Highlights from this issue

doi:10.1136/flgastro-2021-102009

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National census of UK endoscopy services in 2019

This is an important paper reflecting endoscopy practice in the UK in the year prior to the pandemic and will be an invaluable resource in the (ongoing) planning of how best to re-establish and where appropriate reconfigure services. The headline for me was that there were more than two million gastrointestinal endoscopic procedures performed by more than 5000 endoscopists in 2019 and that is likely to reflect under reporting (census returned by 322/471 centres). Predictably more procedures were done by more people than reported in the last census in 2017. The interesting data set will be the numbers for 2020 and 2021 and to reflect on how the restrictions faced during the pandemic will impact on services moving forward including the challenging question as to whether all the procedures done previously will still be considered necessary with the practice changes we have all had to make *(see page 451)*.

Constipation in ulcerative colitis: pathophysiology and practical management

Constipation is well recognised in ulcerative colitis (UCAC) during the acute phase (particularly proximal constipation in the setting of distal disease) and in remission although not always straightforward to diagnose or treat. In this issue Miller and colleagues discuss the pathophysiology and practical management. Factors in the aetiology include that chronic inflammation has significant effects on the enteric nervous system, colonic structure and motility that may predispose to constipation. Diagnosis is (mostly) clinical. The modified ROME 111 criteria can be used (see box 1 in the paper). Plain Abdominal X-ray is not generally useful although bowel transit studies can be helpful. Treatment (not evidence based) includes consideration of biofeedback, prokinetics and laxatives – detailed discussion and excellent algorithm in the paper. This is an important topic. There is no doubt that adequate treatment of UCAC may help achieve clinical remission in flares and may help avoid unnecessary treatment escalation in patients in remission with symptomatic constipation rather than a disease flare. Research questions are highlighted and include - What is the underlying motility disturbance; what is the optimal diagnostic test; what is the optimal diet or dietary intervention and what is the optimal laxative and pharmacological treatment strategy for this condition. Essential reading and Editor's Choice this month *(see page 493)*.

Incidence and prevalence of inflammatory bowel disease in Devon, UK

We are all aware from our clinical practice that the incidence and prevalence of inflammatory bowel disease continues to increase. There has been some suggestion that at least in some settings the incidence has started to plateau. In this issue Hamilton *et al* report their local data from Devon, UK. They confirm the incidence looks to be stabilising although also report prevalence has increased by almost 40% over the last 10 years reporting one of the highest prevalence rates from Northern Europe for UC, CD and IBD unclassified of 479.72, 265.94 and 35.34 per 100 000 persons, respectively and estimating that by 2030 the overall prevalence will reach 1%. The authors also highlight that there have been significant increases in use of biologics over and above the increase in prevalence – 45.8 per 1000 patients in 2010; 148.3 per 1000 in 2017 and that this is likely to continue to increase. This dataset reflects our clinical practice and looking forward we need to reflect on how to best manage patients with inflammatory bowel disease within the healthcare resource available particularly with the clinical practice challenges and opportunities we need to embrace as we start to emerge from the COVID-19 pandemic *(see page 461)*.

Current review of the management of fistulising perianal Crohn's disease

Managing non-IBD fistulising disease

These two articles in education and practice provide an authoritative over view of the aetiology, assessment and management of fistulising perianal disease. In the first Adegobola *et al* cover fistulising perianal Crohn's disease including the medical and surgical management – consensus based, the indications for seton placement, the massive impact of biological usage and when consideration should be given to more invasive surgical options including reparative surgery and in some cases, defunctioning ostomy or proctectomy. Future development are discussed but in summary the treatment of Crohn's perianal fistulas are to drain the underlying sepsis and place setons, aggressively manage proctitis and medically treat the fistulas with a combination of antibiotics, immunosuppressants and anti-TNF therapy.

In the second article Tozen *et al* review non-IBD fistulising disease usually straightforward but sometimes not. These include complex cryptoglandular fistula, rectovaginal fistula (RVF) and those associated with ileoanal pouches which are associated with high levels of morbidity, risk and treatment failure. These conditions are discussed in detail including recognition, assessment and management and the indications for specialist input. The article has multiple helpful images and figures in it. Complex anal fistula are hard to treat, treatment goals should be realistic. In refractory cases IBD should always be considered *(see pages 515)*.

Provision of care for pregnant women with inflammatory bowel disease in the UK: the current landscape

The British Society of Gastroenterology and British Maternal and Foetal Medicine Society have recently published guidance on service setup and minimum standards for care for pregnant women with Inflammatory Bowel Disease (IBD).[1] In this issue Wollof *et al* survey the current landscape. In summary the findings suggest that in many units there is a lack of robust systems to manage IBD during pregnancy and that input and communication with obstetric services is adhoc and not regular. We know women with IBD have a higher

risk of adverse pregnancy outcomes. We know IBD disease activity is associated with adverse pregnancy outcomes and so consideration of ongoing treatment and prompt management of flares is essential. The authors recommend that IBD units should devise systems that ensure regular review during pregnancy by suitable experienced clinicians with regular communication with obstetric services and involvement in key decisions. This might, in larger units include a dedicated specialist clinic *(see page 487)*.

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1 Selinger C, Carey N, Cassere S, *et al*. Standards for the provision of antenatal care for patients with inflammatory bowel disease: guidance endorsed by the British Society of gastroenterology and the British maternal and fetal medicine Society. *Frontline Gastroenterol* 2021;12:182–7.