the recent group (89%) as compared to the past (77%). Although more patients were treated in the recent group, racial disparity for treatment remained (10% Cau vs 2% AA for previous and 48% Cau vs 37% AA in recent). There was no significant difference between fibrosis as assessed by APRI (1.1 vs 0.9) or FIB-4 (2.4 vs 2.6). Recent patients had slightly increased Metavir liver biopsy fibrosis scores (1.7 vs 2.0, p=0.05 or chi-squared 0.002) but recent patient biopsy numbers are lower than in the past (375 vs 75). The majority of recent patients were still naive to treatment (61% recent vs 96% past) and few had cirrhosis (27/405 = 7% recent vs 44/1141 = 11%).

Conclusion: Although the patients in this urban GI referral clinic are older, the majority have not been treated and do not have a history of recurrent bleeding. They also do not have more advanced liver disease either as defined by fibrosis or cirrhosis than patients in the past. The reason that recent patients do not have more severe liver disease could be that current patients are being detected earlier by surveillance or are progressing more slowly to advanced liver disease. The role of access to therapy with respect to the numbers of patients not treated remains to be determined.

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The Comparative Effectiveness of Upper Endoscopy and Angiographic Embolization in Achieving Hemostasis for Recurrent Non-Varietal Upper Gastrointestinal Bleeding
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Introduction: Non-variceal upper gastrointestinal bleeding (NVUGIB) remains a significant source of morbidity and mortality. Consensus recommendations currently advocate for vascular angiography with embolization as an alternative to surgery when endoscopic hemostasis for NVUGIB has failed. There is a paucity of direct comparative data to support endoscopic therapy over angiographic embolization with recurrent NVUGIB. The purpose of this study was to determine the comparative effectiveness of repeat upper endoscopy and angiographic embolization in recurrent NVUGIB.

Methods: Patients admitted to the Cleveland Clinic ICU between January 2008 to November 2011 for the initial evaluation of NVUGIB (confirmed on EGD) were included. Rebleeding was defined as NVUGIB within 30 days of initial bleed. Patients with recurrence were subsequently stratified as to whether they underwent repeat EGD, angiography and/or surgery: The clinical and endoscopic characteristics of patients with rebleeding were reviewed and compared with those without rebleeding. A multivariable analysis was performed to assess factors associated with re-bleeding after the 1st recurrent event and subsequent episodes.

Results: 249 patients (64 ± 13 years, 38% female, average BMI of 30) presented with NVUGIB and had initial EGD for management. The most common indication was melena (51%) and 83% had an ulcer in the stomach. 107 patients (43%) had recurrent NVUGIB. 51% had EGD treatments to manage their bleeding. Average ICU length of stay was 182 days with a mortality rate of 22%. Subjects receiving repeat EGD were 3.5 times more likely to achieve hemostasis after 1st recurrent event (p=0.025). For every 1-unit increase in Hemoglobin and 25-unit increase in platelet count at time of recurrent bleed, the odds of achieving hemostasis increased by 50% (OR=1.5; p=0.012) and 10% (p=0.046), respectively. Subjects who had EGD+IR or Surgery were more likely to have recurrent events than those who had EGD treatment only (p < 0.001). No mortality benefit was recognized.

Conclusion: This study is the first of its kind to directly compare the effectiveness of EGD vs angiographic embolization in recurrent NVUGIB. Subjects who received EGD for the first recurrent bleeding episode were 3.5 times more likely to achieve hemostasis. This is noteworthy and underscores the possibility of endoscopic hemostatic superiority and validates consensus recommendations of repeating upper endoscopy as the next step after initial successful hemostasis.

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Seasonal Variation in Peptic Ulcer Disease Hospitalization: A 10-year Perspective in the U.S.
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Introduction: Seasonal variation in peptic ulcer disease (PUD) has been previously reported, but has been poorly investigated due to the lack of large-scale studies and, thus, poorly understood.

Methods: With the use of the Nationwide Inpatient Sample from 2000 through 2011, we identified PUD-related hospitalizations using International Classification of Diseases (ICD-9), 9th Revision, Clinical Modification code 531.00 to 534.91 as the principal discharge diagnosis. The total number of hospitalizations for each calendar month of the year, added over 12 years period (2000–2011), was calculated and this number was divided by number of days in that particular month to obtain the mean hospitalizations per day for each month.

Results: An estimated 331,920 hospitalizations with the primary diagnosis of peptic ulcer disease (PUD) occurred in the US from the beginning of calendar year 2000-2011. Mean age of the study population was 66.2 ± 17.4 (mean ± SD). 47.5% were females and 73.9% were White. Depending on the average daily hospitalization for each calendar month of the year, the number of hospitalization was highest in the winter season and lowest in the fall season. There was a rising trend in PUD related hospitalizations from January to May (900/day to 920/ day). The average number of hospitalizations was highest in February (939/day); thereafter the hospitalization rate dropped to 845/day; to reach a nadir in November.

Conclusion: A seasonal variation in PUD hospitalization shows higher incidence in the winter season and lowest in the fall season. When data was corrected by monthly admission proportion, winter periods are confirmed as higher risk periods.
The Role of Early Endoscopic Evaluation in Decreasing Morbidity and Mortality After Caustic Ingestion: A Nationwide Analysis
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Introduction: Caustic ingestion is a serious medical problem with potential devastating short- and long-term consequences. Early (within 24-48 hours) upper endoscopy is recommended to evaluate the extent of injury and guide management. There has been no systematic nationwide study evaluating epidemiology, adherence to early endoscopy guidelines, and outcomes among patients with caustic ingestion across all age groups.

Methods: The Nationwide Inpatient Sample database 2003-2011 was used to identify all-age, non-referral, urgent/emergent admissions with E-ICD9 codes indicating caustic ingestion. Information about demographics, hospital characteristics, upper endoscopy (early endoscopy or EaEn < 48 hours since admission, and late endoscopy LaEn = or > 48 hours) were abstracted. Comorbidities were summarized using Charlson Comorbidity Index. Our outcome was the overall morbidity and mortality represented by the occurrence of any of the following adverse events: death, shock, acute renal failure (ARF), sepsis, esophageal perforation, and the need for blood transfusion, parental nutrition, and surgical intervention. Variables that achieved statistical significance (p < 0.05) in the univariate analysis were included in a multivariable logistic regression analysis.

Results: We included 17,488 patients with a median age of 34 years, male 52%, Caucasians 42%, suicidal ingestion 50%. There were 2 age peaks of incidence, < 5 years old with 100% accidental and 15-25 years old with 77% suicidal. Overall mortality rate was 1.5% with significant increase among those >85 years age to 12% (p < 0.001), Figure 1. Upper endoscopy was performed in 37% of the patients (among whom 83% were EaEn). Compared to patients who had EaEn, those who underwent LaEn had statistically significant increases (p < 0.001) in the occurrence of: death, ARF, sepsis, esophageal perforation; shock, and need for a surgical intervention, see Figure 2. Using multivariate analysis, patients who had LaEn were four-fold more likely (OR 3.9, 3.2-4.9, p < 0.001) to have the aforementioned adverse events compared to EaEn. Other predictors for higher mortality include suicidal ingestion, lowest income, and male gender, Table1. Conclusion: In this nationwide study, there were almost 2000 admissions per year over the investigated 9-year time frame. Late endoscopy was associated with significant increase in morbidity and mortality. Mortality rate increased with age reaching a peak of 12% in the elderly.

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In-Hospital Temporal Trends in Gastrointestinal Bleeding Associated With Percutaneous Coronary Intervention in the United States Between 2006 and 2011: Analysis of 3,873,200 Procedures
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Introduction: Contemporary large scale data studying the trends in incidence and outcomes of gastro-intestinal bleeding (GIB) after the introduction of new anti-platelet and anticoagulant agents in patients undergoing percutaneous coronary intervention (PCI) are lacking.