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Highlights from this issue

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Welcome to the first edition of our eighth year of publishing *Frontline Gastroenterology*. With our seven year hitch of being citeable on PubMed now behind us, we look forward to continuing to receive more high quality submissions. Our initiatives for the editions ahead include strengthening the online presence of the journal with Image of the Month and Case of the Month series – so, if you have suitable clinical material for such, do consider submitting. The best material will be included in the print edition.

An update on the Child's-Pugh scale: identifying the cirrhotic patient for palliative care

The editor's choice paper in this edition of *Frontline Gastroenterology* deal is one that we believe will directly influence clinical practice.¹ Following the wide international use of the Bristol Stool Form Scale in gut motility disorders, the city's academics have struck again. This time it is in the equally common presentation of end stage chronic liver disease. The unpredictable clinical course of patients with decompensated liver disease emphasises the importance of providing best quality palliative care of terminally ill patients as recognised by the Lancet standing commission on liver disease. There is no mechanism for optimally identifying such individuals to facilitate patient and family communication as well as initiate timely supportive care whilst considering any appropriate active disease management. Hudson and colleagues in Bristol have designed and validated such a prognostic screening tool to identify patients at risk of dying within a year of an admission with decompensated cirrhosis. The excellent positive predictive value of their tool underscores its clinical utility. A high quality prospective study using the tool to see the effect on patient outcome would be a paper we would be keen to see in the journal.

Apart from such a publication, we would be keen to see other potential contributions from authors who want to use the "Plan-Do-Study-Act" methodology that Hudson *et al* used in development of this instrument. This accelerated protocol for identifying areas for development and rapidly integrating could come to replace the increasingly tired format of clinical audit.

Frontline Gastroenterology and the GI trainee

A key focus of the journal is to assist the trainee gastroenterologist as he/she aims to keep abreast of the wide range of our

speciality. Not only do we have a range of organs and pathologies, but there is also the basic science principles underlying practice. In this edition we are delighted therefore to reflect this diversity in at least three different ways. Firstly, we publish two reviews – one on the basic principles behind virtual touch quantification of liver fibrosis from an expert UK centre,² and the other on the novel therapies available for primary biliary cholangitis from Harvard.³ Secondly, Bhandari⁴ and fellow experts in Japan report on a brief training intervention to improve endoscopic lesion recognition. By making use of existing educational videos they have shown that improvement is possible, and hence make the case for endoscopic training to focus on this aspect as much as the traditional technical ones. Finally, as trainees are encouraged to develop sub-specialty interest, it is timely to see how regional expertise can develop. Gordon *et al*⁵ describe how a network can be developed to allow expertise to be shared across a region. Specifically considering endoscopic ultrasound and fine needle aspiration of solid pancreatic lesions they show that such networks can perform to the same standard as high-volume centres.

The patient experience, and how to influence it

Single sex accommodation has been prioritised by many service providers as an essential requirement. Chatten *et al*⁶ report that whilst it is not of primary importance to most patients in an endoscopy setting. In an out-patient setting, Boland *et al*⁷ describe the deficiencies in provision of support to patients on home enteral nutrition in the setting of the Republic of Ireland. Both papers not only identify shortcomings, they each focus on the opportunity to suggest transformational measures and guideline development to improve the situation.

Can you innovate out of a crisis in health services?

The pressure on medical and surgical services is well known to our readership, as is the desire of health service managers to offload pressures on the system by clinical innovation. But is it possible for innovation to lead us out of such crises in service availability. Th'ng⁸ and colleagues in Edinburgh describe a success story. Following introduction of a consultant-led "hot clinic" to streamline acute surgical referrals they

demonstrate a reduction in admissions and length of stay. By contrast, Greenfield⁹ and colleagues report the results of a UK survey of acute upper gastrointestinal bleed provision. They show that availability of out-of-hours endoscopy remains patchy with many specialists providing the service alongside a commitment to unselected general medical take.

References

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