Highlights from this issue

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At the heart of clinical and academic life is learning from experience. *Frontline Gastroenterology* takes pride in publishing material that highlights excellent clinical practice and identify ways in which it can be adopted. Academic discipline requires that published material is subject to scrutiny, and the best scrutiny comes from readers, more than journal reviewers. Perfectly delivered reader feedback serves the twin purpose of appreciating the quality of published manuscripts as well as improving the messages from those papers. We are delighted to include three thought-provoking letters, therefore, related to liver and luminal papers in recent editions. We would encourage you to please do the same with content in this copy of the journal. Equally, direct online participation and feedback is the core of the established programme of *Frontline Gastroenterology* Twitter debates, #FG Debate and follow @FrontGastro_BMJ —we look forward to hearing from you.

What's the score: risk assessment in upper gastrointestinal bleeding

Adoption of risk stratification, by use of validated scores, is well recognised as critical to managing acute non-variceal gastrointestinal bleeds. The Glasgow Blatchford Score (GBS) has been regarded as advantageous over the Rockall score in not requiring endoscopy and not depending on subjective estimation of severity of systemic disease. However, criticism of the GBS has arisen from its complexity. Palmer and colleagues,[1] in this edition of *Frontline Gastroenterology (FG)* have compared the GBS with a simpler non-endoscopic score, the AIMS65. This 5-point score was found to be superior to GBS in predicting 30-day mortality, but not transfusion requirement. So, which score will you use, and will you be the first to compare these two prospectively (and submit to *FG* for publication)?

Ultrasound surveillance in patients with cirrhosis

Studies of the efficacy of surveillance are notoriously of variable quality, given the inherent difficulties in generating a control group and studying the disease process for long enough. The role of ultrasound in patients with cirrhosis to survey for progression to liver failure and hepatocellular cancer (HCC) is no different. A group of leading UK hepatologists have co-authored a national survey of practice in this area, and published what amounts to a call to action for individuals and the hepatology community as a whole.[2] They also describe a snapshot of the stage of HCC in patients discussed at hepatobiliary multidisciplinary team meetings in tertiary referral centres. This mixture of individual clinical vignettes coupled with a report of wider practice will have ready translation into clinical practice. The manuscript, and accompanying editorial by Ian Rowe,[3] highlight that surveillance in the UK is done on an *ad hoc* basis which will necessarily reduce the effectiveness of that intervention. In the absence of data on clinical- and cost- effectiveness the need for a formal study is highlighted, and in the interim possibly a place for consensus guidance. We hope this paper can act as a stepping stone in the development of such essential endpoints.

The intra-operative cholangiogram: when is a filling defect not a filling defect?

Publication of retrospective series with a direct clinical implication is at the core of what the journal aims to do. Bill and colleagues[4] from St Louis, Missouri USA, have described a series of patients in whom the intra-operative cholangiogram (IOC) is deemed abnormal in the sense of poor passage of contrast, but in whom subsequent endoscopic retrograde cholangio-pancreatography (ERCP) shows no such abnormality. This poor correlation may relate to the difference between a filling defect and simply observing poor progress of contrast, and represents a previously undiscussed aspect of technique and interpretation.

An inflammatory bowel disease school for patients

Self-management is at the core of management of functional disorders, and expert centres have run irritable bowel syndrome (IBS) schools as a means of such patient help. But the concept of extending such a service to patients with inflammatory bowel disease (IBD) has not previously been explored. Sephton and colleagues[5] report on such a pilot venture from Manchester, UK. As patients become aware of the chronic nature of their condition they may increasingly ask for explanations and education about their disease rather than a pill to cure their symptoms as well as share experiences with each other within the group. In IBS, it has been demonstrated that a mixture of information giving and counselling is helpful to patients, and that such education has to be flexible enough to fit all patients, but also structured enough to permit evaluation. This manuscript extends that knowledge to patients with IBD, recognising that when evaluating an intervention such as patient education it is important not only to measure knowledge gain, but also indicators of adherence to the health-care programme.

And finally…

A varied edition also includes another in the series of Curriculum Based Reviews[6] (this one on small bowel imaging in Crohn's disease, accompanied by high value learning images and multiple choice questions); an unusual—and reversible—cause of post-operative intestinal failure; and a timely (given advances in imaging and surgery) clinical update on that medical school favourite, Meckel's diverticulum.

References

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3 Rowe IA. Opportunities to improve surveillance for hepatocellular carcinoma in the UK. *Frontline Gastroenterol* 2016;7:78–9.

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5 Sephton M, Kemp K, Ridgway V. An evaluation study of a pilot group education programme for inflammatory bowel disease. *Frontline Gastroenterol* 2016;7:135–40.

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