

Rectosigmoid tone of patients with IBS

There is no accurate test for a positive diagnosis of IBS, despite the high incidence of the condition; at present, arbitrary criteria are used to arrive at the diagnosis. There are two clinical patterns of IBS—constipation-predominant and diarrhea-predominant—and there have been conflicting reports as to whether altered sensation and/or motor activity in the intestine result in the alterations in motility that give rise to the symptoms associated with this condition.

Di Stefano *et al.*, therefore, measured the postprandial rectosigmoid response of patients with and without IBS, using the rectosigmoid barostat test (they assessed 32 patients with constipation-predominant IBS, 24 patients with diarrhea-predominant IBS, 10 patients with functional diarrhea, 10 patients with functional constipation, 29 patients with organic gastrointestinal disease, and 10 healthy volunteers).

Healthy individuals and patients with organic disease had a reduced rectosigmoid volume after consuming a 200 kcal meal (compared with their fasting rectosigmoid volumes), which indicated a postprandial increase in muscle tone. By contrast, patients with diarrhea-predominant IBS had a postprandial reduction in rectosigmoid tone, and patients with constipation-predominant IBS had little or no postprandial change in muscle tone.

The authors conclude that patients with IBS have an altered gastrorectal reflex, and that the postprandial response patterns differ for patients with constipation-predominant and diarrhea-prominent IBS. They highlight the need for large trials to evaluate the use of postprandial rectosigmoid tone modification as a diagnostic test for IBS.

Original article Di Stefano M *et al.* (2006) Meal induced rectosigmoid tone modification: a low caloric meal accurately separates functional and organic gastrointestinal disease patients. *Gut* 55: 1409–1414

Use of optical access trocars in laparoscopic gastric-bypass procedures

Injury to intra-abdominal structures is a common complication of laparoscopic surgery that is usually caused by blind insertion of trocars.

Some surgeons insert the first trocar using an 'open' minilaparotomy incision, but this technique is time-consuming and associated with air leaks in obese patients, and does not obviate the risk of bowel injury. To decrease the risk of such adverse events, optical access trocars have been developed that allow for the layers of the abdominal wall to be visualized during placement.

Berch and colleagues have now reported on a single surgeon's experience using the Optiview[®] trocar (Ethicon Endosurgery, OH, USA) for 327 laparoscopic gastric-bypass operations that were performed on morbidly obese patients. Access was successfully obtained with this device in all patients, without air leaks, and it gave excellent visualization. No adverse events were reported over a median follow-up period of 18 months (i.e. there were no port-site hernias and no trocar-related viscus or vascular damage). The time taken to insert the optical access trocar was only recorded in 10 patients, in whom the mean time taken was 28 s ± 1.2 s.

The very low complication rate reported in this study is consistent with other published reports that describe use of the optical access trocar. The authors conclude that, when inserted properly, this trocar is safe for use in morbidly obese patients undergoing laparoscopic gastric-bypass procedures.

Original article Berch BR *et al.* (2006) Experience with the optical access trocar for safe and rapid entry in the performance of laparoscopic gastric bypass. *Surg Endosc* 20: 1238–1241

Moderate portopulmonary hypertension need not preclude liver transplantation

Portopulmonary hypertension is a relatively common complication of end-stage liver disease. Mild disease is not a contraindication to liver transplantation, but moderate disease is associated with high perioperative mortality and severe disease is an absolute contraindication to transplantation. The results of a new US study, however, suggest that moderate-to-severe disease need not preclude the possibility of liver transplantation. It might be possible for portopulmonary hypertension to be controlled by therapy with a vasodilator such as epoprostenol, and cured by subsequent liver transplantation.