Highlights from this Issue

doi:10.1136/flgastro-2022-102319

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Management of Crohn's stricture: medical, endoscopic and surgical therapies

Almost 50% of patients with Crohn's disease will develop strictures in their lifetime and as such are at increased risk of developing penetrating disease (including fistula and abdominal abscess formation) and requiring Crohn's disease related surgery. In this issue Ismail and colleagues discuss the key issues and therapeutic options which include medical therapy (mainly biologics), endoscopic intervention and surgical resection. There are multiple factors to consider – clinical presentation, location, length, number of strictures and severity of obstruction. Is the stricture inflammatory or fibrotic or a combination of the two. Is the stricture primary or anastomotic. In their comprehensive overview the authors discuss the assessment, different therapeutic modalities, limitations, and their success rates – a great article which will help clinicians properly evaluate and best manage Crohn's strictures. Essential reading and Editor's choice this month *(See page 524)*.

Managing gastric varices

Gastric Varices are present in up to 20% of patients with portal hypertension. Although oesophageal varices are more common and oesophageal variceal bleeding happens more often than gastric variceal bleeding, Gastric Variceal bleeding tends to be more severe, to have higher associated hospital costs, length of stay, higher rebleeding rates and have higher mortality. In this issue Sallout and colleagues discuss the key issues including endoscopic and non-endoscopic management. Endoscopic methods include banding as a bridge to more definitive treatment, Cyanoacrylate injections, coil embolization (with glue) and thrombin. The authors discuss the relative merits and detail of each in turn. Non endoscopic treatment includes pharmacological agents like Octreotide and Terlipressin (less effective than in bleeding Oesophageal Varices). Surgical intervention is by a Transjugular intrahepatic Porto Systemic Shunt (TIPS) or Balloon-occluded Retrograde Transvenous Obliteration (BRTO). TIPS and BRTO are not recommended as primary prophylaxis for gastric variceal bleeding in compensated patients although are undoubtedly of value in patients with acute gastric variceal bleeding refractory to medical and endoscopic haemostatic attempts. This a great paper – well evidenced and very practical – essential reading for clinicians who manage patients with bleeding varices *(See page 535)*.

Women in gastroenterology: the UK trainee experience

It is well known that the majority of UK gastroenterologists receiving a certificate of completion of training are male, and that there are fewer females working in gastroenterology than in comparable medical specialties. In this issue Sethi and colleagues use data from the BSG trainee surveys, the Royal College of Physicians Medical Workforce Unit and the Joint Advisory Group in Gastrointestinal Endoscopy (JAG) to understand the specialty demographics and the experience of training. The percentage of female trainees has remained stable at around 40%. Female trainees were more likely to have flexible working patterns than men, but the proportion of trainees working flexibly remains lower than in other specialties. Female trainees are less confident than male trainees about their job prospects once they qualify. A greater proportion of male trainees achieved provisional colonoscopy certification during training than female trainees. There are many other differences outlined in the paper with little improvement over time. The paper raises many questions nicely summarised in box one – issues we need to address. The authors rightly conclude that recognising and acknowledging gender inequity in gastroenterology training is the first step in understanding that the additional challenges faced by female trainees impede their ability to deliver high-quality care to patients and take away the collective strength that diversity and inclusion brings to the profession. The is followed by a call for action at an institutional and national level *(See page 484)*.

National census of UK endoscopy services 2021

The Joint Advisory Group on Gastrointestinal Endoscopy (JAG) 2019 census showed that endoscopy services were under continued pressure with increasing demand. This new dataset (2021) is important and gives us an initial view of how endoscopy services are adapting to continued demand exacerbated by the repeated waves of the COVID-19 pandemic. In this issue Ravindran and colleagues discuss the key findings. The census was sent to all JAG registered services in April 2021 (321 services completed the survey). Data for March 2021 showed - in summary - 57.9% of NHS services met urgent cancer waits (comparable to previous years), 17.9% met routine waits and 13.4% met surveillance waits. During the pandemic, 64.8% of NHS services had staff redeployed and there was a mean sickness rate of 8.5%. Services were, on average, at 79.3% activity compared with 2 years previously. It will be interesting to see the data for 2023 if this bi-annual census is repeated particularly in the context of continued pressure with staffing and so capacity. This dataset has implications for future planning as we emerge from the impact of COVID-19. The authors discuss strategies, challenges, and opportunities. I am sure this discussion will continue. Ian Penman, in a linked commentary reflects on this - National endoscopy services: reflections on the impact of COVID-19 and makes the important statement - embedding and extending the use of enhanced vetting and triage, and wider adoption of the innovations and non-endoscopic diagnostic alternatives of recent years will be key: critical thinking about the appropriateness of endoscopy where the chances of important findings are small and alternative pathways exist or in frail, multimorbid patients is imperative *(See page 463)*.

Ustekinumab for the treatment of moderate to severe ulcerative colitis: a multicentre UK cohort study

The challenge for effective management of Inflammatory Bowel Disease is to use the right treatment, at the right time and at the right dose to achieve the best outcome. In this issue Honap and colleagues report on the outcome of Ustekinumab for the treatment of moderate to severe ulcerative colitis – 110 patients, 96% with prior biologic and or Tofacinitib exposure. It is 'real world' data. 60% of patients

with full follow-up data had a clinical response. Corticosteroid free remission rate was 36% (18/50) at week 16% and 33% (13/39) at week 26, corresponding with a significant fall in Simple Colitis Activity Index from 6 (IQR 4–8) at baseline to 3 (IQR 0–5) at week 26, p<0.001. Median faecal Calprotectin measurements fell from a baseline of 610 µg/g (IQR 333–1100) to 102 µg/g (IQR 54–674) at week 16. 17 patients discontinued treatment, 13 patients due to primary non-response or loss of response. Three patients had side effects which required treatment to be stopped. There is a lot of detail in the paper regarding the specifics of treatment, other treatments and outcome. The overall outcome is broadly in keeping with other data. The authors highlight the fact that Ustekinumab should be considered in patients with Ulcerative Colitis to induce and maintain remission where antitumour necrosis factor therapy is contraindicated, has failed or limited by side effects ***(See page 517)***.

The BSG mission possible: the potential and challenges of setting up a colorectal cancer screening programme in Iraq

Colorectal cancer outcomes are unfavourable in lower and middle income countries for many reasons including limited health resources and political and economic instability. In this issue Alrubaiy and colleagues report on progress in Basra, Iraq following a needs assessment then action plan. There were multiple barriers. The following proposals were made following a multidisciplinary meeting including BSG members and the local bowel screening team - adoption of a regional approach using the UK practice as a model; Online training resources; Development of endoscopy simulation training; Research collaboration particularly in the epidemiology of colorectal cancer in Iraq, risk factors, patient behaviours and attitude; Arranging training opportunities for individual endoscopy trainees to access UK style training courses as part of scholarships awarded by the Iraqi Government. Challenging but good to see the joint initiative to improve outcomes ***(See page 547)***.

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