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Highlights from this issue

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R Mark Beattie

Palliative care in liver disease: what does good look like

The morbidity and mortality from chronic liver disease is rising rapidly with a high symptom burden in advanced disease. This is an important priority for hepatology. In this issue Hazel Woodland and colleagues, on behalf of the British Association for the Study of Liver Disease (BASL) review palliative care in liver disease - clinical and service related issues. There are important core principles. Palliative care is not confined to end of life care and includes the optimisation of quality of life for patients and families in parallel with active disease management. This means that 'core' palliative care should be part of 'normal care' offered by the multidisciplinary team with specialist palliative care teams providing input for more complex cases. The article covers basic principles and clinical issues including proposing the establishment of an advanced liver disease multi-disciplinary team to best inform and support care needs, management plans and decisions about limiting care. The article also covers key clinical issues in detail including pro-active management of nutritional impairment, refractory ascites, acute and chronic pain and hepatic encephalopathy and includes helpful discussion of practical issues including psychological, social and financial. Essential reading for clinical teams and should help promote best management of chronic liver disease and other chronic conditions where many of the issues are very similar. ***(Editor's Choice this month – see page 218)***

Undiagnosed microscopic colitis: a hidden cause of chronic diarrhoea and a frequently missed treatment opportunity

Microscopic colitis is a common treatable cause of chronic non-bloody watery diarrhoea but less well recognised than for example inflammatory bowel disease. In this issue Munch and colleague review the topic including discussion of the epidemiology, indications for investigation, diagnostic features and practical management. The primary or presenting symptom is chronic, recurrent non-bloody watery diarrhoea. Importantly faecal calprotectin can be normal. Diagnosis is by colonoscopy with biopsy. Endoscopically it can look normal with characteristic features being present on histology. Management is straightforward including avoidance of risk factors - smoking, specific medications including proton pump inhibitors, non-steroidal anti-inflammatory drugs. Treatment is with corticosteroids in the first instance; thiopurines and other immunosuppressive agents may be indicated in complex cases. This is clearly an important condition to consider and has the potential to be misdiagnosed as Irritable Bowel Syndrome. The article is very helpful and well worth working through. ***(See page 228 and listen to the accompanying podcast)***.

Factors associated with oesophagogastric cancers missed by gastroscopy: a case–control study

Approximately 10% of patients diagnosed with an oesophagogastric cancer have had a gastroscopy within the preceding 3 years. The presumption is that some of these cancers were missed. This is in the context of an environment where there is an increasing demand for endoscopy. In this issue Tai and colleagues from Sheffield in a double matched case control study (patient and endoscopist) explore this further. The findings are of interest. There were 48 cases of missed cancer (7.7%). Risk factors included the number of procedures on an endoscopy list (OR 1.42, 95% CI 1.13 to 1.78). Interestingly the use of sedation, time of day and experience of the endoscopist were not associated with missed cancers. The findings need replication but do suggest we should be careful that service pressures do not have a negative impact on diagnostic yield. ***(See page 194)***

Effectiveness of vedolizumab dose intensification to achieve inflammatory bowel disease control in cases of suboptimal response

Vedolizumab (VDZ) is a monoclonal antibody against alpha-4 beta-7 integrins which selectively inhibits leucocyte migration into the gut. It has proven efficacy in Inflammatory Bowel Disease (Crohn's disease and Ulcerative Colitis) although it is well recognised that some patients fail to respond (primary non response) and some flare having previously responded (loss of response). Recent meta-analysis has suggested that for the patients with loss of response dose intensification is indicated. In this issue Saaman and colleagues report their experience (retrospective cohort 2014–17). 139 patients had been treated 36 had had dose intensification from 8 to 4 weekly. 20/36 had clinically active disease at dose intensification.10/20 had a sustained response. This 50% response is consistent with the experience of others. In this small cohort predictors of response at 24 weeks were low CRP at dose intensification and response at 12 weeks. This data is important for several reasons. We need to learn more about the dose response of agents used in disease management but also, we need to collect this sort of data prospectively and in large numbers to better risk stratify treatment and response. ***(See page 188)***

Consensus standards of healthcare for adults and children with inflammatory bowel disease in the UK

The symptoms and clinical course of inflammatory bowel disease (IBD) vary among individuals. Personalised care is therefore essential to effective management, delivered by a strong patient-centred multidisciplinary team, working within a well-designed service. The previous IBD standards (2009, 2013) have done much to progress IBD care in the UK. Led by IBD UK, a national multidisciplinary alliance of patients and nominated representatives from stakeholders in IBD care worked together to update them using data collected from 689 patients and 151 healthcare professionals. Standards were drafted then modified using Delphi consensus methodology. Consensus was achieved for 59 Standards covering seven clinical domains; (1) design and delivery of the multidisciplinary IBD service; (2) pre diagnostic referral pathways; (3) holistic care of the newly diagnosed patient; (4) flare management; (5) surgery; (6) inpatient medical care; (7) and ongoing long-term care in the outpatient department and primary care setting. This intent of these standards is to promote excellent care, and promote quality improvement, audit and service development. The standards, like their predecessors will help support the development of IBD care. There is a Benchmarking Tool which provides a framework for healthcare providers and patients to assess, reflect on and improve the quality and accessibility of their service. ***(See page 178 and listen to the accompanying podcast)***

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