Highlights from this issue

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Comprehensive care for the management of decompensated alcoholic cirrhosis

In the wake of the 2013 National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report on patients with alcoholic related liver disease, McPherson and colleagues[1] in Newcastle (UK) implemented a "care bundle" to manage these often extremely ill patients. In this edition of *Frontline Gastroenterology* they define the key aspects of care for these complex patients in the first 24 hours prior to expert hepatological input. The emphasis is on fluid management and sepsis, and the paper is complemented by the inclusion of their comprehensive tool summarising the components of assessment and management. It is to be hoped that this instrument may form the basis of future audits.

Provision of liver services: two challenges and an opportunity

A further trio of manuscripts derived from surveys of hepatologists, are included in this edition of the journal. They highlight the challenges healthcare professionals face in dealing with severely ill patients with chronic liver disease. Berry et al[2] highlight the observation that patients with acute on chronic liver failure are often "discriminated against" in terms of being offered intensive care. A survey of doctors of various levels of experience using a range of clinical vignettes identified that as many as 25% of respondents would not offer adequate high intensity care to a hypothetical patient with reversible severe acute alcoholic hepatitis.

Low *et al*[3] publish a survey of over 500 healthcare professionals showing that whilst hepatologists recognise when cure is no longer likely in a patient, they suffer from not having either access to, or good understanding, of the specialist palliative care team. Many end-stage cirrhosis patients are managed in primary care, and the potential development of primary care hepatology clinics to help the GP to manage these patients is explored in this paper.

O'Neill *et al*[4] address a timely topic on implementation of alcohol screening. While such screening and subsequent brief intervention is frequently recommended, it is clear that there is almost no data on actual delivery outside of primary care and emergency care. The deficit of the lack of information on how to implement processes of care for such intervention is bridged by this publication. Using standard methodologies of implementation of change in the workplace, which are probably novel to liver specialists, the authors have demonstrated that effective change can be brought about in the even a busy hospital outpatient setting.

Dysplasia in Barrett's oesophagus: the (beginning of the) end of oesophagectomy

Oesophagectomy, associated with almost invariable cure, has long been the mainstay of therapy for Barrett's dysplasia. However the morbidity and complexity of the procedure has driven the search for alternative therapy. Endoscopic mucosal resection followed by radio-frequency ablation has emerged as the likeliest option. This edition of *Frontline Gastroenterology* has a manuscript from one of the centres with greatest experience of such ablative therapy. Ortiz *et al*[5] report that new lesions may develop following resection and ablation, this recurrent disease may still be treated by a further course of similar therapy. Implicit in this message is the need to develop centres of expertise for Barrett's dysplasia ablation, and for patients to be concentrated in such units for the benefit of clinical and academic outcomes.

Travel: another frontier of inflammatory bowel disease therapeutics

Greveson and colleagues[6] have contributed to the emerging body of work on pre-travel advice for patients with IBD. It is well described that patients tend to limit overseas travel. In this edition of the journal they report a study examining the reasons why patients avoided travel outside their continent, identifying differences between those taking immune-suppression and those not. In addition, the survey looked at health care proffesionals, in particular IBD nurse specialists. The shortfall in confidence in certain areas of advice raise the possibility that collaboration with a tropical or infectious diseases unit may greatly enhance service delivery for IBD patients in an era when international travel is increasing by about 5% every year.

References

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