Highlights from this issue

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Following the Endoscopy special edition to coincide with Endolive 2017, this edition of *Frontline Gastroenterology* sees us return to mixed content, spanning service assessments in pancreato-biliary practice, patient education exercises in hepatology and guideline development in paediatric gastroenterology. As articles published in the journal are now cited on PubMed we have seen an increase in submissions, and unfortunately therefore a reduction in acceptance rate. The intention of the editorial team is to keep the journal strong in the domain of publishing articles with direct clinical impact for the specialist and trainee, and we continue to look forward to submissions with that theme.

The introduction of vedolizumab: pragmatic data from two centres

The advent of a new therapy for chronic inflammatory bowel disease represents an important milestone in practice for the clinician. And while large scale international randomised clinical trials provide regulators with evidence to licence these medications, local access to formulary often requires country-specific data. As such we are delighted to include in this edition of *Frontline Gastroenterology* a manuscript on observational data that complements the results generated by the GEMINI trials of vedolizumab. This is especially the case when those latter trials have suggested the efficacy of the drug primarily in patients who are naïve to anti-TNF therapies, and so the clinician needs to know at what stage of the treatment algorithm a novel strategy such as leucocyte migration inhibition may be effective in their patient cohort. Samaan *et al* report from two centres with early large clinical experience with the drug, and their findings will have a direct translatable message for the clinic.[1]

Gastrointestinal (GI) bleeding in special situations

GI haemorrhage remains a major cause of mortality in our specialty and while there are well understood and followed guidelines for upper gut bleeds, there are situations which remain a challenge for the clinician. One of these is when a patient on the intensive care unit (ICU) has a haemorrhage, when comorbidity is associated with a higher rate of haemodynamic instability and death. We are pleased to publish a paper from Columbia University, New York of consecutive admissions to an ICU over a 7 year period and the course of those who went on to have a GI bleed.[2] The paper gives prevalence data for GI bleeds in this cohort and confirms their high risk, but importantly also helps identify those at greatest risk according to baseline ICU admission clinical and serology status – understanding these factors could significantly assist the gastroenterologist called to see a patient on ICU.

Our ever-popular Curriculum Based Review series considers another important and often overlooked part of the teaching syllabus – lower GI bleeding. Ishaq *et al* update the textbook approach often taken to the subject with the provision of a pathway of investigation and management, but importantly in considering some of the recent developments in lower GI haemorrhage.[3] This includes the role of colonoscopy in post-polypectomy bleeding, the complementary approach of endoscopy and GI radiology in terms of site localisation, the role of the colorectal surgeon in refractory anal bleeding. While the MCQs at the end of the manuscript are directed at trainees, the paper as a whole should prove valuable for all endoscopists as well as clinicians who have a role in acute care.

Patient education in practice in chronic liver disease: channelling your inner Scorsese

Patients with chronic disease represent the majority of work undertaken by gastroenterologists and hepatologists. Tailored education allows the patient to make informed decisions with their physician regarding their care, particularly with regard to questions of surveillance (for hepatocellular carcinoma and varices). Goldsworthy and colleagues in Leeds report a study in which they initially assessed the knowledge of a cohort of cirrhosis patients and then applied a novel approach to patient information delivery: an educational video.[4] The details of this form of clinician-narrated 'screencast' to help provide an explanatory model is described, and then its efficacy assessed. While such a modality cannot replace one-to-one counselling it can provide a contemporary alternative to the increasingly redundant 'information leaflet'. The potential application of such film-making to other aspects of practice in chronic disorders, organic and functional, are evident.

Developing practical guidance in the absence of robust evidence

It is a common aspect of gastroenterology that clinical practice is based as much on experience and expertice rather than necessarily on evidence. Such empiricism is one of the attractions of the discipline for many, but guidance is critical to offer a framework for practice in the light of what evidence is available. It is therefore a pleasure to include a paper from a group of paediatric gastroenterology experts on the indications and utility of combined oesophageal pH-impedance monitoring in children.[5] While the tables and normal data included are likely to be frequently accessed by those with a technical interest, the manuscript and accompanying editorial will be of value to the general clinician with a view to detailing when to test and how to interpret abnormal (and normal) results.

REFERENCES

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