Highlights from this issue

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Risk stratification in inflammatory bowel disease

Understanding risk from epidemiological studies and translating that in to clinical practice can be difficult for gastroenterologists. It is a challenge to help some patients understand the relative (un)likelihood of certain events, it is a challenge to help regulators and funders of health care to understand certain "off-label" requests, and it is a challenge to change practice in light of some risks (health and financial). *Frontline Gastroenterology* has launched a monthly Journal Watch series online, with selected items included in the quarterly editions you are now reading. One of these Journal Watch pieces addressed that first challenge, reviewing the recent journal articles on the relatively very low risks of malignancy with immunosuppressants and anti-TNF therapies.[1] In this edition, the St Thomas' group have tried to address that latter challenge.[2] Readers will be familiar with the STORI trial looking at maintenance with immunosuppressants after cessation of anti-TNF therapy, which identified certain high-risk parameters for withdrawal of the latter. The St Thomas' team have reviewed their extensive experience of anti-TNF therapy to help risk stratification using these STORI criteria. Their clearly written experience argues strongly the cause for a prospective (national?) study applying a similar methodology, and will hopefully help readers consider how to fit their current clinical practice in line with NICE recommendations.

This edition also publishes another challenging inflammatory bowel disease paper related to risk management, specifically with regard to faecal calprotectin (FC) assessment.[3] James Turvill describes his experience of serial determinations of FC and C-reactive protein in 76 patients receiving anti-TNF therapy. He proposes that FC is a more sensitive marker than C-reactive protein in assessing disease severity, and proposes a possibly controversial care pathway. We encourage readers to contact us with any thoughts on this proposed pathway.

Three colonoscopies a week in a 40-week clinical year

Verma *et al* have presented a challenge to the Joint Advisory Group on GI Endoscopy (JAG) as well as to colonoscopists. They have in a paper in this edition of *Frontline Gastroenterology* further analysed the prospective data of the National Colonoscopy Audit and proposed an increase in the annual number of colonoscopies required in order to maintain quality standards.[4] Analysing 129 different endoscopists they identified a numerically neat 90% caecal intubation rate cut-off that correlated with performance of 120 procedures a year – this represents 20 more cases than the current JAG recommendation of 100 per year. Interestingly, this number of procedures was only undertaken by 36 of the 129 (28%) of their cohort – how much of a challenge is that going to present to training and service provision for you. Again, we encourage your participation in the debate.

Practical approaches to common and complex problems

This edition has two reviews which give clinical guidance for two conditions which can be problematic to manage. High output stomas are a much less common problem, but one which can be poorly managed. Mountford and colleagues offer the latest of our Curriculum Based Review series on this topic.[5] Rooted in explanation of the pathophysiology of intestinal secretion and fluid balance, they provide a thoroughly practical step-wise approach to care which incorporates appropriate use of medications, how and when to supplement micronutrients, and concludes by considering the surgical options to manage such high outputs.

From the same institution, Dyson *et al*[6] offer a pragmatic algorithm to case-finding and then staging non-alcoholic fatty liver disease. One strength of their proposed approach for this common condition is the clarity of when to use or not–specialised investigations such as transient elastography which are not widely available. In a recurring theme of this edition of *Frontline Gastroenterology* the importance of risk stratification of these patients is stressed, in order to concentrate care on those with steatohepatitis.

References

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4 Verma AM, Dixon AD, Chilton AP. Correlation of caecal intubation rate to volume: colonoscopists should undertake at least 120 procedures per year. *Frontline Gastroenterology* 2014;5:155–9.
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