UpFront

Roland Valori

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This issue of *Frontline Gastroenterology* is more clinically based than usual and is packed with practical information for frontline teams. There is a particular focus on gastro-oesophageal reflux disease (GORD). GORD may seem like old hat but there are still many contentious issues and we have three excellent articles that explore these in detail. GORD is so common that even small changes in our practice will have big effects so please take the time to review these articles.

What you need to know when you prescribe a proton pump inhibitor

We have waited a long while for Chris Hawkey's thoughtful paper on prescribing proton pump inhibitor (PPIs), but the wait has been worth it. I thought using PPIs was pretty straightforward but this paper has proved me wrong. Hawkey argues that we can look at PPIs in a different way now that their cost is no longer a significant issue. He explains the key areas of difficulty very clearly, and makes balanced judgments on current literature and careful recommendations for practice.

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Respiratory and laryngeal symptoms secondary to gastro-oesophageal reflux

In recent years the literature on this important topic has been very confusing – so much so that I have been saying different things to my patients and to my respiratory and ENT (ear, nose and throat) colleagues after consecutive American drowsy driving warning system. We have, at last, in this edition of *Frontline Gastroenterology*, a sensible and digestible summary of the issues and some very practical advice for clinicians.

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A debate on the roles of antireflux surgery and long-term acid suppression in the management of gastro-oesophageal reflux disease

It is informative and reassuring to read this balanced review of the role of surgery and medication for GORD. The observation that there are no absolutes, and the conclusion that recommendations should be tailored to the individual, make a lot of sense. One key tip highlighted in the paper, which we have adopted locally, is to reconsider the diagnosis of GORD before switching to surgery when a patient is refractory to medical treatment: poor response to a PPI is a sound predictor of poor response to surgery. I like the neat little section entitled 'issues where there is simply no evidence'. Maybe we should encourage more reviews entitled 'common practice for which there is simply no evidence'.

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Mortality following blood transfusion for non-variceal upper gastrointestinal bleeding

Management of gastrointestinal bleeding is often complicated by the number of teams involved and the variation in treatment this leads to. Patients receiving blood they don't need is not uncommon. While the jury is still out on the headline of this original paper, 'transfusion does harm', surely it makes sense for us to review our transfusion practice and ensure we use no more blood than is necessary. Too often patients are 'topped up' with insufficient thought about whether they actually need the blood or whether some other form of volume replacement would suffice. A cautious approach, until we have more secure evidence, must make sense – and save money.

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Inflammatory bowel disease in transition: challenges and solutions in adolescent care

Few could argue with Sara McCartney's view that we could do a lot better managing adolescents with inflammatory bowel disease (IBD). Caring for adolescents with IBD is difficult enough without clinical teams being constrained by a lack of clarity about what a good service looks like and about the organisational challenges involved in achieving such a service. Dr McCartney's thorough review (based on much experience as well as the literature) outlines the problems coherently, offers solutions to how we might think through the issues and provides suggestions for patient-centred solutions to fit local contexts.

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A survey of patients' attitudes to upper gastrointestinal endoscopy identifies the value of endoscopist–patient-interactive factors

The endoscopy service in the UK has become very patient-focused in recent years, but there is some way to go before we can truly claim we have got it right for our patients. Understanding what matters most to them, and appreciating that their priorities might change with time, is critical to achieving this goal. It is very likely that as problems are overcome (eg, long waits and poor environments) patient concerns switch to new issues. This is why this study, and ones that will follow, are so important.

Hitherto patients have taken the expertise of doctors for granted. In this study they rate the technical and personal attributes of the endoscopist and the comfort of the procedure as their top three concerns. Our challenge is not just to get these things right, but to be able to show patients information about quality

and comfort that they can understand and that will inform their choices of where they have their endoscopy. If we achieve this then patient power will be the strongest driver of quality in future years.
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Premedications for infliximab infusions does not impact the risk of acute adverse drug reactions

This Canadian study questions the need for premedicating patients before they are given infliximab infusions. This is not a randomised controlled trial (RCT) but it should encourage IBD teams to audit their practice, reflect on outcomes and consider changing protocols. Of course the key issue is the rate of serious adverse events (0.2% or 5.5% of 4% in this study). It is unlikely that the sample in this study is big enough to determine an important difference when the rate of events is so low: I calculate 12 000 patients would be needed in an RCT to detect an increase in events from 0.2% to 0.4%. The real difference in serious adverse events (if there is one) in patients not given premedication is likely to be smaller than this and, if so, the sample would need to be huge to detect a difference. We are unlikely to get better evidence without a central reporting system – the sooner the better.
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