Highlights from this issue

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Practical management of polyposis syndromes

Polyposis syndromes are rare hereditary multisystem disorders which require lifelong specialist surveillance and are responsible for approximately 5% of all bowel cancers. In this issue Patel *et al* provide a considered overview. This includes discussion of the different syndromes, including the adenomatous polyposis syndromes (eg, familial adenomatous polyposis), serrated polyposis syndrome and hamartomatous polyposis (eg, Peutz-Jeghers syndrome, juvenile polyposis syndrome). There is detailed discussion of the diagnosis, genetics, need for surveillance and practical management, including reference to recent developments in the field. The principal goals of management are first to identify 'at-risk' patients, through screening and predictive genetic testing, and then endoscopic surveillance to allow therapy and guide surgical prophylaxis. The field is complex and there are multiple conditions and treatment plans, and patients and their families should be referred to a genetics centre or a polyposis registry where dedicated management can take place.

This is an invaluable reference source to help with detection, assessment and management, and is Editor's Choice this month. (*see page 379*)

Therapeutic drug monitoring in patients treated with infliximab

Therapeutic drug monitoring (TDM) by measuring infliximab trough levels and antibodies to infliximab is widely used to optimise treatment in inflammatory bowel disease. There are only limited data on efficacy in the real-world setting. In this issue Kamperidis *et al* explore this in a large retrospective cohort (291 patients, 238 had TDM, 672 results) looking at the action following the result and impact on outcome, including remission rate, discontinuation of treatment and surgery rate. Undetectable levels and the presence of antibodies were common in 39.9% and 31.9% of patients at least once. Infliximab was discontinued in 37.5% of patients, more commonly in those who had not had TDM (75.5% vs 29%). Multivariate logistic regression showed not having TDM was an independent risk factor for surgery (28.3% vs 12.2%). These data suggest the potential for significant impact if testing is systematic, according to specific indications (primary or secondary loss of response) and the results dealt with according to a treatment algorithm. (*see page 330*)

There is an excellent accompanying editorial: Putting therapeutic drug monitoring knowledge into practice. (*see page 327*)

A multidisciplinary approach to the management of NAFLD is associated with improvement in markers of liver and cardiometabolic health

In this issue Moolla *et al* report the outcome of cases referred to a multidisciplinary metabolic hepatology clinic established in 2014 (n=165, two or more appointments). Interventions offered included lifestyle advice, signposting to weight loss services, and pharmacological treatment of diabetes and cardiovascular risk factors. The median follow-up was 13 months (range: 2–34). The median alanine aminotransferase reduced by 11 IU/L ($p<0.0001$), and the median weight reduced by 3.3 kg ($p=0.0005$). There were significant reductions in HbA1c, total cholesterol and liver stiffness. In summary, a multidisciplinary approach to the management was associated with improvements in liver-related and cardiometabolic-related health parameters. This has obvious long-term health implications. (*see page 337*)

There is an excellent accompanying editorial: NAFLD: a multisystem disease that requires a multidisciplinary approach. (*see page 328*)

How to manage chronic diarrhoea in the elderly

Chronic diarrhoea is common in primary and secondary care, affecting up to 5% of the population at any given time. Management is not always straightforward or consistent. This is addressed in the recent British Society of Gastroenterology guidelines.[1] In this issue Crooks *et al*, as part of the 'How to Manage…' series, look specifically at chronic diarrhoea in the elderly. The authors use a case-based approach to apply the guidance and explore the assessment, investigation and management. This includes consideration of the fact that 'diarrhoea means different things to different people'—chronic diarrhoea is the persistent alteration from the norm with stool consistency between types 5 and 7 on the stool chart and an increased frequency greater than 4 weeks in duration. It is important to exclude an organic cause, and this is well covered in the article, including colorectal cancer, inflammatory bowel disease, and drug-induced and faecal incontinence. The approach is pragmatic and helpful and an essential reading for clinicians who regularly see these patients in practice. (*see page 427*)

Shape of training review: an impact assessment for UK gastroenterology trainees

This is a concern for trainees with the reduction in duration of higher specialist training from 5 to 4 years and the need within that to incorporate general internal medicine training. The 2018 British Society of Gastroenterology trainees' survey suggests a high degree of satisfaction but expresses concerns with only half achieving colonoscopy certification, with fewer procedures achieved compared with previous surveys. It is clear that novel strategies will be required to improve the rate of progression in endoscopy training, in particular if high-quality gastroenterology higher specialist training is to be delivered in 4 years, and this will include the likely need for training (and time to be allowed for training) to continue post-CCT. (*see page 356*)

Guideline review: acute lower gastrointestinal bleeding

In our series of Guideline Reviews, Ashley Bond and Phillip Smith summarise and comment on the recent guidance on the diagnosis and management of acute lower gastrointestinal bleeding[2]—the problem is common, the focus is on hospital care, and the guideline reflects the collaborative work of gastroenterologists, surgeons, radiologists, haematologists and patients. It is a great summary including the key points and reference to the specifics of management. This is a great way to highlight new guidelines. Please contact the editorial office if there is new guidance

you would like to cover using this format. (*see page 417*)

Finally

I am delighted to announce that we have linked formally with the British Association for Parenteral and Enteral Nutrition, and *Frontline Gastroenterology* will now be an official journal of the society. This is great news for us and entirely in keeping with our mission to publish clinically focused research and reviews in gastroenterology, hepatology and nutrition to help clinicians in their practice and impact on patient care.

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REFERENCES

1 Arasaradnam RP, Brown S, Forbes A, *et al*. Guidelines for the investigation of chronic diarrhoea in adults: British Society of gastroenterology, 3rd edition. *Gut* 2018;67:1380–99.
2 Oakland K, Chadwick G, East JE, *et al*. Diagnosis and management of acute lower gastrointestinal bleeding: guidelines from the British Society of gastroenterology. *Gut* 2019;68:776–89.