

between patients with high-titer auto-antibodies and insulin resistance and hypothesized that auto-antibodies may represent an epiphenomenon of insulin resistance leading to the progression of NAFLD. We were able to examine for this association in a subgroup of 68 patients from our cohort who had fasting insulin and glucose measurements available. In this subgroup, 15 (22%) patients had antinuclear antibodies (ANA) or antismooth muscle antibodies (SMA), and 4 (6%) had titers >1:100. Using Mann-Whitney analysis, the presence of auto-antibodies was neither associated with higher fasting insulin levels ( $22.1 \pm 20.8$  vs  $16.0 \pm 10.6$   $\mu$ U/ml,  $p = 0.3$ ) or insulin resistance measured by homeostasis model of assessment (HOMA) ( $6.5 \pm 6.1$  vs  $4.4 \pm 3.9$ ,  $p = 0.2$ ), nor lower levels of insulin sensitivity measured by the quantitative insulin sensitivity check index (QUICKI) ( $0.14 \pm 0.02$  vs  $0.14 \pm 0.02$ ,  $p = 0.2$ ). Similarly, the presence of high-titer auto-antibodies (>1:100) as compared to auto-antibody negative patients, were neither associated with higher fasting insulin levels ( $10.8 \pm 7.5$  vs  $15.9 \pm 10.5$   $\mu$ U/ml,  $p = 0.4$ ) or HOMA ( $2.6 \pm 1.9$  vs  $4.4 \pm 3.9$ ,  $p = 0.3$ ), nor lower levels of QUICKI ( $0.15 \pm 0.02$  vs  $0.14 \pm 0.02$ ,  $p = 0.3$ ). Similar results were observed after logarithmic transformation. To control for the potential confounding effect of age, we performed logistic regression and found that neither fasting insulin, HOMA, nor QUICKI were predictive of the presence of auto-antibodies or high-titer auto-antibodies. Using linear regression analysis, serum insulin, HOMA, and QUICKI were significantly correlated with fibrosis stage ( $r = 0.48$ ,  $p < 0.001$ ;  $r = 0.45$ ,  $p < 0.001$ ; and  $r = 0.42$ ,  $p < 0.001$ , respectively).

Thus, Loria's findings remain intriguing but were not replicated in a subset of our patients. The discordant results between our patients and those reported by Loria may be because of different patient populations stemming from geographic and ethnic differences as well as differing inclusion criteria.

*Leon A. Adams, M.B.B.S.  
Paul Angulo, M.D.*

*Division of Gastroenterology and Hepatology,  
Mayo Clinic and Foundation,  
Rochester, Minnesota*

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## Restarting the Gastroenterology Match

TO THE EDITOR: Now that Congress has passed and the president has signed legislation clarifying that the NRMP

does not violate antitrust laws (1), and now that the lawsuit against the match has been dismissed (2) (although appeals and other legal skirmishing remain), the debate about whether to reinstate the match can focus on the merits, and how best “to attract the best. . . without pressure or coercion” (3).

Pardi (4), and Lim and Shah (5) both reflect on the benefits of the match, as found by comparing the fellowship recruiting process when the match was in operation to the market for gastroenterology fellows before the match was instituted, and after its demise (6, 7). During the years the match was in operation, gastroenterology fellows had more mobility than before or since. And since the demise of the match, offers have become earlier and more dispersed, giving potential fellows fewer choices and less time for decisions than in internal medicine subspecialties that continue to use a match (but without a substantial effect on salaries) (7–10).

Both letters also suggested that an interim step that would achieve some of the benefits of the match while the lawsuit played out (and until consensus can be established), would be to fix dates before which offers of fellowships should not be made, and times at which interviews and offers might be coordinated, to give applicants adequate time to make informed career decisions. Now that the legal status of the match has been clarified, such an interim step might not be necessary.

Equally important, the lessons of other markets strongly suggest that most of the benefits of the match cannot be achieved and sustained in this way.

For example, for several years prior to the beginning of the National Resident Matching Program in 1951 (then called the National Intern Matching Program), the market for interns was organized by a series of dates before which offers could not be made, and durations for which offers had to remain open. That market eventually deteriorated to one in which interns faced exploding offers and hasty, limited decisions (11, 12). (Gastroenterology itself had a similar experience. Before the adoption of a match, there was a period in which guidelines were set for interviews and offers, and it was the failure of this system that led to the adoption of the gastroenterology match (13).) More recently, the market for clinical psychology interns was organized by a date on which all offers should be made, and it deteriorated into a chaotic market in which applicants were pressured to signal in advance which offers they would accept (14), and from 1999 it adopted a centralized match (<http://www.appic.org/match/index.html>). And, as we speak, the market in which law graduates are hired by federal appellate judges as law clerks has been trying to regulate itself via a set of dates, the eighth such attempt in the last 30 yr (15, 16), each of which has collapsed under a barrage of exploding offers made despite attempts to prevent them.

The match for residents, the matches for fellowships in other specialties, and the prior history of the gastroenterology match suggest that a well organized match can relieve the problems currently facing the market for gastroenterology fellows. The collapse of the gastroenterology match, in response to the unusual events beginning in 1996 (7), deprived fellowship programs and potential fellows of that relief, and

led to the re-emergence of the problems that led to the creation of the match. Now that the legal challenge to the match has been dismissed, gastroenterologists have the opportunity to restore order to the market by taking steps to restart the match.

*Muriel Niederle, Ph.D.*  
Department of Economics  
Stanford University

*Alvin E. Roth, Ph.D.*  
Department of Economics  
Harvard University; and  
Harvard Business School

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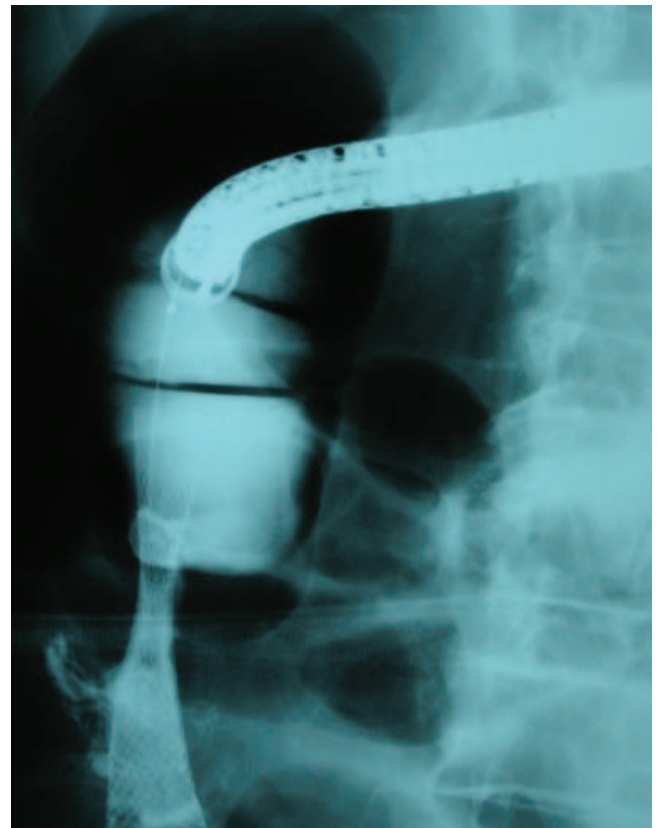
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## Endoscopic Insertion of Self-Expanding Metal Stents as First Step to Treat Malignant Colorectal Obstruction

TO THE EDITOR: I read with great interest the extensive review published recently in the *Journal* by Sebastian *et al.* (1) about Self-Expanding Metal Stents (SEMS) in colonic obstruction. I would point out several aspects on SEMS inserted by endoscopists. From the endoscopic view, insertion of a SEMS is an interventional procedure not so complex as, for instance, ERCP is. Especially, if stents are placed through the working channel of a therapeutic endoscope. The main step in success is to pass a guidewire beyond the stricture (2).

Until now, in published series (2-12), SEMS inserted by endoscopists have an average of less than one stent per month (0.77 in the quoted series). It is expected that this rate will increase when surgeons realize the advantages to decompress the obstructed colon by means of such a minimally invasive procedure.

It appears that the success rate is the same between radiological and endoscopic insertion. Sebastian *et al.* (1) did not find significant difference in the failure rate). Nevertheless, it has been commented (13) that perforations were more reported in radiological publications. Perhaps, it would be



**Figure 1.** Insertion of an enteral Wallstent in the ascending colon by means of a therapeutic colonoscope. Note the waist on the endoprosthesis at the site of obstruction.