Highlights from this issue

doi:10.1136/flgastro-2019-101361

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Recognising eosinophilic oesophagitis as a cause of food bolus obstruction

Eosinophilic oesophagitis is a chronic inflammatory disorder. Diagnosis is by strict histological criteria which include >15 eosinophils per high power field (upper and lower oesophagus). Eosinophilic oesophagitis is increasingly recognised as a common (prevalence 0.4%–0.7%) and treatable cause of dysphagia. Food bolus obstruction is a common presentation. In this issue, Ntuli *et al* report the outcome of a retrospective analysis of acute presentations (2008–2014, 313 episodes, multiple different clinical teams) to their unit. A total of 200 required endoscopy, 80 had biopsies and in 21 of them, new diagnoses of eosinophilic oesophagitis were made. The authors highlight the fact that in a high proportion biopsies were not done and suggest that if more patients had biopsies more diagnoses would have been made. The authors advocate a shared specialty protocol—with routine endoscopy plus biopsies and standardised reporting. This is important because most patients respond well to treatment once diagnosed and longer-term complications, such as stricture formation, can be avoided. There is an excellent accompanying editorial discussing recognition and early management. ***(See pages 3 and 11)***

Diagnosis and management of catheter-related bloodstream infections in patients on home parenteral nutrition

Catheter-related bloodstream infections (CRBSI) remain a very important complication in patients receiving home parenteral nutrition and act as a key quality indicator of their care. The target of the nutrition support team is to have a CRBSI of less than 1 per 1000 catheter days. This is, however, hugely variable and dependant on many factors. In a well-evidenced and authoritative review, in this issue, Bond *et al* take us through the guidance for prevention, diagnosis and management. It is really interesting to work through, straightforward to follow and pragmatic. This includes the need for multidisciplinary management and strict adherence to protocols. Tunnelled central venous catheters are the line of first choice. Line locks should be considered, particularly in settings where CRBSI's are above average or in patients with recurrent infections (taurolidine first choice and alcohol second choice). Paired central and peripheral cultures are essential when infection is suspected to avoid under treatment and overtreatment. Line salvage is important, if possible, to minimise loss of the line sites—there is a useful definition of line salvage which is highly predictive and includes negative blood cultures collected 48 hours post-treatment plus no clinical or microbiological evidence of CRBSI with an indistinguishable micro-organism within 90 days of the end of treatment. The authors discuss common organisms, treatment strategies and the indications for line removal. With the increase in the use of home parenteral nutrition and these patients being seen in many different settings, this article is essential reading to ensure that we offer the best and most evidence-based management. Editor's choice this month. ***(See page 48)***

How to manage—acute liver failure

This is a great article. Acute liver failure is a rare but life-threatening clinical syndrome with multiple different aetiologies. Liver transplantation is an important option. In this issue, Tavabie and Bernal discuss the definition, aetiologies, presentation and treatment, including N-acetylcysteine administration for paracetamol poisoning, management of sepsis, management of coagulopathy and the indications for liver transplantation. Paracetamol poisoning is the most common cause in the UK, with viral hepatitis, particularly hepatitis E worldwide. Early recognition is essential with an early transfer to a specialised unit if the patient has an international normalised ratio of greater than 1.5 and the onset of hepatic encephalopathy or other poor prognostic features. There is a useful box listing the investigations at presentation. Indications for super-urgent liver transplantation listing for paracetamol poisoning and (separately) other causes are listed. Outcome of transplantation following risk-based assessment is 90% at 12 months. ***(See page 70)***

Optimising inflammatory bowel disease patient selection for de-escalation of antitumour necrosis factor therapy

This is a complex and challenging issue, particularly in patients who are well and treatment has had a massive impact. National Institute for Clinical Excellence (NICE) recommends considering cessation after 1 year of therapy unless there is clear evidence of ongoing disease activity, although there are no detailed criteria. In this issue, Swann *et al* report their 'real-world' experience, that is, outside a controlled clinical trial. All patients on biologics were discussed at a biologics review panel and considered for a trial off therapy. Patients with no suitable maintenance immunomodulator, previous surgery or evidence of active disease, additional indications for antitumour necrosis factor therapy and previous relapse on a biologic were excluded. Of 136 patients reviewed, 45 met NICE criteria. A total of 27, following application of the biologics review panel modifiers, had a trial off treatment with a 20% relapse rate at 2 years, that is, a reasonable number getting off treatment. The challenge of moving this forward is to refine the decision-making algorithm further to ensure treatment is optimised while overtreatment, and therefore, potential toxicity, is avoided. There is a sense that there is still much to learn about how best to optimise the use of monoclonal antibody therapy in patients with inflammatory bowel disease (IBD). ***(See page 16)***

Antibiotics and probiotics in IBD: when to use them

Antibiotics and probiotics are often used in IBD. In this issue, Abraham *et al* review the evidence, although there are few randomised controlled trials. There are some key messages regarding the role of antibiotics in the induction of remission in Crohn's disease, combination therapy in perianal disease and their potential to reduce the risk of post-operative recurrence in Crohn's disease. The authors also discuss the role of antibiotic combinations in active ulcerative colitis, active pouchitis and chronic refractory pouchitis. The best evidence for probiotics is in pouchitis—acute and chronic, particularly VSL#3. Data in other situations are inconsistent, better in ulcerative colitis than Crohn's with multiple potential confounders in most of the studies done. It is well-worth working through the article which does a great job of evidencing all of this and providing practical guidance and as such is an essential read for clinicians managing IBD.***(See page 62)***