Multiple symptoms, multiple systems

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A consequence of being a specialty with several organs is that gastroenterologists see patients who report a range of symptoms. And while we may subspecialise in one area or another, a lot of what comes through our door is a reflection of the high prevalence of gastrointestinal and hepatological symptoms, test abnormalities and diseases. This edition of *Frontline Gastroenterology* has a diverse range of papers which address the catholic nature of our specialty.

Thinking more efficiently about liver blood tests

Recent years have seen a major increase in the number of liver enzyme bloods (liver function tests, LFTs) being undertaken, possibly related to the increasing prevalence of non-alcoholic fatty liver disease requiring early identification and intervention, as well as an increasing ability to treat diagnosed liver disease, such as viral hepatitis. As many as 1 in 5 of these blood tests are abnormal, potentially needing further diagnostic work-up. Miller and colleagues[1] report an initiative to introduce a streamlined, efficient direct approach to resolve this issue in an attempt to minimise unnecessary further testing. They report a two-phase study that aimed to first develop the criteria, and second to validate a diagnostic pathway for abnormal LFTs. The group identifies the critical importance of non-invasive fibrosis scoring in triaging these blood results. What remains to do is a prospective validation study of the proposed criteria in a primary-secondary care interface scenario, with an associated health economic analysis. Here then is a *Frontline Gastroenterology* paper to not only influence clinical practice but also point towards a future grant application for an ambitious young researcher.

Abnormal LFTs are a common reason for referral to gastroenterology and hepatology services. In the pregnant patient the potential risk to the mother and fetus adds an extra dimension of time urgency to interpreting these results. Kelly and Pericleous[2] present a highly practical manuscript that presents the diagnostically helpful features that help differentiate the potentially serious pregnancy-specific liver diseases from the less worrisome ones.

Messages from studying the pathways for patients with colorectal cancer

We are pleased to present a study by Lyratzopoulos and colleagues exploring the association between different diagnostic pathways to diagnose colorectal cancer and the patients' reporting of their experience in the subsequent care.[3] The study does so in a quantitative manner, and as such bridges studies of diagnostic pathways and patient experiences. Timely diagnosis emerges as of primary concern to patients, and hence patients identified from screening programmes were most satisfied. The area of most concern was for patients presenting with an emergency – so as well as emphasising the importance of screening, this also calls for improved patient pathways for acute presenting patients.

Globus: making light of a 'heart sink' symptom

Throat discomfort is something of an orphan symptom. Once an ENT surgeon has excluded a mucosal lesion, patients with a hypersensitive throat are often offered a proton pump inhibitor (PPI) and discharged before often drifting in to a gastroenterology service. This edition of *Frontline Gastroenterology* has two papers that address this patient cohort. An algorithmic approach to managing globus is proposed by Harvey, Theron and Trudgill.[4] The place for double dose PPI versus consideration of psychological therapy is placed in the context of when a patient may benefit from an upper GI endoscopy or oesophageal physiology studies.

Another often poorly understood cause of a painful throat is a cervical inlet patch. This congenital condition may be noticed coincidentally at upper gastrointestinal endoscopy, but it does represent an underestimated cause of chronic globus sensation. The place for narrow band imaging endoscopy as diagnosis is discussed by Dunn and colleagues, as well as the emerging novel therapeutic options available at endoscopy.[5]

Deep sedation versus general anaesthesia in the endoscopy unit

As endoscopists begin to undertake innovative and more complex endotherapy, the need for safe, effective and readily available deep sedation becomes paramount. Propofol sedation for complex endoscopy procedures is recommended by expert bodies, but the requirements of service provision often limit its availability. Smith and colleagues[6] present a retrospective audit on the use of propofol sedation and report safety, tolerability and efficacy outcomes. What remains to be addressed are the governance issues of resources allocation and training competence when considering such deep sedation vs intubated general anaesthesia.

Hey-Long and colleagues[7] report a challenging development of this argument. They prospectively assessed older high-comorbidity patients undergoing double balloon enteroscopy (DBE). They propose the thought provoking option that elderly patients undergo propofol-assisted DBE since they have equal safety and higher diagnostic yield when compared with young patients. So, are you ready to embrace deep sedation over general anaesthesia in your unit?

A final relevant paper for endoscopy pre-medication practice is the position statement from the British Society of Gastroenterology, Joint Advisory Group and Bowel Cancer Screening Programme on the use of hyoscine, which we are delighted to publish.

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