Highlights from this issue

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Gastrointestinal endoscopy during COVID 19 when less is more

The last few months have been challenging. The country has been locked down as a consequence of COVD-19 with a significant impact on the delivery of services for non COVID disease including endoscopy. In an insightful commentary in this issue - Gastrointestinal Endoscopy, when less is more - Cathyrn Edwards, President of the British Society of Gastroenterology and colleagues discuss the need for and achievement of UK wide consensus on how best to proceed. Most endoscopy has been paused with a rapid fall off in procedures done. This pause was felt to be the least damaging approach at the height of the crisis when there was (and still is) so much uncertainty about what will happen next during this now worldwide pandemic. The paper includes live links that will be updated as the evidence base develops around issues like the potential for faeco-oral transmission, the best personal protective equipment strategy, antigen and antibody testing. It is crucial that we get it right for patients first to minimise the secondary morbidity for non COVID disease but also to ensure patients and staff are safe as services resume during what is likely to be a very prolonged recovery period. *(See page 256)*

Successful implementation of remote video consultations for patients receiving home parenteral nutrition

The implementation of telephone and video consultations has become a top priority as a consequence of the service restraints that have a occurred with a the COVID-19 lockdown and which are likely to continue for many months. This practice change does present a potentially exciting service development opportunity. In this issue Coutier *et al* report the successful implementation of remote video consultations for patients requiring home parenteral nutrition in one of the national centres. The work predates the COVID-19 pandemic. Implementation started in 2015. Calls were by Skype. 25 patients (105 contacts) used the service, including for psychology follow-up. Clinicians felt the consultations were (mostly) successful. Patient satisfaction was high with a mean satisfaction score of 85%, 63%>90% (visual analogue score) and admissions were lower (8%) than in the whole home parenteral nutrition cohort (24%), although this may have reflected patient selection. Cumulative mileage saved was 18, 346. This is of course pilot data for what is becoming common place and may reflect a change in how we deliver at least some of the follow-up for patients with chronic medical problems who require regular multidisciplinary team review and will likely be the focus of future research and service change. Editor's Choice this month. *(See page 280)*

Alcohol care teams – where are we now

The high morbidity and mortality from alcohol consumption is well known and developing strategies to impact on this are part of the 2019 NHS Long Term plan for England and the United Nations Sustainable Development Goals. The practicalities of implementation are less straightforward. In this issue Kieran Moriarty discusses the background, components of and evidence base for Alcohol Care Teams. These have been set up as part of acute services over the last 10–15 years, although not yet universally. Key components include a clinician-led, multidisciplinary team, with integrated alcohol treatment pathways across primary, secondary and community care, coordinated alcohol policies for emergency departments and acute medical units, a 7 day alcohol specialist nurse service, addiction and liaison psychiatry services, an alcohol assertive outreach team, and consultant hepatologists and gastroenterologists with liver disease expertise in order to facilitate collaborative, multidisciplinary, person-centred care. All are discussed in detail. The paper is essential reading and will help clinicians and policy makers to achieve progress in controlling the global issue of alcohol use and the consequences of it on well-being and long term health outcomes. *(See page 293)*

British Society of Gastroenterology (BSG)-led multisociety consensus care bundle for the early clinical management of acute upper gastrointestinal bleeding

There is no doubt that medical care bundles improve standards of care and clinical outcomes. The best impact is likely to be seen in conditions where there is significant variation in management. In this issue we publish the British Society of Gastroenterology led multi-society consensus care bundle which detail the key interventions to be performed within 24 hours of presentation with acute gastrointestinal bleeding. This was achieved after extensive literature review and a modified Delphi process with key stakeholders. The paper includes key recommendations (19) and 14 care bundles items across six important management domains – recognition, resuscitation, risk assessment, Rx (treatment), refer and review justified in the accompanying text. The paper is essential reading especially during the current Coronavirus pandemic when the priority is to keep our patients safe but also to reduce secondary harm in non-COVID patients who are at risk as consequence of the necessary restrictions on endoscopy services. Longer term this excellent piece of work will undoubtedly give us the potential, using evidence and consensus, to improve the quality of care and outcomes of patients with Acute Upper Gastrointestinal Bleeding. *(See page 311)*

Finally

In these uncertain times there is a need to rapidly publish the best evidence to inform public health decisions and clinical practice. Key articles on COVID −19 from Frontline Gastroenterology are free to access and there are a number in this edition. We have also included an evidence summary which I hope is helpful and will continue to publish articles relevant to our clinical practice on COVID 19 and the many other conditions we deal with. I am grateful for the continued enthusiasm and support of the authors, reviewers, editors and readers during this challenging time.

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