Highlights from this issue

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Neuroendocrine tumours – what gastroenterologists need to know

Neuroendocrine tumours are more common than we might think (annual incidence 7-8/100,000). The most common primary sites are the gut and pancreas. In this issue Khan and colleagues provide a comprehensive overview. There are multiple tumour types. Diagnostic delay is common as symptoms can be similar to, for example, irritable bowel syndrome. The authors helpfully discuss the clinical features and investigation when NETS are suspected including biochemistry (not helpful for screening), CT/MRI/Nuclear Medicine and Endoscopy. Diagnosis is by histology. Treatment requires a comprehensive work up and multidisciplinary team discussion. Tumour resection is usually advised for localised NETS. Long-acting somatostatin analogues are the treatment of choice for unresectable low-grade NETS. There are multiple other treatment options for more extensive disease. Outcome is generally good influenced by tumour site, size and spread at diagnosis (appendiceal NETS have the best prognosis). Gastroenterologists have a a key role to play in the whole pathway including in particular the longer-term control of gut symptoms. This is a very comprehensive update. Read and enjoy, listen to the accompanying podcast. *(See page 50)*

The bowel cancer screening workforce survey: developing the endoscopy workforce for 2025 and beyond

The demand for bowel cancer screening is expected to continue to increase although there is very little data to inform how this will be best delivered. In this issue Ravindran and colleagues report national data on the clinical time spent by endoscopists on screening and their future career intentions. It makes interesting reading – 578 respondents. Most consultants had 1 PA per week for screening and would happily take on more if they could relinquish outpatient clinics, acute medical/surgical on call and ward cover. Of note a significant number of endoscopists were considering giving up colonoscopy in the next few years. By data modelling and based on future projected numbers of colonoscopies the authors predict the need for a significant increase in the numbers of screening colonoscopists and time doing colonoscopy within their job plan by 2025. The data challenges us to think creatively about all aspect of this service – there are suggestions in the paper and there is an excellent accompanying commentary – **Colonoscopy in the post-COVID-19 era.** *(See pages 3 and 12)*

The joint advisory group on GI endoscopy (JAG) framework for managing underperformance in gastrointestinal endoscopy

This is an important topic. Patient safety is fundamental to high-quality clinical care. There are multiple factors which impact on this including clinician performance. It is challenging to manage when performance falls below the desired minimum standard acceptable for patient care. In this issue Ravindran and colleagues report the JAG (Joint Advisory Group on Gastrointestinal Endoscopy) framework for managing underperformance in gastrointestinal endoscopy. There are many issues discussed. This includes strategies to aid detection through performance data, self-reporting, feedback, specific incidents (governance) and appraisal. There is a helpful table of causative factors which includes extrinsic factors such as patient case mix, overbooked lists, staffing, equipment. There are four steps to manage – verify underperformance, identify additional causative factors, provide support and re-assess. There are some useful guidance notes and figures in the document under these headings. It is obviously important that the process is managed with sensitivity and professionalism. The guidance is helpful and pragmatic and could be applied to many other areas with the intent of supporting individuals and teams to provide safe and high quality clinical care. *(See page 5)*

Side effects of drug treatments for gastro-oesophageal reflux disease: current controversies

It is important for us to know about the side effects of commonly used drugs such as proton pump inhibitors (PPI's) and histamine-2 receptor antagonists (H2-RA) which are used extensively to treat Gastro-oesophageal reflux disease. In this issue Dhar and colleagues discuss the evidence for reported side effects most of which are associations rather than causal. PPI's have been associated with osteoporosis, kidney injury, dementia, micronutrient deficiency, infections (including Clostridium Difficile) and gastric cancer. H2-RA have been associated with tachyphylaxis, hip fractures, gynaecomastia, impotence and headache. More recently (2019) contamination of H2-RA with N-nitrosodimethylamine, a potential carcinogen has led to the withdrawal of some of these drugs. The authors discuss all of this in detail. The conclusion is that the drugs are pretty safe but the article does reinforce the importance of reviewing the patient's medication regularly for efficacy and consideration of toxicity even if not common. *(See page 45)*

Recent advances in liver transplantation

Liver transplantation is a life-saving treatment with 1- and 5 year survival rate of 90% and 70%. In this issue Burke and colleagues discuss recent advances. Organ demand continues to exceed supply. There are useful sections on new 'opt-out' systems for organ donation being rolled out in the UK, organ utilisation (normothermic machine perfusion) to enable better assessment and preservation of grafts) and a new (UK) national system for organ allocation. There is a detailed discussion of pre-operative optimisation 'prehabilitation' to reduce waiting list mortality and improve outcomes following transplantation. This includes nutritional and psychological input and exercise. Novel indications for liver transplant include Alcoholic Steatohepatitis (severe) and Acute on chronic liver failure which is now accepted as a

distinct clinical entity. There is considerable interest in how to best optimise post transplantation management – this includes identification and management of potential modifiable risk factors such as hypertension, hypercholesterolemia, obesity, diabetes, renal dysfunction and cardiac and cerebrovascular events. Further work is required to identify which patients may safely discontinue immunosuppression during long-term follow-up and how to deliver the 'optimal' post-LT management. ***(See page 57)***

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