



Testing, testing

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The practice of gastroenterology involves seeing patients with common complaints. The skill of the professional lies not just in the ancient axioms of history taking, but, in the modern era, knowing when and who to investigate. The remit of content in *Frontline Gastroenterology* remains to provide information to allow the reader to hone best practice: as such a number of articles in this edition are directed at helping put in context the appropriate use of laboratory and endoscopic investigation for common clinical scenarios.

Diarrhoea – to test or not for bile acid malabsorption and inflammatory bowel disease?

A condition which may affect 1% of the population, which is relatively easy to diagnose and for which there is an unequivocal first line treatment. This could describe Coeliac disease in the UK, and it is true that for this condition there is little controversy about the above. However, for the condition of bile acid diarrhoea (BAD) which has similar attributes, there is greater uncertainty about practice. In this edition of *Frontline Gastroenterology*, Davies *et al*¹ describe a targeted research approach to identify and summarise updates to the evidence base that was reviewed by the National Institute for Health and Care Excellence (NICE) in 2012. They present a case for the development of formal guidance to help clarify practice in patients presenting with diarrhoea, in particular with regard to the question of the diagnostic value of using the *SeHCAT* (tauroselcholic (75 selenium) acid) test. The authors advocate for the value of this diagnostic test and cite evidence suggesting that a positive test is more likely to result in treatment adherence, both due to patient conviction as well as professional confirmation. If the reader's practice is to treat empirically, rather than test, this article may provoke a change of practice or better still a desire to participate in a definitive study to address the question of test versus treat in patients with colonoscopy-negative diarrhoea.

Another paper in this edition provides an update of the place of calprotectin. In a patient with an index of suspicion for inflammatory bowel disease, when values

are either clearly abnormal or normal, interpretation is straightforward. The manuscript by Brookes *et al* reviews that situation when there is more uncertainty and looks at the limitations of testing.² Particularly valuable in this review is the summary of how to use calprotectin effectively in decision making for the management in the established IBD patient.

Ethnicity considerations in non-alcoholic fatty liver disease – and their potential solution

The prevalence and severity of non-alcoholic fatty liver disease (NAFLD) varies according to ethnicity, and people of South Asian are especially vulnerable to complications of type II diabetes and obesity even at relatively normal levels of body mass index. Use of currently available non-invasive (namely not liver biopsy) liver investigations is validated in primarily white populations, and so may have less validity to this at-risk group of patients. Risk stratification is central to implementation of guidance on management of NAFLD. Alazawi and colleagues, working in East London, describe a cohort of individuals in whom these tests are less accurate and may be falsely reassured that they do not have significant liver disease.³ The paper stresses the importance of considering the pre-test probability of advanced fibrosis in each case. Finally, the authors propose possible solutions to this clinical problem with the need for more nuanced cut-offs of existing scores.

Towards standardisation of flexible sigmoidoscopy

In the wake of the well documented outcome improvements arising from standardising of colonoscopy, there is a move towards doing the same for upper gastrointestinal endoscopy and flexible sigmoidoscopy. Given the role of the latter investigation in the detection of polyps, and the known variability of this outcome in clinical practice, Maliampurakal and colleagues⁴ report a cohort study to address the technical and practical factors associated with polyp detection rate. As flexible sigmoidoscopy emerges as a possible

screening modality of the future, their findings are an important part of the process of standardising the procedure.

When to see, when to treat and when to investigate: the development of a specialist triage service

There is a pressure on gastroenterologists and hepatologists to maintain service quality in the face of increasing primary care referrals for specialist service. Pelitari and colleagues⁵ describe the development and implementation of a clinical assessment service to both optimise the management pathways for individual patients but also to increase the confidence and willingness of general practitioners to manage chronic GI and liver illness. Safety, efficacy and cost analysis is presented at 3 years. Providing such a service while preserving safe and optimal patient-centred management is a challenge, and the authors describe the steps in their development process. In sharing their pro forma and management chart the authors allow the reader to adapt and explore the potential utility of the model to their own care.

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