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Cold snare polypectomy (CSP) for subcentimeter polyps drastically prevails because of less complication such as bleeding, coagulation syndrome and perforation. The true incidence of incomplete muscularis mucosa resection with CSP is however unknown. Shichijo et al. therefore aimed to examine the incidence of incomplete muscularis mucosa resection both with and without cold snare defect protrusion (CSDP) by a prospective study using 250 polyps. The overall incidence of incomplete mucosal layer resection was 63% (158/250), 76% (88/90) with CSDP and 57% (91/159) without CSDP, respectively. Size (≥ 6 mm), resection time (≥ 5 s), and serrated lesions were risk factors for CSDP. They concluded that CSDP was a good indicator for incomplete mucosal layer resection. CSP should be used for intra-epithelial lesions only, because mucosal layer of more than half of polyps was not removed by CSP.

Although a wide spectrum of bronchopulmonary manifestations has been reported in inflammatory bowel disease (IBD), the relationship between IBD and idiopathic pulmonary fibrosis (IPF) remains unclear. Kim et al therefore aimed to evaluate the risk for developing IPF in 38,921 patients with IBD by comparing with age- and sex-matched individuals without IBD, using a nationwide population-based study. The overall risk of IPF was significantly higher in IBD patients than in non-IBD controls. The risk of developing IPF in patients with IBD was higher in male patients than in female patients. They concluded that patients with IBD, especially CD, have an increased risk of developing IPF. Patients with IBD should be aware of the potential risk for the development of IPF.

There have been no reports that have compared the endoscopic features of superficial Barrett’s esophageal adenocarcinoma (s-BEA) between short-segment Barrett’s esophagus (SSBE) and long-segment Barrett’s esophagus (LSBE). Yamasaki et al. therefore aimed to clarify the endoscopic features and clinicopathological differences in s-BEA derived from SSBE and LSBE using 141 lesions in 130 patients with pathologically confirmed s-BEA. Complex-type s-BEAs had high incidences of T1b invasions and poorly differentiated components. In SSBE, 72.6% of lesions were located at the right anterior wall. All flat-type or depressed-type lesions derived from SSBE were identified as reddish areas, whereas only 65.2% from LSBE were identified as reddish areas. They concluded that s-BEAs in LSBE should be more carefully evaluated on endoscopic appearance including flat-type and complex-type lesions than in SSBE.

Cardiovascular disease is the leading cause of mortality in patients with nonalcoholic fatty liver disease (NAFLD). Dyslipidemia is commonly associated with NAFLD and is a major risk factor for cardiovascular disease. In this multicentre study on Asian NAFLD patients, Khoo and colleagues determined the cardiovascular disease risk of individual patients and looked at the prescription of statin and whether patients who were on statin were treated to target. They found that an alarmingly high proportion of patients (58.9%) who were not on statin should have been on statin, and that among patients who were on statin, an even higher proportion (74.1%) did not achieve treatment target. This study serves as a timely reminder to pay more attention to the treatment of dyslipidemia in order to reduce cardiovascular disease risk in patients with NAFLD.
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