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FIT negative clinic as a safety net for low-risk colorectal cancer patients: impact on Endoscopy and Radiology utilisation - a retrospective cohort study

Faecal immunochemical testing (FIT) is recommended by the National Institute for Health and Care Excellence to triage symptomatic primary care patients who have unexplained symptoms but do not meet the criteria for a suspected lower gastrointestinal cancer pathway. During the COVID pandemic FIT testing was used to triage patients referred to the cancer pathway. FIT-negative patients were assessed and safety netted in a FIT negative clinic. In this issue Nigam and colleagues report a case note review of 622 patients referred to a FIT negative clinic – 2020/21, median age 71.5 years, median follow-up 2.5 years. Patients were referred with a change in bowel habit (61%), iron deficiency (24%), anaemia (11%), weight loss (9%), blood per rectum (5%). Further investigation by endoscopy/radiology was only indicated in around a third. Malignancy rate was low (1.5%) including rectosigmoid neuroendocrine tumour, oesophageal cancer and lung adenocarcinoma. The authors rightly suggest that using FIT as a triage in patients referred to the 2 week wait cancer pathway can result in fewer patients requiring further investigation and so more effective and efficient use of healthcare resources. *(See page 190)*

Colonoscopic cancer detection rate: a new performance measure – is it FIT for purpose?

A faecal immunochemical test (FIT) result of ≥10 µg has high sensitivity and negative predictive value for colorectal cancer (CRC) detection. In this issue Bashir and colleagues report the impact of the local implementation of a FIT diagnostic pathway (figure one) on cancer detection rate. The authors use National Endoscopic Data to compare local diagnostic rates in 2019 (before pathway implantation) and 2021. There was a significant increase in cancer detection rate from 3.01 to 4.32% (p=0.003) due to a combination of 10% more cancers and 25% fewer colonoscopies being done. Nationally there was a smaller but significant increase. The study further supports the use of a FIT triage strategy to better define if colonoscopy is indicated with cancer detection rate being a potential performance metric to monitor the referral and vetting pathway. *(See page 198)*

The above two papers are discussed in an excellent commentary by Logan and Andrews **FIT for the future** in which the authors conclude by saying FIT is a welcome addition to the 2 week wait colorectal cancer pathway. However, with greater use of FIT, we will need to ensure our pathways are robust enough to manage the demand for further investigations, as well as to provide a safe service to those patients who are FIT negative and in whom there is a low but not non-existent risk of CRC. *(See page 181)*

Evaluation of emergency hospital admissions for Inflammatory Bowel Disease as a possible marker of quality of care of British IBD Inflammatory Bowel Disease units

Key performance indicators (KPI) can be used to facilitate quality improvement. In this issue Selinger and colleagues explore the potential use of numbers and variation in emergency admissions. The authors compare emergency admissions (HES data 2018/19) with patient reported outcomes from the IBD patient survey 2019. Patient-reported accident and emergency (A&E) attendances and hospital admissions for IBD were also compared with patient-reported quality of care. For 124 services (England) the association between hospital admissions per 100 000 population (or per case) and patient rated quality of care was not statistically significant (data is in the paper). Patients with ≥2 A&E attendances (OR: 0.72, 95% CI: 0.57 to 0.91; p<0.001) were less likely to report quality of IBD care as good or very good compared with those without A&E attendances. Patients with ≥2 admissions were less likely to rate their care as good or very good (OR: 0.75, 95% CI: 0.65 to 0.88; p<0.0001) compared with those without hospital admissions.

In summary therefore the authors showed no correlation between emergency admissions derived from Hospital Episode Statistics with patient-assessed quality of care. However they did find a clear association for individual patients with ≥2 admissions or A&E attendances with a lower patient reported quality of care. There are likely to be many confounders. Further work is required to determine whether hospital admissions could be a useful KPI for IBD. *(See page 228)*

The role of diet in prevention versus treatment of Crohn'S disease and ulcerative colitis

Diet is a potentially modifiable risk factor for disease course in inflammatory bowel disease. In this article Halmos and colleagues review the evidence for Crohn's disease and Ulcerative Colitis – pre disease, during active disease and during disease remission. Key themes emerge - the role of diet in the management of Crohn's disease and ulcerative colitis is different; features of healthy eating are associated with prevention of Crohn's disease, but less certain for ulcerative colitis; exclusive enteral nutrition treats inflammation in Crohn's disease and data are emerging for diets of similar composition exerting similar impact (including the Crohn's disease exclusion diet and CD-TREAT); emerging diets used to treat ulcerative colitis may be different from Crohn's disease; the role of diet to maintain remission in Crohn's disease and ulcerative colitis is unknown, so default to healthy eating guidelines is recommended.

The evidence base behind these themes is discussed in detail with a helpful section detailing implications for practice. The mediterranean diet and ultra processed foods are discussed. The article is well worth reading through. It is clear, based on current evidence, that regular sensible healthy eating is the best approach with specific diets best reserved for disease flares or when there is evidence of a nutritional deficit when correcting this is likely to improve response to medical therapies and therefore outcome. More research is needed. Editor's choice this month. *(See page 247)*

Gastroenterology Trainee experience, confidence and satisfaction in nutrition training: a cross-sectional survey in the United Kingdom

Nutrition is an essential part of gastroenterology specialist training. In an environment where the duration of gastroenterology training has been reduced there is increasing debate about how that time should be best utilised, particularly with the conflicting demands of covering medical on call, clinical exposure to gastroenterology and hepatology, endoscopy and clinical nutrition. In this issue, Sartain and colleagues report the outcome of their survey of gastroenterology trainees conducted in 2022. 86 responses were received of which 40% had undertaken advanced training or a core placement in Nutrition. It is clear from the survey that confidence in and management of nutritional problems including intestinal failure was greatest in those who had completed a nutritional placement. Nutrition training was described as important or very important by most trainees. Perceived reported barriers included the lack of education and training opportunities and limited exposure to it during the early stages of specialist training. The outcome of this is important. Nutrition is a priority in the management of patients with chronic gut and liver disease. This includes management of disorder eating and obesity (see table 3 in the paper). It is clear moving forward nutrition placements are beneficial and important to trainees and should be encouraged as an integral part of specialist training rotations. ***(See page 233)***

Twitter debate: should upper gastrointestinal bleeding training and certification be formalised?

The joint advisory group in Gastrointestinal endoscopy has recently revised the guidance for training and certification in gastroscopy, sigmoidoscopy and colonoscopy. More controversial is whether training and certification for upper gastrointestinal bleeding should be formalised. This was the subject of a recent Frontline Gastroenterology twitter debate. The rational for certification was discussed, what formal training might look like and barriers – all very relevant in the era of 'competence based' but in reality 'time based' training. Most participants felt that implementation would be difficult although how much that should be a barrier is a matter for ongoing debate. ***(See page 258)***

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