Highlights from this issue

doi:10.1136/flgastro-2016-100719

Anton V Emmanuel

Telephone clinics in inflammatory bowel disease: an extended role for the nurse specialist

Chronic management of patients with inflammatory bowel disease (IBD) is, appropriately, in the community supported by expert input from secondary care. Increasingly, in the UK, the role of the specialist nurse is central to provision of such services to patients with chronic illnesses. So it is appropriate that a telemedicine service has been developed and reported on, from Scotland, in this issue of *Frontline Gastroenterology*. In a cycle of health care funding in which there is great pressure on general practitioners, this becomes especially acute, and it is maybe not surprising that one-third of the utilisation of the service was for non-IBD related matters. Average call times were 20 minutes, reflecting the importance of giving sufficient time to patients and emphasising the value of such telephone services to support best care of patients with IBD. The paper by Squires *et al*[1] also includes a simple financial analysis which supports such a service on the grounds of reducing other healthcare utilisation. Do read the article to see if the volume of calls is something that could be scheduled to improve patient care in your service.

Managing common symptoms of primary biliary cirrhosis

Pruritus and fatigue are the most disabling symptoms of primary biliary cirrhosis (PBC) and this edition of *Frontline Gastroenterology* has articles on each of these complaints. An internationally authored review of management of pruritus highlights the chronicity of the symptom and the prevalence in younger presenting patients. This is followed by highly clinically usable tools to quantify the symptom and then an elegant summary of the available treatments, underpinned by their aetiological plausibility and the evidence of clinical benefit. The importance of combining specific antipruritic therapy with disease-modifying drugs in a step-up approach with guideline recommended therapies is stressed.

The importance of optimising cardiorespiratory function in these often fatigued PBS patients is elegantly demonstrated by Hallsworth *et al*[2] in a Case Report. They describe how a personalised exercise programme effectively "pre-habilitated" a patient to successfully undergo a liver transplant. Interestingly, whilst objective exercise parameters improved with the programme, subjective fatigue did not, highlighting the importance of looking beyond just patient self-report in treating these individuals.

Service provision and training in endoscopy: what do patients want and what do endoscopists want?

One of the challenges of contemporary "patient-centred" care is to make it truly so, rather than just reflecting clinician's views of what patients would want. As such, the manuscript by Tierney *et al*[3] in this edition is potentially critical to practice and training in endoscopy. The methodically performed study highlights that competence and courtesy are valued significantly higher than waiting times.

Another driver of service development is learning from external peers. Surveys represent an opportunity for this and Callaghan *et al*[4] present findings on variation in gastroscopy practice around the UK. They identify the potential for standardising duration of fast pre-procedure, as well as raising the debate about mucolytic use in an era of identifying subtle mucosal lesions for focussed histology.

Training in endoscopy has been driven in equal measure by teaching technique and by standard setting. A possible consequence of this is highlighted in a study from a busy endoscopy unit with the numbers to support the finding that 1 in 50 colonoscopy cases are "down-sized" to flexible sigmoidoscopy in order to maintain the 90% standard set for complete examination. The authors suggest a possible "third way" – proposing a new procedure option of "planned limited colonoscopy". Is this semantics or an important measure of performance – please do engage in the debate.

Endoscopic management of biliary strictures: defining best practice

Biliary strictures remain a major clinical challenge to gastroenterologists, specifically with regard to identifying benign from malignant aetiology in order to prioritise surgery. In a succinct internationally co-authored review Dawwas *et al*[5] point to the role of existing and emerging endoscopic techniques in the assessment and treatment of this complex problem.

Mohammed *et al*[6] provide a case series and literature review of management of common bile duct stones. They highlight the centrality of duct clearance by all possible modalities with stenting in only selected patients.

References

1 Squires SI, Boal AJ, Naismith GD. The financial impact of a nurse-led telemedicine service for inflammatory bowel disease in a large district general hospital. *Front Gastroenterol* 2016;7:216–221.
2 Hallsworth K, Jopson L, Jones DE, *et al*. Exercise therapy in primary biliary cirrhosis: the importance of moving while sitting on a surgical waiting list—a case study. *Front Gastroenterol* 2016;7:216–221.
3 Tierney M, Bevan R, Rees CJ, *et al*. What do patients want from their endoscopy experience? The importance of measuring and understanding patient attitudes to their care. *Front Gastroenterol* 2016;7:191–8.
4 Callaghan JL, Neale JR, Boger PC, *et al*. Variation in preparation for gastroscopy: lessons towards safer and better outcomes. *Front Gastroenterol* 2016;7:187–90.
5 Dawwas MF, Oppong KW, Webster GJ. Endoscopic assessment and management of biliary strictures. *Front Gastroenterol* 2016;7:170–5.
6 Mohammed N, Pinder M, Harris K, *et al*. Endoscopic biliary stenting in irretrievable common bile duct stones: stent exchange or expectant management—tertiary-centre experience and systematic review. *Front Gastroenterol* 2016;7:176–86.