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metrics

this

Highlights from this issue

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Real-life experience to improve

The degree of patient co-morbidity

is well recognised as significant

contributor to the outcome of

patients presenting with an upper

gastrointestinal bleed (UGIB). In

Gastroenterology Taha et al1 have

published a single centre series of

2669 patients over 15 years which

confirms the impression of front-

line endoscopists that the patients

they are seeing are getting increas-

ingly more complex and more

unwell. They also suggest that the

introduction of a multidisciplinary

approach for this growing complex-

ity of case-mix has resulted in

improved outcomes. The journal

has published several high quality

articles looking at provision of

UGIB services, and this paper adds

to that in helping define what a

We have also published a series of

articles on quality improvements in

colonoscopy, and are delighted to

publish more in this edition to com-

plement those. Vaughan-Shaw et al²

have investigated a large series of

repeat colonoscopies from a single

endoscopy training centre over three

years. With the burgeoning of pos-

outcome it is proposed that the

detection of new pathology in such

repeat procedures be included.

Another aspect of quality improve-

ment that we can learn from in

endoscopy is the improvements in

surgical safety brought about by

of

colonoscopy

metrics

bring to this common problem.

approach

multidisciplinary

sible

BMJ

of

Frontline

endoscopy outcomes:

edition

optimising teamwork and

they also provide a videolink to demonstrate its utility and potential to improve safety and teamwork.

Increasing patient choice through tailoring pain relief is another potential key metric in endoscopy units. Ball et al4 report a survey of UK bowel cancer screening colonoscopists in the UK which highlights that whilst Entonox is generally thought to be effective and convenient, it is used relatively infrequently. Interestingly, most colonoscopists would opt to receive Entonox themselves if they had to have the procedure. The final themed article in this edition is the Curriculum Based review (with BMJ Learning module online) by Mohanaruban et al.5 They provide a practical and complete review of the process of consenting for endoscopy.

Risk stratification in the assessment of iron deficiency anaemia

If upper GI bleeding is the most frequent component of the acute gastroenterology workload, matching clinic issue is that of iron deficiency anaemia (IDA). A way of risk stratification therefore holds potential to rationalise investigations in this common condition. Undertaking careful analysis of a large cohort of patients presenting over an eight year period, Snook et al6 have identified three key, clinical variables simple, predict the likelihood of GI malignancy in patients presenting with IDA: do read the article to find out what those are... The potential for developing a scoring system to investigate IDA-similar to those developed for upper GI bleeds—is raised by the robust statistical analysis presented by the authors.

Another potentially cost effective way of approaching IDA is to utilise faecal occult blood testing of stool. The UK bowel cancer screening programme has shown that this

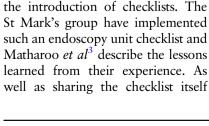
test may be of great value when used in a focussed manner. Chowdhury et al⁷ explore the value of faecal occult blood testing in IDA, showing that a negative test has a 99% sensitivity at excluding colonic disease by colonoscopy. Given the costs and intrusiveness of colonoscopy in this often multiply co-morbid population, it is possible that faecal occult blood testing may represent a viable screening tool.

Treatment of Non-Alcoholic Fatty Liver Disease

This edition's focus on common clinical scenarios includes a review increasingly prevalent problem of non-alcoholic fatty liver disease (NAFLD). Dyson et al⁸ have summarised a large body of research to provide a hands-on management approach based on meticulous risk-stratification (as per the publication by the same authors in the last edition of Frontline Gastroenterology). They provide an evidenced approach to care based on addressing four main targets of therapy in patients with NAFLD: lifestyle modification, aspects of the metabolic syndrome, liver-directed pharmacotherapy and the complications of cirrhosis.

References

- 1 Taha AS, Saffouri E, McCloskey C, et al. Falling mortality when adjusted for comorbidity in upper gastrointestinal bleeding: relevance of multi-disciplinary care. Frontline Gastroenterology 2014;5:243-8.
- Vaughan-Shaw PG, Aung M, Sahnan K, et al. Findings on interval colonoscopies: an auditable performance indicator for colonoscopy quality? Frontline Gastroenterology 2014;5:249-53.
- Matharoo M, Thomas-Gibson S, Haycock A, et al. Implementation of an







- endoscopy safety checklist. *Frontline Gastroenterology* 2014;5:260–5.
- 4 Ball AJ, Campbell JA, Riley SA. Nitrous oxide use during colonoscopy: na national survey of English screening colonoscopists. *Frontline Gastroenterology* 2014;5:254–9.
- 5 Mohanaruban A, Flanders L, Dor R. Consent in the endoscopy department.
- Frontline Gastroenterology 2014;5:291–6.
- 6 Castro Silva A, Sheppard ZA, Surgenor SL, et al. Clinical risk factors for underlying gastrointestinal malignancy in iron deficiency anaemia: the IDIOM study. Frontline Gastroenterology 2014;5:237–42.
- 7 Chowdhury ATMD, Longcroft-Wheaton G, Davis A, *et al.* Role of faecal occult bloods in the diagnosis of iron deficiency anaemia. *Frontline Gastroenterology* 2014;5:231–6.
- 8 Dyson JK, Anstee QM, McPherson S. Non-alcoholic fatty liver disease: a practical approach to treatment. *Frontline Gastroenterology* 2014;5:277–86.