



Highlights from this Issue

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No-biopsy strategy for coeliac disease is applicable in adult patients: a 'real-world' Scottish experience

Previously the gold standard for the diagnosis of Coeliac Disease was small intestinal biopsy. The advent of increasingly robust serological testing has resulted in the development of 'no-biopsy' diagnostic algorithms led by the European Society of Paediatric Gastroenterology, Hepatology and Nutrition. In summary (the detail is in the paper) if the TGA-IgA is >10 times the upper limit of normal then biopsy is not required. In this paper the authors test their 'real world' experience in their 2016 cohort. Of 1429 patients with positive serology 1037 proceeded to biopsy, of which 796/1037 (76.8%) were diagnosed as CD. A total of 320/322 (99.37%) patients with TGA-IgA $\geq 10 \times$ ULN were diagnosed as CD giving the cut-off a positive predictive value of 99.38%.

No significant co-pathology was found at endoscopy in these patients. The authors rightly conclude that the no biopsy strategy used in children can be adopted in adults with the potential to improve time to diagnosis and reduce the endoscopy burden. There is an excellent accompanying commentary A no-biopsy approach to the diagnosis of coeliac disease.

(See page 97).

UK endoscopy workload and workforce patterns: is there potential to increase capacity? A BSG analysis of the National Endoscopy Database

There is a continued mismatch between demand for endoscopy services and supply with insufficient capacity to meet demand. In this issue Beaton and colleagues analyse the procedures done between March 2019 and February 2020 – 1639640 procedures; 407 sites; 4990 endoscopists. The authors look at procedure type, where is was done, by whom, how many were training procedures and age ranges in both the NHS (89% of procedures) and private sector. Of note a large

proportion of endoscopists do not reach recommended minimum annual procedure numbers. Non-medical endoscopists (NMEs) deliver substantially more procedures on average than medical endoscopists. The independent sector performs endoscopy on a younger cohort of patients and does almost no endoscopy training. Substantial additional endoscopy capacity exists at weekends. All important issues to consider. This is an impressive and comprehensive data set with the potential to inform policy. There is an excellent accompanying commentary - The wind of change - what can we learn from the National Endoscopy Database.

(See page 103).

Aetiology, diagnosis and management of small intestinal bacterial overgrowth

Small Intestinal Bacterial Overgrowth is multifactorial and can be difficult to diagnose and difficult to treat. In an excellent review in this issue Ahmed and colleagues discuss aetiology, diagnosis and management. Chronic diarrhoea and bloating are the most common symptoms. Risk factors include – gut dysmotility, anatomical changes (including surgery during infancy/childhood), altered gastrointestinal secretions and impaired gut immunity. Breath testing (discussed in detail) is the most common first line investigation although not particularly sensitive or specific. Effective treatment includes diet and lifestyle, antibiotics and addressing the underlying pathophysiology where possible. The authors discuss the different antibiotics and regimens used – treatment and prophylactic (generally cyclical). Rifaximin has the strongest evidence base but many others including metronidazole are frequently used alone or in combination. There is no universally agreed protocol. The topic is important and this helpful and practical review is Editor's Choice this month.

(See page 149).

Changes to UK BCG vaccination schedules with implications for women on biologic medications during pregnancy

In an important letter this month Matthew Parsons and Rachel Cooney highlight important changes to the UK BCG vaccination schedules with the timing of vaccination (in at risk groups) being deferred from birth to 4 weeks. This means that community rather than obstetric and midwifery services will be responsible for the timing of vaccination. Readers will be aware that the British Society of Gastroenterology recommend that babies exposed to biologics in pregnancy should not receive live vaccines for the first year of life, although the implementation of this is largely dependant on maternal recollection and understanding of exactly what type of medication they have received and the implications for vaccination of their baby. The authors recommend written information is given to mother's during pregnancy listing which vaccines cannot be given and why, maternity and neonatal records are updated (including the red book) and relevant to much of medicine generic rather than proprietary names are used to avoid and confusion.

(See page 175).

Twitter debates – dysphagia and green endoscopy

Please read and enjoy the write ups from two of our recent twitter debates – these are a great forum to discuss topical and practical issues. For both there were a wide range of participants with plenty of tweets and a wide reach. Aditi Kumar reports on the debate 'Controversies in the Management of Dysphagia' discussing the management of food bolus obstruction, eosinophilic oesophagitis, oesophageal strictures and further investigation including the investigation of oesophageal motility. Well worth reading through - full of 'real world' issues and discussion. Jennie Clough reports on the second debate - Green Gastroenterology: Are we nearly there yet? – topical and relevant but what can we actually do about it. Issues discussed include attendance at conferences, green endoscopy, diet and reflecting

on personal choices – very engaging to read and includes an excellent table summarising the steps required to create a sustainable endoscopy environment. (See page 155).

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