# Highlights from this issue

doi:10.1136/flgastro-2022-102244

R Mark Beattie

## Moving forward post pandemic - BSG Live 2022

Please read and enjoy this special edition of Frontline Gastroenterology put together to celebrate BSG live 2022 with the overarching theme – Moving forward post pandemic. The content reflects the breadth and strength of our speciality with first class reviews written by speakers from, and linked to content at the meeting.

## Greener gastroenterology

We have rightly started with a summary of the BSG Climate Change and Sustainability Strategy written by Andrew Veitch, the next BSG president ***(see page e3)***. Of course, moving forward is about practicalities and for Green Endoscopy there is an excellent summary from Leigh Donnelly including practical tips about things you can do to make things better – many are 'easy wins', which are such powerful motivators to bring the team together to develop an effective long-term strategy ***(see page e7)***.

## The microbiome

The gut microbiota play an important role in maintaining gut health through a symbiotic relationship with the host. Altered gut microbiota is a common feature of gut disease. However, understanding the development and function of the gut microbiota in health and the role in the inflammatory response is more complex. Sheena Cruickshank and colleagues review this in detail using Inflammatory Bowel Disease and Necrotising Enterocolitis as examples both of which demonstrate common features of gut microbial dysbiosis and a dysregulated immune response. In comparing and contrasting these two diseases, common features are highlighted. It is clear from the discussion of recent advances and key areas of interest that the challenge of identifying a causal relationship between the microbiota and specific diseases is ever present but might potentially give us better insight into shared mechanistic pathways and better treatments longer term ***(see page e13)***.

## Inflammatory Bowel Disease

We have a number of expert reviews covering different issues in Inflammatory Bowel disease (IBD). Matthias Zilbaur's team from Cambridge discuss Epigenetics in paediatric IBD, presenting a conceptual framework for disease pathogenesis. This includes discussion of the basics of epigenetics and just how hard it is to study. The potential involvement of epigenetics in IBD is considered in detail ***(see page e22)***. Gordon Moran's team have pulled together an excellent review on Imaging in Inflammatory Bowel Disease: Current and Future Perspectives – this includes basic information about what the different imaging modalities look at and so help inform the best use of ultrasound, CT and MRI for the specific patient. This includes a discussion on how best to differentiate inflammatory change from fibrosis – which we all know is not always straightforward but does impact on management. The authors explore the need to better absorb artificial intelligence to improve clinical performance ***(see page e28)***. There is no doubt that the advent of anti-TNF therapies have dramatically improved clinical outcomes in IBD. However primary failure, secondary loss of response and toxicity remain significant issues. There is an increasing number of new options emerging or already on the market. In a comprehensive update Ayesha Akbar and her team review IBD therapeutics – what's in the pipeline which is worth working through so we can at least find out what we might be prescribing next ***(see page e35)***. Shahida Din and colleagues review the complex issue of managing IBD in patients with previous cancers particularly with increased use of second and third line immunosuppression. The authors review the evidence – treatment decisions can be challenging, the risk of immunosuppression related cancer recurrent is probably less than perceived, the risk of uncontrolled IBD vs cancer recurrence need to be carefully considered with 'open' discussion with patients including around perception of and acceptance of risk ***(see page e44)***.

## Oesophageal disorders and reflux

Anjan Dhar and colleagues cover the important and rapidly advancing field of Eosinophilic Oesophagitis: Improving Diagnosis and Therapy - reducing the burden of repeated endoscopy – discussing criteria for diagnosis, best treatment strategies, long term risks and how best to follow-up. Based on current knowledge long term follow-up is essential although it is less clear, for example, what the long-term outcome is including risk of stricture and need for follow-up/serial endoscopies ***(see page e51)***. It is well known that laryngopharyngeal reflux – the backflow of acidic stomach contents towards the larynx – is associated with symptoms such as cough, throat clearing and globus although less straightforward to decide if, when these are the presenting symptoms, they are secondary to reflux. It is even more complex when symptoms such as persistent sore throat and hoarseness are considered. Sabrina Brar and colleagues review this important topic discussing (in detail) the ENT manifestations and complications of reflux including how to best assess and treat. There is an emphasis on the multidisciplinary team approach, clinical assessment strategies and the role of direct visualisation of the pharynx and larynx with a good and helpful discussion of the treatment options ***(see page e57)***.

## Endoscopy

There are a number of excellent endoscopy papers. The potential for Transnasal endoscopy (TNE) is highlighted. TNE uses an ultrathin endoscope to visualise the upper gastrointestinal tract and is a safe, well tolerated and resource-efficient alternative to conventional transoral endoscopy. Jason Dunn's team discuss their experience and the practicalities with the provocative title Trans Nasal Endoscopy - moving from endoscopy to the clinical outpatient; blue sky thinking in oesophageal testing ***(See page e65)***. Familial adenomatous polyposis (FAP) – prevalence 1 in 10,000 - is a hereditary disease that, without intervention, will cause nearly all patients to develop colorectal cancer by the age of 45. The crucial role role of endoscopy in patients is reviewed by Andrew Hopper ***(see page e72)***. Colonoscopic screening should start from age 12 years with then annual surveillance in affected cases, extended to 2 yearly in patients with a low polyp burden. This will inform the timing of colectomy. The importance and practicalities of post colectomy surveillance are discussed in detail. Upper gastrointestinal surveillance (duodenal polyps almost inevitable)

should start from around age 25. Patients clearly require structured management within a specialist centre to best manage the condition and (the evidence shows) markedly reduce the risk of cancer long term. The diagnosis and management of Lynch Syndrome is reviewed by Kevin Monahan and colleagues – dominantly inherited cancer susceptibility syndrome (1 in 400, 5% aware of the condition). The authors discuss the need to look for in all new colorectal or endometrial cancer. Patients diagnosed through that route or through family screening require lifelong multidisciplinary input including colonoscopic surveillance starting from 25 to 35 years depending on the specific pathogenetic variant. Aspirin reduces colorectal cancer risk by 50%. Prophylactic hysterectomy and bilateral salpingo-oopherectomy should be considered for specific variants – the guidance is detailed and helpful *(see page e80)*.

## Pancreas

Pancreatobiliary medicine is increasingly recognised as a specialty in its own right. Pancreatic cancer is one of the most important causes of cancer related mortality among all solid organ malignancies, with less than 20% of patients eligible for potentially curative resection. John Leeds and colleagues discuss the role of the pancreatobiliary physician (as part of the extended multidisciplinary team) in the management of inoperable pancreatic cancer. The cornerstone of management is palliation to improve quality of life with early engagement with palliative care services. The authors discuss various issues including the 'analgesic ladder', symptoms and management of gastric outlet obstruction and pancreatic exocrine replacement. There is a nice table detailing areas that need assessment and management. It is a very helpful article which effectively summarises and contextualises interventions that are likely to be helpful in the patient with inoperable pancreatic cancer *(see page e88)*

## Hepatology

In Hepatology, like all other specialities, multidisciplinary teams are at the core of good medical practice- relevant to assessment, diagnosis, treatment and follow-up. Dermot Gleeson's team discuss the interface between the clinician and histopathologist in the diagnosis and management of Autoimmune Hepatitis. Diagnosis is based on a combination of clinical, laboratory and histological information. There are many issues to consider – new histological criteria, acute vs chronic presentation, other conditions might co-exist, prognostic factors acutely and in remission – all nicely summarised in this excellent review *(see page e94)*. Non Alcoholic Fatty Liver Disease (NAFLD) is common with significant liver, cardiovascular and cancer related morbidity – William Alazawi's team review What's new in NAFLD. This includes discussion of terminology, risk stratification for fibrosis, initiatives to develop biomarkers, lifestyle and behavioural change (the most effective management) and drugs under investigation (none are licensed). The increasing prevalence of this condition means this is an important topic to keep up to date on *(see page e102)*. Mark Wright and colleagues cover the important topic of Symptom Control in Advanced Chronic Liver Disease – integrating anticipatory palliative and supportive care – very much an opinion piece as there is a real lack of evidence *(see page e109)*. It is clear however that this is an increasing issue with the increased prevalence of chronic liver disease. The article includes barriers and practical strategies. There is a strong emphasis on open and honest discussion, better symptom control – pharmacological and non-pharmacological – and the active and best use of the multidisciplinary teams to bring together and best use the available resources. This includes management of refractory ascites which is covered in a multi-centre consensus document on behalf of the British Association for the Study of the Liver/British Society of Gastroenterology - Palliative Long-term Abdominal Drains for the Management of Refractory Ascites due to Cirrhosis *(see page e116)*.

## In conclusion

The pandemic has impacted on all of us in different ways. Within our specialty we can now look to how we deliver the most effective and best care for our patients. There are multiple hurdles to overcome but it is important to look forward – we have learnt much about many things we need to take forward including the rapid developments in telehealth, the real opportunity for effective virtual consultations with patients and their families, the rational and best use of investigations and the opportunity through a combination of face to face, hybrid and virtual meetings to communicate better with each other. The recovery period is about refining all of this and using the 'new' developments and initiatives to enable us to together to better manage patients, improve quality, research collaboratively and so improve outcomes for our patients.

Please enjoy this issue. Please continue to read, enjoy, and feedback on the journal. Follow us on twitter @FrontGastro_BMJ and listen to our regular podcasts accessed via the journal website https://fg.bmj.com/