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Gastroenterology for the generalist and the specialist

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ABSTRACT This symposium provided an update in aspects of gastroenterology that are of relevance and interest to both the general physician and specialist gastroenterologist. Everyday practical dilemmas, such as the investigation of iron deficiency anaemia, consideration of PEG feeding and the management of IBS, were considered alongside updates in the management of variceal bleeding and alcoholic and non-alcoholic fatty liver disease. Looking to the future, developments in endoscopy safety and quality, with particular reference to the colorectal cancer screening programme, were outlined.

KEYWORDS Alcoholic hepatitis, Crohn's disease, endoscopy, iron deficiency anaemia, non-alcoholic fatty liver disease, variceal haemorrhage

LIST OF ABBREVIATIONS gastrointestinal (GI), inflammatory bowel disease (IBD), iron deficiency anaemia (IDA), irritable bowel syndromoe (IBS), National Confidential Enquiry into Patient Outcome and Death (NCEPOD), non-alcoholic fatty liver disease (NAFLD), non-alcoholic steatohepatitis (NASH), percutaneous endoscopic gastrostomy (PEG)

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EDUCATION

SESSION 1 EVERYDAY PRACTICAL DILEMMAS

Dr J Morris, Dr K Matthewson, Professor M Ford

Iron deficiency anaemia occurs in around 5% of the adult population[1] and its investigation has a high yield for the diagnosis of gastrointestinal malignancy. The presence of IDA is included in current referral guidelines for suspected cancer.[2] Despite this, awareness and adherence to published guidelines is poor, in both primary[3] and secondary care.[4]

Even when appropriate investigation is undertaken, no diagnosis will be reached after bidirectional gastrointestinal endoscopy in up to half of all patients,[5] with no clear guidance on how to proceed. A pragmatic approach was therefore outlined. In those with an isolated episode of IDA that fully resolves, further investigation is usually pointless. In those with recurrent anaemia, implying 'obscure' GI bleeding, further investigation offers considerable additional diagnostic potential, particularly when the obscure bleeding is overt. Capsule endoscopy was proposed as the investigation of choice by an 'enthusiast' for the technique. However, on a more practical level, there remain obvious drawbacks in terms of lesion reporting and interpretation, subsequent need for enteroscopy and implications of resource availability and cost, both of which may limit this approach.

It is perhaps even less easy to formulate guidelines for the appropriateness of PEG creation for nutritional support. However, the recent NCEPOD report[6] certainly raised areas of concern, suggesting that up to one fifth of all such procedures are futile. Interactive case discussions highlighted some difficult decisions in PEG creation, and appeared to split the audience vote. Interestingly, the overwhelming majority of those responding did not themselves wish to be sustained in this manner. Perhaps we need to be far more frank about the risks of PEG creation and more willing to tackle the preconception that prolonging life in this way is always in the patient's best interest.

Irritable bowel syndrome is the most common presentation to gastroenterology in secondary care and yet arguably one of the most poorly managed. In considering it as a paradigm for functional disorders in general, it was highlighted that we appear to be failing a large number of patients. As physicians, most of us are comfortable in diagnosing and managing organic disease but perhaps often feel ill-equipped to explore any underlying psychosocial agenda. And yet this failure compounds the situation, often leading to inappropriate investigation and, potentially, persistence of symptoms.

In IBS there are explicit, well-validated diagnostic criteria,[7] which, with adherence, should obviate unnecessary investigation. It appears that our current management, based on our reliance on pharmacological therapies, is suboptimal and not evidence-based. A novel approach, highlighting the role of psychotherapies, including relaxation, hypnosis and cognitive behavioural therapy, was

outlined. This also served to highlight that such resources and expertise are not readily available. Indeed, it is often difficult even to devote sufficient time to build the rapport necessary to deal with the full physical, emotional and situational context of functional disorders.

SESSION 2 VARICEAL BLEEDING AND ACUTE ALCOHOLIC HEPATITIS

Dr D Westaby, Professor I Gilmore

There have been significant recent advances in the treatment of variceal haemorrhage, resulting in a reduction in the rates of rebleeding and mortality, though mortality after an acute variceal bleed remains considerable at about 20%. Variceal band ligation has replaced sclerotherapy as the optimal endoscopic therapy in the treatment of acute haemorrhage, with fewer side effects and a lower rebleeding rate.[8,9] Benefit is thought to arise from local tamponade derived from the tension applied by the bands in the distal oesophageal wall, rather than necessarily banding the exact bleeding point. However, the technique requires skill and expertise, and there are still many endoscopists who appear more comfortable applying sclerotherapy in this situation.

In addition, the importance of the non-endoscopic aspects of management was emphasised. While there is some controversy over consensus on optimal fluid balance and blood/volume replacement, this should not detract from the fact that prompt and appropriate resuscitation saves lives. In addition, there is clearly a beneficial effect of early administration of vasoactive agents in these patients.[10] It was suggested that these should be administered more selectively, based on the potential for harm from these agents and the possibility of an alternative bleeding source. Timely endoscopy, in a stable patient and a controlled environment, is undoubtedly the definitive approach, but where there is any delay to achieving this it would seem appropriate to start vasoactive agents early. Least controversially, prophylactic antibiotics should be given to all with suspected portal hypertensive bleeding.

The burden of alcohol-related liver disease appears set to continue to rise. Alcoholic hepatitis, a clinical syndrome relating to progressive inflammatory injury associated with chronic alcohol excess, is increasingly common, and patients with severe alcoholic hepatitis have a poor prognosis.[11] Its pathogenesis is incompletely understood, but the role of the cytokine TNFα in inducing liver injury was highlighted. Polymorphisms in TNFα may account for at least some of the genetic susceptibility.[12] Much of the current management of alcoholic hepatitis relates to supportive care or dealing with the complications of underlying chronic liver disease. More controversially, it was suggested that there was little role for corticosteroid treatment in alcoholic hepatitis. However, this is not a consensus view, with good evidence demonstrating an improvement in mortality among patients with severe alcoholic hepatitis treated with corticosteroids.[13] Despite the reservations outlined, there are several centres in the UK where such an approach is employed.

SESSION 3 ENDOSCOPY SAFETY AND DEVELOPMENT

Dr J Green, Dr E Swarbick

Issues regarding safety and quality in practice underpin much of the focus of current service development in endoscopy. With respect to safety, the recent NCEPOD report[6] highlighted some real concerns with particular reference to therapeutic endoscopy in the UK. The data within the report are retrospective and arguably incomplete, yet the conclusions presented were undeniably valid and have served as a focus to drive an improvement in standards. In particular, much emphasis has been placed on quality training in colonoscopy and the need for assessment of performance and accreditation, both of which should lead to the achievement of higher standards in endoscopy practice.

Achievement of quality and safety has also underpinned the establishment of the National Bowel Cancer Screening Programme, which is currently being introduced across the UK. Individual colonoscopists must demonstrate the highest standards of endoscopic practice to gain accreditation, and inspection of each endoscopy unit is undertaken to ensure that clinical quality and safety, along with patient satisfaction, is achieved. Only once these standards are achieved can the screening programme be successful, and its introduction is hoped to reduce the mortality from colorectal cancer by as much as 15%.[14] Early data from the programme are eagerly awaited.

SESSION 4 FUTURE PROBLEMS

Dr D Wilson, Dr G Aithal

A significant proportion of patients with Crohn's disease are first diagnosed in childhood or adolescence. It is therefore important to appreciate the challenges faced in the management of their disease at this time, if we are to understand how best to transition the adolescent with Crohn's disease from paediatric to adult care. There are practical issues regarding diagnosis and investigations appropriate for younger patients. The impact on growth and pubertal development must be appreciated, with real concern regarding the wider implications for education and social functioning. While treatment strategies employ our familiar therapies, a steroid-sparing approach is employed where possible, with particular emphasis on (and impressive success with) nutritional therapy.

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Many centres now run transition clinics for adolescents with IBD, with shared adult and paediatric expertise, to provide optimal consideration for these concerns.

With a prevalence of 20–25% in Western society, NAFLD is now the most common chronic liver disease – a remarkable achievement for a diagnosis that has only emerged within the past 30 years. Non-alcoholic fatty liver disease is the hepatic manifestation of the metabolic syndrome in which a dangerous liaison of dietary indiscretion, sedentary lifestyle and genetic predisposition contribute to obesity, visceral fat, insulin resistance and diabetes mellitus. The presence of features of the metabolic syndrome are well recognised to predict the development of NAFLD, or the more aggressive form of fatty liver (NASH). In addition, it seems that hepatic insulin resistance precedes and likely predicts peripheral insulin resistance, with liver enzyme measurements predicting the development of diabetes mellitus.[15]

In patients with NAFLD, advancing age, increased weight, the degree of insulin resistance and the number of features of the metabolic syndrome are all associated with the progression to fibrosis.[16] It should be possible to incorporate such parameters, or use other non-invasive markers, to quantify such a risk.[17] At present, there are few evidence-based treatment options for NAFLD. Novel data suggest that the thiazolindinedione class of insulin sensitisers, which also appear to have anti-inflammatory and anti-fibrotic properties, may be effective treatments,[18,19] though further studies are awaited.

SUMMARY

The symposium was well attended by a range of generalists and specialists. Positive feedback was received, indicating that those attending found it educational and enjoyable.

EDUCATION

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