Gastroenterology Elsewhere


Systemic antibiotics combined with percutaneous drainage is the mainstay of treatment of pyogenic liver abscess (PLA).

Sixty-four subjects with PLA (>3 cm size) were started on intravenous antibiotics (ampicillin, cefuroxime, metronidazole) and then randomized to continuous catheter drainage (CCD; 8F male-pigtail catheter, n=32, median age 50 y) or intermittent needle aspiration (INA; 18G trocar needle, n=32, median age 57 y). Subjects with expected life-span <2 mo due to associated disease, or in whom other antibiotics had been started, were excluded. Intravenous antibiotics were given until fever had subsided or for at least 7 days; thereafter, oral antibiotics were given for a total of 6 weeks. Catheter was removed if there was no drainage for >24 h and sonography showed disappearance or reduction or stabilisation of abscess cavity with clinical recovery. Needle aspiration was repeated if there was no clinical improvement or no reduction in size of the abscess.

The duration of intravenous antibiotics required was similar in the two groups. Klebsiella was the commonest organism isolated. Aspiration was done once in 13, twice in 13, and ≥3 times in 6 subjects in the INA group. Median duration of CCD was 13 (4-52) days. Ultrasonography before discharge showed absence of abscess cavity in 50% of subjects in both groups. The time to clinical response was similar. No procedure-related complications were seen. One subject each required surgery. Median hospital stay was slightly longer with CCD (15 vs 11 d; p=0.12). Treatment was successful in 27 patients with CCD and 30 with INA (p=0.42). Four subjects with CCD and one with INA died (p=0.35); all patients in the CCD group who died had malignancy.

INA and CCD were equally effective for the treatment of PLA. INA is cheaper and simpler, with greater patient comfort and no catheter-related problems.


Compliance with gluten-free diet (GFD) is a major issue in the management of celiac disease (CD). There has been controversy about the need to eliminate oats from the diet of such patients.

One hundred and sixteen patients with CD (age 6.5 y [8 mo-17.5 y]) were randomized to standard GFD (n=59) or to GFD with oats (n=57) for one year. The oats were specially grown and tested for absence of gluten.

Twenty-two children withdrew from the study (15 GFD-oats and 7 GFD; p=0.08), the commonest reasons being abdominal pain and diarrhea (6 on GFD-oats and 2 on GFD); this was more frequent in children aged below 2 years. Ninety-two children (GFD 50, GFD-oats 42) completed the study. Median daily intake of oats was 15 g in the GFD-oats group. All patients were in clinical remission, and all except 2 in the GFD group had normal follow-up intestinal histology. The two groups had similar serological response (EMA and IgG).

Thus, addition of oats to standard GFD is well tolerated by children with CD over one year and does not prevent clinical or histological improvement.


There is controversy regarding the natural history of non-alcoholic fatty liver disease (NAFLD), especially in terms of risk of cirrhosis.

Two hundred and fifteen subjects with histologic diagnosis of pure fatty liver during 1976-87 were identified through a computerized register. Subjects with other cause of liver disease, malignancy, HIV infection, jejunostomy bypass or on TPN were excluded. One hundred and twenty-one patients were followed up until death or December 1999. Those with alcohol intake >35 g/day or an alcohol-related diagnosis during follow-up were considered to have alcoholic fatty liver. Patients were labeled to have cirrhosis if this diagnosis was included in a discharge or death certificate or was established histologically on follow-up.

Subjects with alcoholic fatty liver (n=106, age 50 [26-72] y) and NAFLD (n=109, 39 [19-80] y) were followed up for 9.2 (0.6-23.1) and 16.7 (0.2-21.9) y, respectively. Those with NAFLD had obesity more often (81% vs 30%). At the time of index biopsy, diabetes was less frequent (3% vs 9%), AST (44 [10-576] vs 25 [9-20] U/L) and bilirubin (10 [3-57] vs 7 [2-49] U/L) levels were higher, and albumin (584 [303-726] vs 630 [407-754 micromol/L]) lower in the alcoholic group. Only one patient (1%) with NAFLD developed cirrhosis as compared to 22 (21%) with alcoholic liver disease. A total of 106 subjects died during follow up (79 with alcoholic liver disease vs. 27 with NAFLD), including 20 and 1, respectively, with liver disease as the cause. Survival in the NAFLD group was longer than in the alcoholic group and was similar to that of the Danish population.

Subjects with non-alcoholic pure fatty liver disease thus had a benign course without excess risk of cirrhosis or death.

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