UpFront

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Anti-TNF therapy for Crohn's disease: where are we in 2011

The use of anti-tumour necrosis factor for patients with Crohn's disease is now common place but remains far from straightforward. Getting it right for the patient requires both doctors and nurses to have a wide range of skills. Making the best clinical judgement based on a balance of benefit and risk (while being mindful of the constraints of cost) and presenting this to the patient and sharing the decision, is a tough task. Good judgements require a sound understanding of the evidence. This short summary of that evidence, and the recommendations of National Institute for Health and Clinical Excellence, is just what the busy gastroenterologist needs to make the best judgements.

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Establishing a biologics service for patients with inflammatory bowel disease

I have long believed that making decisions about treatment should not be affected or constrained by the prospect of having to make complicated arrangements to deliver the treatment. Most treatments we prescribe do not require much more effort than writing a prescription and dictating a letter. Prescribing biologics is different. Patients need careful counselling, they need screening before treatment can start and the majority still require intravenous infusions. Being well organised and having all of this on automatic pilot not only makes life for the prescriber easier, it also creates a much more efficient, patient centred and safe service. When patients are processed in a systematic way, using carefully thought through and properly resourced pathways, there is much less room for error. The Leeds biologics service is an exemplar of this approach and there is much to be learnt from reading how it operates.

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Interendoscopist agreement in diagnosis of Barrett's oesophagus

When observing trainees endoscope that have been performing endoscopy independently, I can be surprised how much detail they miss during the procedure and how they can struggle to describe what they see. Too often we are focused on the technical aspects of the procedure and it is perhaps no surprise that Doherty *et al* have found poor interobserver agreement in the endoscopic diagnosis of Barrett's. If this was a study about the morphology of colonic polyps, the conclusion would be the same. Sometimes we are not very good at doing the most basic things well. Endoscopists, particularly those that train, should take note of this paper and think about what they might do differently to enhance their own observational and cognitive skills (as well as their technical ones) and how they pass these on to their trainees.

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Patient understanding of Barrett's oesophagus and Shared Decision Making

Talking to patients in a language they understand, and at a pace they can assimilate what is being discussed is not easy. The paper of patients' understanding of Barrett's oesophagus illustrates how easy it is to get it wrong. Helping patients make an informed decision when their options are far from clear is even more difficult. We generally assume that the patient's understanding of a consultation is close to our own and that we have helped the patient make an informed decision. Most often we are blissfully unaware of how much better we could do this basic clinic task, until we become a patient, when shortcomings in the process become obvious, or when things go wrong and the patient's recollection of what was said (and if they are lucky what was discussed) is quite different from our own.

Shared Decision Making, and the aids that support the process is strongly supported by our current government, but it is much more than the latest political whim. It is a fundamental requirement for a modern consultation and arguably a fundamental patient right in a modern society. Furthermore, there is good evidence that it achieves better patient outcomes, with less chance of complaint if things don't go to plan. This paper describes Shared Decision Making, how shared decision making aids can help patients make informed decisions, and the evidence base underpinning it. It is essential reading for anyone who helps patients make decisions about their management.

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Service provision and training for endoscopic ultrasound in the UK

We are slow to adopt innovations in the UK and not very good of positioning services strategically in a way that ensures high quality and good patient access, within an affordable budget. This haphazard approach is further compromised because we are unable to plan how it should be implemented, and in particular how we define and train the workforce required to deliver the service. To overcome these problems we need a more favourable commissioning environment. However, commissioners cannot commission in a vacuum so they will need advice. This report is an example of the sort of advice they will need – in this instance what is required for a modern endoscopic ultrasound service. There are examples of such guidance for some

clinical conditions (such as home parenteral nutrition); we need more for the technical things we do.
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Utility of screening for hepatocellular carcinoma among cirrhotics

This paper raises issues in common with other themes in this edition of *Frontline Gastroenterology*: is screening (or more correctly surveillance) effective and is it affordable; if we implement it how can we do the basics well; and finally, how do we communicate with the patient to agree a management plan they will comply with, while ensuring their expectations are realistic?

The paper from Niravath and colleagues lends further weight to the accumulating evidence in favour of surveillance of patients with cirrhosis. However, in the absence of a randomised controlled trial (RCT) we shall never be certain that it is effective at reducing deaths from hepatocellular cancer, never mind cost-effective. Despite the lack of evidence we have now reached a point where it is difficult not to offer such a service and with increasing options for treatment it will be even more difficult. This is because an RCT of surveillance which showed no benefit would become out of date as new treatments become main stream.

So surveillance of cirrhotics is here to stay and we best make the most of it. Making the most of it requires two things: being clear exactly what you are going to do to whom, and doing whatever it is in an as effective and efficient way as possible.

The uncertainty of benefit gives teams some freedom of what they do to whom. At the very least there should be an agreed protocol based on the best available evidence and guidance. Most teams will get this bit right but struggle with the next step: how to make sure the protocol is adhered to, how to ensure some patients are not disenfranchised (particularly those with the common forms of liver disease) and how to ensure that the whole thing is delivered effectively, safely and with the minimum amount of effort and cost. To achieve and sustain a successful surveillance service requires effective clinical leadership, careful planning, good communication, an implementation strategy and meticulous audit. This may not seem the most exciting part of clinical medicine, or necessarily the easiest thing to do, but it is the most important, because without it, the best intentions will achieve very little, and waste a lot of money.

Frontline Gastroenterology welcomes submissions of how to do the simple things well: examples of service delivery that illustrate how patient care can be improved by having clear evidenced based guidance implemented in an efficient and cost effective way. We have considerable evidence of the benefits and risks of treatments and interventions we use for our patients. If we implemented them as well as is possible (your best examples please) we could, within our budget constraints, make a huge difference to patient care.
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