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Gastroenterology symposium

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DECLARATION OF INTERESTS TGB has performed consultancy work for Gilead

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This is an exciting time in gastroenterology. The boundaries of clinical care continue to be expanded with enormous strides achieved in our ability to treat and cure disease. The technical possibilities of therapeutic endoscopy continue to evolve, permitting ever increasing minimally invasive management. Nonetheless, the questions of how these tools are best used, and how we as a profession continue to strive for excellence in our practice that will make a genuine impact for patients we care for, are still there. Against this backdrop, this symposium attracted leaders in the fields of hepatological and gastroenterological disease from across Europe to share their expertise and insights both with delegates in Edinburgh and also at over 30 centres worldwide via live webcast.

SESSION 1 – HEPATOLOGY

Dr Ewan Forrest (Glasgow Royal Infirmary) described the clinical status of alcoholic hepatitis worldwide and the recently published multicentre randomised controlled trial of corticoSTeroids and/Or Pentoxyphylline in Alcoholic Hepatitis (STOPAH).[1] While STOPAH showed no therapeutic effect of pentoxyphylline and no overall benefit of prednisolone (given at 40 mg daily for 28 days), subgroup analysis shows a potential role for prednisolone for in-patients with severe disease (Glasgow Alcoholic Hepatitis score ≥9) who show response to steroids (defined by Lille Score <0.45 at day 7). Therefore while alternative treatments are required we are moving towards a consensus of management for this severe condition.

Professor David Goldberg (Health Protection Scotland) shared his experience in establishing the Hepatitis C Action Plan in Scotland with the involvement of the Scottish Government. This strategic plan has combined strategies for the prevention, diagnosis, and treatment in a multidisciplinary manner, together with effective data monitoring of outcomes, which has put Scotland in a world leading position in hepatitis C therapy. Professor Goldberg provided data on the use of the newer hepatitis C treatment regimens, showing that they are more cost-effective than previous regimens in specific populations.

Professor Scott Murray (University of Edinburgh) then provided a stimulating insight into the crucial, but perhaps underappreciated, clinical challenge of managing palliative care specifically in patients with end stage liver disease.[2] With the analogy of the 'Dance of Death' together with a suite of musical accompaniments he described research in the field and dissected the clinical, emotional, social, existential and informational needs of these patients. A crucial take home message was a holistic approach with early and open discussion about prognosis with the patient and their family together with the involvement of general practitioners who generate a Key Information Summary (KIS). The KIS can aid the phased introduction of anticipatory and palliative care and can be shared with other healthcare providers.

SESSION 2 – ENDOSCOPIC MANAGEMENT OF EARLY NEOPLASIA

Professor Oliver Pech (Barmherzige Regensburg, Germany) discussed detection and therapy of early squamous and Barrett's neoplasia. He described the advantages of using acetic acid over trimodal endoscopic imaging for Barrett's neoplasia screening, and how, in specialist centres, focused biopsies could replace random quadrantic biopsy assessment. Optimal treatment of high grade dysplasia or mucosal Barrett's adenocarcinoma is with endoscopic resection, followed by radio frequency ablation of the remaining Barrett's segment, followed by longer term acid suppression and endoscopic follow-up.[3] Squamous neoplasia is managed differently due to the increased

risk of metastasis in the early stages, making endoscopic submucosal resection and subsequent pathological assessment preferable.

This year's Freeland Barbour lecture was delivered by Professor Pradeep Bhandari (Queen Alexandra Hospital, Portsmouth) on the subject of 'New techniques for endoscopic management of early neoplasia in the GI tract'. He exemplified how a highly skilled endoscopic therapist can push the boundaries of possibility with endoscopic resection using newer techniques such as knife assisted snare resection or per-oral endoscopic myotomy for complex colonic polypectomy or achalasia, respectively. In addition to describing patient selection for these procedures he discussed how training and team development can be achieved at the cutting edge of therapeutic endoscopy.

SESSION 3 – INFLAMMATORY BOWEL DISEASE

The expanding field of the microbiome and gastrointestinal disease was covered by Dr Georgina Hold (University of Aberdeen). This wide topic explored from how Helicobacter pylori colonisation affects the microbiota of the stomach, to the alterations of that which occur in the microbiome with chronic liver disease.[4] These interactions between patient and microbiome are critical in the establishment, maintenance and progression of a wide range of diseases. There is an ongoing need for mechanistic and translational studies in the field, however therapeutic targets are in development and may offer a much more targeted and palatable option than faecal microbiota transplantation.

Professor Simon Travis (University of Oxford and John Radcliffe Hospital, Oxford) gave a very useful and highly authoritative talk on the decision-making process in a patient with acute severe colitis. He described the use of prognostic scoring systems which can be used throughout admission to aid clinical decision making. He discussed rescue therapy in colitis and showed that there is no difference between cyclosporine and infliximab when the Construct trial is compared to more recent data. He explained that while cyclosporine is more cost-effective, infliximab may be preferable when the patient is already using azathioprine.

SESSION 4 – HOW WOULD I MANAGE?

Stephen Attwood (Northumbria Healthcare NHS) shared his experience in the management of dysphagia. He described the more subtle endoscopic features of eosinophilic oesophagitis and how it can be diagnosed (>15 eosinophils per hpf), together with the memorable pathological description of 'tomatoes with sunglasses' to identify eosinophils in pathological specimens. He covered the disease's management with drugs, diets and dilatation using pharmacological therapy of an initial trial of proton pump inhibition followed by swallowed steroids (fluticasone spray 250 ug 4/day) and supported by preparations such as viscous budesonide or montelukast, together with an overview of the future biological therapies. He additionally covered other causes for dysphagia together with an overview of oesophageal high resolution manometry and impedance testing.

Professor Robin Spiller (University Hospital Nottingham) tackled the common problem of managing functional dyspepsia and vomiting and described the various forms of functional dyspepsia and cyclical vomiting syndrome and how they are related to underlying pathology. Fifty percent of patients with dyspeptic symptoms will have a normal upper gastrointestinal endoscopy. Of these, approximately 50%, 40% and 30% will have abnormalities in hypersensitivity to distension, impaired gastric accommodation or delayed gastric emptying, respectively. Treatment depends upon the underlying mechanism but may include amitriptyline for pain and buspirone for early satiety[5] or mirtazapine for weight loss.

Dr Sean Weaver (Royal Bournemouth Hospital) closed the symposium by giving an innovative presentation about his approach to the patient with diarrhoea and a normal colonoscopy. Here the art of clinical acumen is vital, together with an open diagnostic mind. A wide variety of conditions were explored including microscopic colitis, pancreatic insufficiency, bile acid malabsorption, small bowel disease, functional bowel diseases, and vasculitis. Dr Weaver's gave a strong message that we should continue to remain inquisitive and develop our clinical skills and interact with colleagues to improve the service we offer patients.

TAKE HOME MESSAGE

This symposium highlighted the enormous changes that are currently occurring in clinical gastroenterology. The increasing evidence base for all conditions, from the often fatal alcoholic hepatitis to more frequent causes of morbidity such as functional dyspepsia, and the therapy which we have to offer patients continues to be expanded and their uses refined. This combined with remarkable developments in therapy, such as those for hepatitis C viral infection, means that elimination of this disease is now impeded by logistical and financial barriers rather than by ineffective treatment. These advances, combined with our improved ability to recognise and treat disease endoscopically, continue to advance the field almost

beyond recognition. However, we frequently returned to the key themes of the day such as the importance of paying attention to detail, and the vital role of working as part of multidisciplinary team to improve the service we deliver to an ever increasing number of patients.

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