Table 1. Clinical backgrounds of the patients undergoing or not undergoing LCAP

Factors	LCAP + ($n = 29$)	LCAP − ($n = 43$)	*P* value
Sex (F:M)	8:2	19:2	0.6050
Truelove and Witts' categories (mild:moderate:severe)	8:17:4	18:19:6	0.4276
Matts grade classification (1:2:3:4)	4:5:6:2	5:12:12:1	0.5084
Age at operation (years)	31.1 ± 2.0	34.0 ± 2.4	0.5203
Age at disease onset	25.2 ± 1.8	27.0 ± 2.2	0.7566
Disease duration (years)	6.9 ± 0.93	6.9 ± 0.95	0.5315
Albumin (g/dl)	3.5 ± 0.1	3.4 ± 0.1	0.3614
Hemoglobin (g/l)	11.7 ± 0.4	11.0 ± 0.4	0.2005
Choline esterase (ΔpH)	0.65 ± 0.05	0.72 ± 0.05	0.4316
Body mass index (kg/m^2)	19.1 ± 0.6	20.1 ± 0.5	0.893
Total amount of steroids (g)	14.7 ± 2.1	11.6 ± 1.7	0.1795
Surgical duration (min)	273 ± 13	258 ± 12	0.1701
Operative blood loss (g)	358 ± 41	620 ± 87	0.053
Perioperative blood transfusion (Y:N)	5:24	12:31	0.2960
Covering ileostomy (Y:N)	27:2	34:9	0.1045
Surgical site infection (Y:N)	3:26	23:20	<0.01

LCAP, leukocyte apheresis

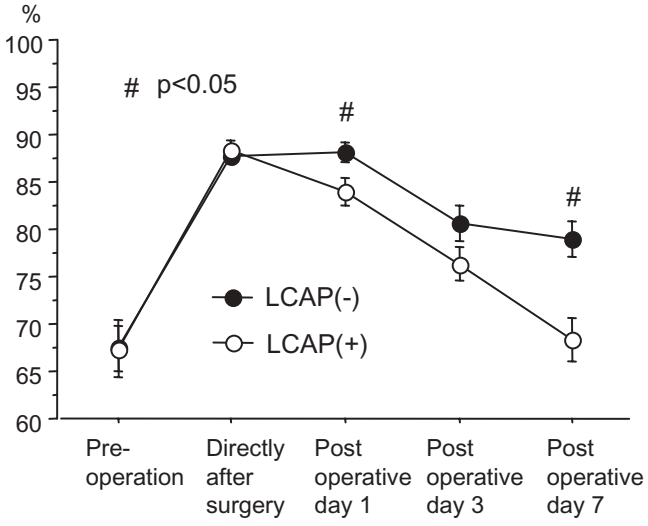

Fig. 1. Serial changes in the percentage of peripheral neutrophils in patients undergoing or not undergoing leukocyte apheresis

were observed. SSIs were identified in 23 (53%) patients without LCAP: 11 had incisional SSIs and 12 organ/space SSIs. By contrast, only three patients undergoing LCAP developed SSIs: two had incisional SSIs and one an organ/space SSI (Table 1). To assess the elimination rate of neutrophils, we counted the numbers of circulating lymphocytes and neutrophils and assessed the changes in the percentage of neutrophils in white blood cells as described by Kobayashi and Yamauchi.[4] Interestingly, the postoperative percentage of peripheral neutrophils was significantly suppressed in the LCAP (+) group, suggestive of some control of the systemic inflammatory response in these patients (Fig. 1). It has been hypothesized that surgical UC patients carry a considerable risk for a neutrophil respiratory burst after intense surgical stress, which results in higher rates of morbidity and complications.[5] Although our study was preliminary, the indications are that early postoperative LCAP therapy may control neutrophil hyperactivation, leading to an improved clinical outcome following IPAA. Larger controlled studies are needed to confirm the clinical advantages of this novel strategy.

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Received: January 12, 2007 / Accepted: February 22, 2007
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DOI 10.1007/s00535-007-2035-y

IBS and depression in young adults in Turkey: results of a questionnaire survey

To the Editor: We read the article by Shiotani et al.[1] with great enthusiasm. These authors stated that epidemiological studies of irritable bowel syndrome (IBS) among young adults are few, especially in Asian countries. We have just finished the first part of a similar study in Abant Izzet Baysal University in Turkey. We

recruited students from our university newly enrolled during the 2005–2006 school year. Self-administered questionnaires were sent to the addresses of the eligible students before matriculation to the university. In all, 2217 students filled out the self-administered questionnaires (which included Rome II criteria for functional gastrointestinal disorders and Beck's Depression Inventory). The median age of the students was 18.7 (range, 15.2–31.1 years). Of the 2217 questionnaires, 2045 were regarded as valid. The prevalence of IBS was 10.8% (n = 220); 45.0% of cases were constipation-predominant (C-IBS), 17.7% were diarrhea-predominant (D-IBS), and 37.3% were nonspecific IBS. The prevalence of IBS was also more common in women than in men (14.0% vs. 7.1%, $P < 0.001$). C-IBS was predominant in women, whereas D-IBS was more common in men. This study thus yielded very similar results to those of the study of Shiotani et al.,[1] indicating that eastern and western Asia might have similar prevalences of IBS in young adults. Moreover, the distribution of IBS subtypes was also similar in that C-IBS was more common in women whereas D-IBS was more common in men.

Might depression account for this difference?[2] It seems so, but not in the way that is thought. In our study, we found that depression increased the risk of IBS 2.8 times (95% confidence interval, 1.8–4.2). However, this increase was valid only for the male subjects. The prevalence of IBS was 5.9% in nondepressed men, whereas it was 17.6% in depressed men ($P < 0.001$). The presence of depression only slightly increased the prevalence of IBS in women, from 13.8% to 19.1% ($P = 0.3$). Contrary to what is reported in the literature, depression was also more common in men than in women (8.4% vs. 5.5%, respectively, $P = 0.019$).

Our study population consisted mostly of young people (99.3% of study population was 15–24 years of age) who were just about to begin university studies. Attending a university might bring about major changes in a student's life, which might be a source of stress.[3] Also, this period of life is the threshold between adolescence and adulthood. For these reasons, it is important to follow these students with respect to differences in the prevalence of depression and IBS over time. Even though they might not be representative of the general population, careful surveillance of young people during this period of their life and management of risk factors might provide new insights into the pathogenesis and treatment of IBS.

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Received: January 3, 2007 / Accepted: February 4, 2007
Reprint requests to: G. Baysoy
DOI 10.1007/s00535-007-2023-2

Is oral combination therapy with a proton-pump inhibitor and H2 receptor antagonist effective as initial treatment?

To the editor: We have reported findings that an H_2 receptor antagonist (H_2RA) acts significantly faster and provides stronger inhibition of intragastric acid secretion than proton-pump inhibitors (PPIs)[1,2] and have assessed the effects of intravenous administration of a PPI and a H_2RA in combination as the initial treatment.[3] In our previous study, the administration of omeprazole plus famotidine increased intragastric pH more rapidly than either omeprazole alone or famotidine alone in healthy volunteers.[3]

Six healthy male volunteers, median age, 22.5 years (range, 21–41 years), participated in our randomized, crossover study. All subjects were negative for anti-*Helicobacter pylori* immunoglobulin G antibodies (SRL, Tokyo, Japan), and the subjects were genotyped for their isoenzyme CYP2C19 profiles: three were homozygous extensive metabolizers (homo-EM), three were heterozygous extensive metabolizers (hetero-EM), and none were poor metabolizers (SRL).

All subjects were given a 30-mg lansoprazole capsule (LPZ), a 10-mg lafutidine tablet (LAF), and 30 mg LPZ plus 10 mg LAF orally at different times, with a washout period of at least 7 days between each. The subjects fasted overnight before each dose and for 6 h after taking it. An antimony or glass pH electrode was inserted transnasally, and its tip was positioned in the body of the stomach. Gastric pH was measured with a pH meter after administration, and the data were analyzed with established software (Chemical Instrument, Tokyo, Japan). Statistical evaluations were performed with the Friedman test and the Wilcoxon signed-ranks test, and P values < 0.05 were considered significant. The studies were conducted in accordance with the Declaration of

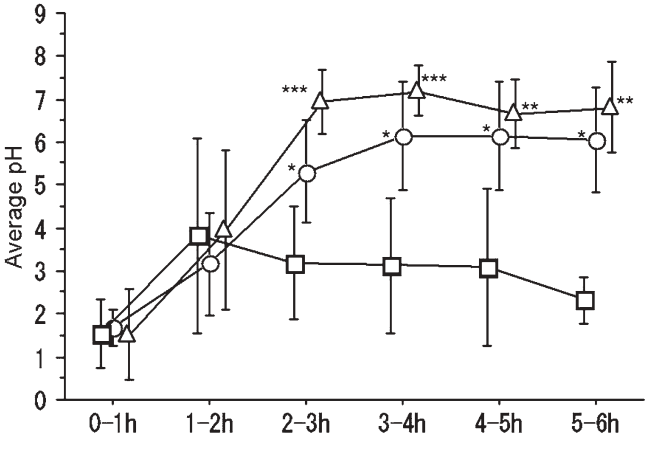

Fig. 1. Average pH after lansoprazole (LPZ) plus lafutidine (LAF) (*triangles*), LPZ alone (*squares*), and LAF (*circles*) alone. ***$P < 0.05$, comparison among LPZ plus LAF, LPZ alone, and LAF alone. **$P < 0.05$, LPZ plus LAF versus LPZ alone. *$P < 0.05$, LAF alone versus LPZ alone. Friedman test and the Wilcoxon signed-ranks test. Symbols represent mean values; bars show ± SD