UpFront

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Developing specialised pancreatic and EUS services

The commissioning landscape is changing dramatically. The key to using the available resource most effectively will be to ensure patients see the right health professional, in the right place, in a timely way. This approach will result in movement of many patients towards primary and self-care, and movement of a minority in the other direction, towards more specialised care. Patients with pancreatic disease and those requiring EUS probably fall into the second category. These excellent papers argue why and explain how. We need more examples of how subspecialist care can be delivered effectively and efficiently. This will provide the evidence gastroenterologists and hepatologists need to define the future landscape of commissioning. There also needs to be clarity, on the basis of this type of experience, of what services need to be provided at a regional level and how they should be configured.

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Collaborative psychiatric and liver care

The UK has moved into the premier league for alcohol related liver disease. There appears to be a political will to reverse this unwelcome change but financial and other levers will take time to take effect. Meanwhile, much inpatient gastroenterology will be devoted to managing patients with acute and end stage liver disease (mostly alcohol related). It is common sense to treat more than the physical manifestations of alcohol related liver disease. In this paper, Dr Moriarty describes how he has created a partnership with mental health services and developed a coherent multidisciplinary team to look after patients with liver disease in Bolton. It is a fine example of how to achieve the very difficult. It is very much in the spirit of a different way of managing long term conditions in the future. His model should underpin any conversation about how alcohol related liver disease can be managed more effectively.

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Bariatric surgery

The UK has been relatively slow to adopt bariatric surgery but it is difficult to envisage that it will be anything other than a growth industry. The editorial team of *Frontline Gastroenterology* was of the view that surgical management of bariatric patients is of relevance to gastroenterologists and hepatologists, and that there were fascinating health economic issues from which we could learn a great deal. Pollard provides an excellent insight into what bariatric surgery involves and what impact it can have. Ashrafian *et al* explains that the health economic perspective is far from straightforward. We are left asking whether we can afford to deliver more bariatric surgery, or whether we can afford not to.

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Radiological alternatives to colonoscopy

Unless a cure for bowel cancer is discovered, the demand for imaging of the colon will continue rising. The paper from Shariff *et al* puts another, perhaps final, nail in the barium enema coffin, putting further strain on colonoscopy as barium enema is rightly replaced by colonoscopy. Despite the emphasis on the poor performance of barium enema, colonoscopy, in this study, also missed cancer. This shortcoming has been identified in other studies. Only very careful (which mostly means slower) colonoscopy will reduce miss rates to the best published levels (1%) and this will put further strain on capacity. Wylie and Burling present an alternative providing an excellent review of the current position of CT colonoscopy (CTC). They make a strong plea for gastroenterology and radiology teams to work closely together to 'improve diagnostic efficiency and the patient experience'. As well as working together, teams should compete with each other to produce the best quality outcome data and the best outcomes. Team work *and* competition will be a win-win for patients.

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Predicting adverse events at EUS

The core principles of improving safety are to deliver care as well as possible first time round and, when things go wrong, learn from the episode and change things to reduce the chance of it happening again. Doing it as well as possible first time requires knowing what can go wrong and, very importantly, in what circumstances. The system can then be designed, and health professionals can be trained to minimise further problems. This paper from Kalaitzakis *et al* describes 'the what', and potential influencing factors. The results, from a large single centre experience, provide a benchmark against which they can improve and against which others can compare themselves. Moreover, the data provide key information for patients when consented for EUS.

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