *et al.* (2005) Effects of the cannabinoid-1 receptor blocker rimonabant on weight reduction and cardiovascular risk factors in overweight patients: 1-year experience from the RIO-Europe study. *Lancet* **365:** 1389–1397

Gemcitabine plus capecitabine in biliary cancer

Biliary cancer has a poor prognosis. Surgical resection is a potential cure; however, only 25% of patients are resectable at presentation and relapse rates are high. The median survival time for unresectable biliary cancer is <1 year. There is currently no standard chemotherapy that can clearly prolong survival, but newer chemotherapies such as gemcitabine, newer fluorouracil regimens, capecitabine and platinum analogs seem to be active. Combinations of newer drugs may be more active still.

In this single-institute trial in 45 patients with locally advanced or metastatic biliary cancer, patients received a three-week cycle of oral capecitabine 650 mg/m^2 twice-daily for 14 days with 30-minute intravenous gemcitabine 1000 mg/m^2 on days 1 and 8 of the cycle. 23 patients had cholangiocarcinoma and 22 had gallbladder cancer.

The overall response rate was 31% and disease stabilization was 42%, giving an overall disease-control rate of 73%. Median progression-free survival for disease-controlled patients was 10 months, and median overall survival was 14 months. Overall response rates for cholangiocarcinoma and gallbladder cancer were similar, but there was a shorter median survival in patients with gallbladder cancer, which probably reflects its more aggressive biology. The combination was generally tolerated well: no patients discontinued because of toxicity and there were no treatment-related deaths.

The authors conclude that the amount of antitumor activity seen and the tolerable toxicity profile may yield benefits for this population. A large, multicenter, randomized trial to determine whether this combination is superior to a single agent is warranted, and has the potential to change global practice.

Original article Knox JJ *et al.* (2005) Combining gemcitabine and capecitabine in patients with advanced biliary cancer: a phase II trial. *J Clin Oncol* **23:** 2332

Elevated rectal cancer risk following prostate radiation

Radiation therapy for prostate cancer has been linked to an elevated risk of bladder cancer and other pelvic malignancies. A recent study by Baxter *et al.* now reveals that the risk of rectal cancer is similarly increased.

Using Surveillance, Epidemiology, and End Results registry data, a retrospective analysis was carried out on 85,815 men diagnosed with prostate cancer between 1973 and 1994. By comparing the incidence of rectal cancer in men who underwent radiation treatment (n = 30,552) and those who underwent surgery only (n = 55,263), an independent association was found between radiation treatment and development of rectal cancer. After adjusting for other factors, this corresponded to a 1.7-fold increase in risk in the radiation-therapy group, compared with the surgery-only patients. No significant associations were found between radiation therapy and the development of tumors at potentially irradiated sites (rectosigmoid, sigmoid and cecum) or in the remainder of the colon; thus, the observed increase in the risk of cancer was related to highly irradiated tissue only.

While these findings are unlikely to affect prostate cancer treatment patterns, the authors point out that there are implications for colorectal cancer screening. They recommend that screening for rectal cancer should start 5 years after prostate cancer radiation therapy.

Original article Baxter NN *et al.* (2005) Increased risk of rectal cancer after prostate radiation: a population-based study. *Gastroenterology* **128:** 819–824