Highlights from this issue

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Faecal calprotectin: implementing NICE recommendations in the light of current evidence

Faecal calprotectin has been the subject of NICE review in 2013, specifically being recommended for use in primary care to aid in the differentiation of inflammatory bowel disease from irritable bowel syndrome in adults with recent onset lower gastrointestinal symptoms. Its utility is specifically in situations where the differential is inflammatory bowel disease rather than cancer, and the recommendation for use in the primary care setting has been to reduce referrals to secondary care for consultation or endoscopy.

But what is the utility of faecal calprotectin in secondary care? This is the subject of two papers and an associated editorial in this edition of *Frontline Gastroenterology*. Dhaliwal *et al*[1] present a prospective analysis of 311 patients with either IBS or inflammatory bowel disease suggesting that a cut off of 50 µg/g could differentiate inflammatory from non-inflammatory lower gastrointestinal symptoms with a sensitivity and specificity of 88% and 78% respectively. The second paper, by Banerjee *et al*[2] addresses another question about use of calprotectin in specialist care: how to identify relapse or treatment failure in patients with known inflammatory bowel disease. They propose a cut off value of 250 µg/g in this situation. These two papers have the potential to influence practice and have been incorporated in the recent British Society of Gastroenterology position statement on faecal calprotectin which could form the basis of future audits of practice. The accompanying editorial is by Attwood.[3]

An emerging clinical group: patients with gastrointestinal symptoms following pelvic radiation

The longest paper in this edition is one that is likely to be reprinted and pinned to the walls of clinics. It is a review of the management of patients with symptoms following pelvic radiation, by the group with the greatest experience in this disease area, from the Royal Marsden Hospital in London.[4] The manuscript is intended for the clinician, and is centred on an evidence based algorithm. In essence each possible symptom is itemised, with an approach to investigation followed by first-line treatment and when necessary more complex treatment options. Symptoms are often multiple in this patient group, and when management needs to be ordered sequentially, the algorithm indicates this.

Do you follow guidance or not? How good are you at monitoring renal function in patients on 5-ASA?

Nephrotoxicity with 5-amino salicylic drugs is well recognised. In 2011 the Medicine Healthcare Regulatory Authority (MHRA) explicitly recommended the frequency of blood monitoring, specifically creatinine measurement prior to commencing treatment, then 3 monthly for the first year, 6 monthly for the next four years and annually thereafter. Mueller *et al*[5] have audited their practice, exploiting a 300 000 patient database of patients with early kidney injury and identified that 0.27% of this cohort were consuming 5-ASA medication. They found that less than 1 in 5 patients had annual blood monitoring and that 48% had no measurement of creatinine whilst on 5-ASA drugs. Whilst a rare complication, a compelling case to improve monitoring is made. Firstly, monitoring with a simple blood test is easy, and, secondly, the fact that earlier identification of renal toxicity and drug discontinuation results in a greater the likelihood of recovery of renal function.

A clinical guideline that saves money

Hewett *et al*[6] have studied the potential for cost saving by implementing the 2014 British Society of Gastroenterology guidelines on Barrett's oesophagus. The guidelines stratified patients according the length of the Barrett's segment and the presence of intestinal metaplasia: recommended surveillance intervals are then tailored to match risk of progression to adenocarcinoma. Hewett and colleagues have undertaken a retrospective endoscopy database analysis and suggest a total NHS saving of £100 million over the next 10 years. Guidelines tailored to improve patient experience that also have a positive influence on health economy are hard to ignore.

References

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