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Optimising triage of urgent referrals for suspected IBD: results from the Birmingham IBD inception study

We are all aware that diagnostic delays in inflammatory bowel disease (IBD) result in adverse outcomes. In this issue, Rimmer and colleagues report the outcome of a bespoke diagnostic pathway to combine clinical history and faecal calprotectin for early diagnosis. Patients were triaged using symptoms and faecal calprotectin (including initial and repeat faecal calprotectin). 767 patients reported of which 423 were diagnosed with IBD. The most common symptoms in Crohn's disease were abdominal pain (84%), looser stools (84%) and fatigue (79%) and in ulcerative colitis per-rectal bleeding (94%), urgency (82%) and looser stools (81%). Repeat faecal calprotectin testing showed a reduction from baseline in non-IBD. Both measurements >100 µg/g (area under the curve (AUC) 0.800) and >200 µg/g (AUC 0.834) collectively predicted IBD. Second value ≥220 µg/g considered alone, regardless of the first result, was more accurate (Youden's index 0.735, AUC 0.923). Modelling symptoms with FCP increased AUC to 0.947. In summary therefore persistently elevated faecal calprotectin is predictive of inflammatory bowel disease. Modelling symptoms with faecal calprotectin increase the accuracy of the prediction. Low or reduced levels, in the absence of symptoms, make inflammatory bowel disease less likely. I appreciated the paper in some respects just confirms what we think but adapting this evidence into triage algorithms does have the potential to reduce time to diagnosis by streamlining better who needs endoscopy. *(See page 281)*

Liver outcomes following proctocolectomy in patients with primary sclerosing cholangitis and ulcerative colitis

80% of patients with primary sclerosing cholangitis have concomitant ulcerative colitis. In a significant amount proctocolectomy with the potential for either end ileostomy or restorative options including ileo-pouch anal anastomosis or ileo-rectal anastomosis (IPAA) is required. In this issue, in a systematic review Ryan and colleagues assess the impact of the different approaches on liver disease. The literature is limited although the question is important; eight studies. In summary—in the data set—proctocoletomy did not result in any deterioration in the liver disease and outcome was better for ileostomy than IPAA although more data is needed. *(See page 314)*

Oral manifestations of inflammatory bowel disease: a guide to examination

Orofacial symptoms are common in patients with IBD. They present as a primary manifestation of the disease (Crohn's disease) or secondary to disease manifestations such as iron deficiency or drug therapy. The impact of orofacial manifestations can result in significant morbidity and systematic examination—not always done—is an essential prerequisite to the best treatment. In this issue, Joshi and colleagues present a comprehensive guide to the extraoral (includes lymph nodes, lips and skin) and intraoral examination. The authors have included figures, tables and an extensive series of images. Oral Crohn's disease and orofacial granulomatous disease (OFG) are discussed in detail including treatments. There is an approximate 25% chance of developing intestinal Crohn's over 10 years when the diagnosis of OFG is made before age 16 years. Secondary manifestations of IBD include aphthous ulceration, Stomatitis (including Stomatitis Gangrenosum) and Staphylococcal mucositis. The various drugs used in IBD and drug-related side effects are discussed in detail. This is an excellent paper and essential reading for all clinicians managing IBD.

Editor's Choice – *See page 328*

Real-world effectiveness of upadacitinib in Crohn's disease: a UK multicentre retrospective cohort study

Upadacitinib—JAK inhibitor—has recently received approval for use in Crohn's disease in the UK based on positive results in phase three trials. In this issue, Elford and colleagues report their 'real world' experience based on retrospective data collection from National Health Service Lothian and the Royal Devon and Exeter NHS Trust; 135 patients started taking upadacitinib, 93 with active Crohn's disease followed to at least 12 weeks were included. Most had received at least two advanced therapies previously. All patients were started on 45 mg (apart from one with impaired renal function) and most received 30 mg as maintenance. There is a lot of data in the paper. Treatment persistence was 87.1% at week 12, 81.7% at week 24 and 62.8% at week 52. Follow-up data is recorded where available. Rates of clinical remission were 64% (42/66), 48% (22/46) and 38% (8/21) at weeks 12, 24 and 52, respectively. C reactive protein remission rates were 55% (40/73) at week 12, 38% (20/53) at week 24 and 19% (6/22) at week 52. Faecal calprotectin remission rates were 50% (24/48) at week 12, 36% (15/42) at week 24 and 19% (3/16) at week 52. There was a significant number of adverse effects—see table 2—although these were in a cohort of patients with moderate to severe disease and resistant to other therapies and it is not always clear whether the side effects were disease or drug-related or a combination of both. This is an important paper which supports the trial data and demonstrates that upadacitinib is an effective treatment option, in real-world, medically refractory, Crohn's disease. *(See page 297)*

To biopsy or not to biopsy (for the diagnosis of Coeliac disease): insights from the #FGDebate

This is an important and topical question particularly with the ongoing pressures with waiting list and access to endoscopy. In this issue, McGinty and colleagues summarise the discussion from the September 2023 #FGdebate. The authors provide a helpful summary of the quick facts—Coeliac disease can be diagnosed using serology alone; there is growing UK data that a TTG-IgA level greater than 10× the upper limit of normal can be used in patients with no red flags to diagnose and a summary of the BSG guidance (box 2). The discussions were around the safety of the no biopsy strategy—more data will be helpful—but in summary the no biopsy strategy was felt to be effective in those with a TG-IgA>10 times the upper limit of normal (in the absence of red flag symptoms). D1 and D2 biopsies are indicated for best interpretation.

There was some discussion about seronegative Coeliac disease and how best to assess for that perhaps questioning the BSG guidance that if TTG-IgA is negative the biopsy is not indicated. There is also the required note of caution that a mildly elevated TTG-IgA does not confirm the diagnosis and more considered assessment of such cases is required. Enjoy the write up and look out for future debates. ***(See page 340)***

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