Highlights from this issue

doi:10.1136/flgastro-2015-100619

Anton V Emmanuel

After our "Endoscopy Special" last edition, it is a return to the mixed content of our normal editions, with contributions from trainees and tertiary specialist units. This breadth of submissions is a vital component of *Frontline Gastroenterology's* appeal —to have educational value to trainees as well as clinical value to practicing gastroenterologists. This ambition is mirrored in our monthly Twitter debates which utilise the generosity of internationally renowned experts who give up time to interact with readers and address critical areas of current practice as well as consider emerging aspects. If you haven't already, do get involved—#FGDebate and follow @FrontGastro_BMJ.

The "Model for Improvement" model: if they can do it, could you?

The Salford Intestinal Failure Unit is internationally recognised and nationally accredited. Using a model of constantly reviewing quality, efficiency, and productivity they demonstrate in this edition of *Frontline Gastroenterology* how to drive improvements in practice, outcomes, and patient experience. The article provides valuable insight about systematic methods of service development to fledgling and more established Intestinal Failure centres seeking formal accreditation. But they also pose the reader with the challenge and opportunity of how to apply this cycle of PDSA (Plan-Do-Study-Act) in their own services, including those which don't necessarily deal with Nutrition. The messages that emerge are that regular consultant-provided input and multidisciplinary working are the cornerstone of improved outcomes. The gauntlet is laid down: how can your service implement a PDSA model and demonstrate improved outcomes?

Do we need another Inflamatory Bowel Disease (IBD) severity score?

Inflammatory bowel disease clinicians are not short of severity indices to use. But we know that these indices are rarely used in the clinical setting outside of clinical trials. Existing scoring systems incorporate symptoms, signs, results of laboratory tests and sometimes endoscopic assessments. To overcome this disconnect between research/regulatory practice and clinical practice, there is need for alternative measures of outcome, and thereafter definitions of response. Part of this process is the development of patient-reported outcomes, but in this edition of *Frontline Gastroenterology* Alrubaiy and colleagues propose a combination of end points—the IBDex©—from existing indices to complement such assessment.[1] A challenge of these composite indices is to make them readily applicable in practice, and the authors propose achieving this with high validity and simplicity of scoring by recording over the last three days.

The costs of managing patients with IBD

A recent publication pointed out that in the USA 86% of all health care spending was for people with one or more chronic medical conditions. Whilst there has been much literature on the cost effectiveness of particular treatments there has been little on the care models for the complex situation of chronic IBD where there is a range of treatment costs, adverse effects and the costs of managing those and an unpredictable relapsing-remitting course. In advance of reading the article by Ghosh and Premchand[2] in this edition, the reader may want to speculate on the magnitude of difference in annual costs between an IBD patient in remission and one with a relapse. It behoves us in frontline IBD services to consider these costs as managed and commissioned care programmes may use costing methods like this to decide where patients be looked after.

Clinical updates for "semi-common" conditions

Gastroenterology clinics and multidisciplinary meetings are populated with patients who have conditions that are seen sufficiently frequently to require knowledge but insufficiently often to develop specific expertise in. A particular place exists in a journal like *Frontline* Gastroenterology to help educate clinicians in these disease areas. We are delighted to include in this edition a review by Ramesh and Goyal[3] from the University of Alabama on pancreatic fluid collections. This is especially timely in light of the recent change in nomenclature and the Atlanta classification system which is subject to debate. The rapid pace of development in imaging and endoscopic modalities for diagnosis and treatment further highlight the importance of this clinical review.

Also in this edition, Cheung and Trudgill[4] describe the condition of burning mouth syndrome, unusual in functional disorders in being especially seen in post-menopausal women. In highlighting the differential diagnosis the authors also review the evidence to identify a pragmatic treatment strategy based on patient preference and local service availability.

References

1 Alrubaiy L, Dodds P, Hutchings HA, *et al*. Development and validation of a new disease severity index: the Inflammatory Bowel Disease Index (IBDEX). *Frontline Gastroenterology* 2015;6:161–8.
2 Ghosh N, Premchand P. A UK cost of care model for inflammatory bowel disease. *Frontline Gastroenterology* 2015;6:169–74.
3 Goyal J, Ramesh J. Endoscopic management of peripancreatic fluid collections. *Frontline Gastroenterology* 2015;6:199–207.
4 Cheung D, Trudgill N. Managing a patient with burning mouth syndrome. *Frontline Gastroenterology* 2015;6:218–22.

Frontline Gastroenterol: first published as 10.1136/flgastro-2015-100619 on 9 June 2015. Downloaded from http://fg.bmj.com/ on April 19, 2024 by guest. Protected by copyright.