JPCSG

The Journal of the Primary Care Society for Gastroenterology

Primary Care Society for Gastroenterology

Autumn 2011 edition

Editorial

Welcome to the Autumn edition of the society's Journal. As you may have noted the title of the journal has changed and we have decided that the title needed a revamp. Although the old title did give the chance to produce tons of puns (OK, just the one) such as GiPpy tummy, most people could not make the connection with the Society so hours and hours of deliberation resulted in the decision to name the journal the Journal of the Primary Care Society for Gastroenterology or JPCSG.

While I am talking about changes, we are also going to be applying mod cons and a splash of paint, metaphorically speaking, to the website and we will be posting up videos of the lectures given at meetings. The first ones posted will be from the recent ASM which was a fantastic meeting. Hopefully, members will not feel that this means that they don't need to attend meetings as the general consensus at the last meeting was that the discussions and questions following the talks were just as important.

Talking about discussions, (gosh, this sort of seamless segueing couldn't be done better by Radio 2), I am also on the hunt for people who can provide case histories that can provoke debate. As you can see in previous editions, we try and get a consultant to give a response and for a great example, I would like to draw your attention to Dorothy King's and Amit Singhal's article on haemachromatosis. We have had the past few journals theme based but I thought the next few could be more mixed so I would be grateful for any articles that you think would be of interest to fellow members or if you think there is a subject you would like covered , let me know and I will cajole somebody to write 1000 words or so.

This month's JPSCG is loosely (I know, but gastroenterology is a minefield of unfortunate words) based on constipation and IBS. The latter is certainly of interest to many commissioners as they try to reduce referral rates and at the same time handle the large numbers of patients in primary care in novel ways. We also have an article by June Rogers on the important yet often hidden problem of continence and the lack of translation of NICE guidance into frontline care. Translating NICE guidance into practice is also the theme of Jude D'Cruz's article on IBS. Finally, I have pulled together from the website some of the more interesting journal articles for your perusal.

My thanks to all the contributors to this issue and also to our sponsors who make it all possible.

Best wishes

John O'Malley

Contents

Implementation of NICE guidelines – the reality !

NICE guidelines are based on the best available evidence and we are all encouraged to integrate them into our day to day practice. To help us do that NICE also develop and make freely available a range of downloadable resources to support implement of the recommendations.

However as a specialist nurse and Team Director of PromoCon (a bladder and bowel charity working under the umbrella of Disabled Living) I am aware not only of the issues as a clinician in actually implementing the guidelines but we also have a national view of both patients and clinicians experiences. Currently there are 83 NICE guideline and appraisal publications for gastrointestinal diseases and focusing on only 3 of those covering constipation and faecal incontinence we can clearly see what the issues are .

Faecal Incontinence

In June 2007 NICE produced a guideline for the management of faecal incontinence (NICE 49) and made clear recommendations for further specialised management once initial interventions had failed. These recommendations included access to:

- Pelvic floor retraining
- Bowel retraining
- Specialist dietary assessment and management
- Biofeedback
- Electrical stimulation
- Rectal irrigation

NICE also recommended that individuals should have free access to specific products and advice to help them cope with the problem and these included:

- Choice of disposable body worn pads and
- disposable bed pads in sufficient quantities too meet their needs
- Anal plugs if appropriate
- Skin care advice
- Odour control and laundry advice

The reality is that very few areas have community based specialist bowel services and most continence services do not have allied health care professionals such as physiotherapists as part of their team, also specific interventions such as biofeedback and electrical stimulation are not widely available. However of more of a concern is the current issue regarding the provision of disposable products which are often restricted to the most serve problems in some areas and certainly 'rationed' in most others – for those with an ongoing soiling problem this can be devastating. Also some treatments such as rectal washout kits have been excluded from local formularies due to the perceived 'cost' – yet well managed bowel problems can save a huge amount long term as well as improving self esteem and enabling the individual to carryout normal social activities and go out to work.

Constipation in Childhood

NICE produced the guideline for the management of constipation in childhood in May 2010 (NICE 99) and made a number of key priorities for implementation including that dietary interventions alone should not be used as first line treatment. NICE made clear recommendation that Movicol PP should be offered as first line treatment for both disimpaction and maintenance for all children with idiopathic constipation, including those under the age of 2 years. The BNFC supported this recommendation by including the appropriate advice and dosage regimes within the current formulary.

However, despite this and other recommendations, 12 months on from publication the calls to our helpline and discussions with colleagues clearly suggests that there is still some lack of awareness and understanding by both GP's and community nurses regarding the guideline recommendations with children still being offered inappropriate treatments with clear lack of appropriate support.

Prucalopride

In December 2010 NICE produced a technology appraisal document for the use of Prucalopride in women with intractable constipation, who have failed to gain adequate relief of the symptoms following 2 failed cycles of laxatives from different classes at the highest tolerated recommended dosages for at least 6 months. They recommended that Prucalopride should only be prescribed by a clinician with experience of treating chronic constipation and in the community that could be a GP for example or an experienced continence advisor or specialist nurse.
Looking at the Map of Medicine it is quite clear that a trial of Prucalopride could be offered in the community when referral to secondary care is being considered. However 6 months on despite the NICE recommendations very few colleagues have considered using the treatment in practice and calls to our helpline since the launch identified that those women, suffering with chronic constipation , who where desperate and had contacted us for advice and information were totally unaware this new treatment option existed!

It is quite clear that despite clear recommendations from NICE regarding the treatment and management for

individuals with ongoing problems with constipation and soiling those recommendations are only being integrated into practice on a very limited basis and certainly for those individuals who are affected there is a distinct lack of awareness regarding what treatment options and management should be available to them

In 2009 the Picker institute looked at the level of public awareness and involvement of new technologies. The PCT's interviewed felt that NICE heavily influenced prioritisation, decision making and public policy however they also felt that NICE gave them limited room for manoeuvre with clear financial implication. As a result the PCT's restricted what information they gave to the local population and made in house decisions what services they could 'afford' to provide. This view is unfortunately often reflected across many PCT's and there is great concern that with the move towards GP commissioning services for individuals with bladder and bowel problems will get pushed lower down the list of priorities.

There appears to be a myth that good quality services are expensive to run, however clinical experience has shown us that in fact well run services can actually not only improve patient outcomes but also save money long term. Working with others a 'Cost effective Commissioning guide for Continence Care' has been produced which provides a framework for implementing and monitoring a truly integrated continence service and shows how effective use of care pathways can provide high quality care yet reduce costs. The document is available online from www.appgcontinence.org.uk.

We would encourage all those working in Primary Care to review existing services for continence care in light of both the NICE recommendations and the Cost Effective Commissioning guide for Continence Care

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Irritable Bowel Syndrome:

Providing a Unique Solution Through a Community Hypnotherapy Service

Introduction

Irritable Bowel Syndrome (IBS) is characterised by abdominal pain, a change in bowel habit and a severe disturbance of quality of life.[1,2] IBS is one of the most commonly reported gastrointestinal problems, estimated to have between ten and twenty percent prevalence. Local (West Midlands) gastroenterologists estimate that 50% of their workload relates to IBS. Symptoms commonly include diarrhoea, constipation, abdominal pain which is relieved by passing stool, and abdominal distension; some experience back pain. [1] Unresolved symptoms can lead to high consumption of primary and secondary care resources through patients being referred to numerous specialities and undergoing a range of tests in the quest for a definitive diagnosis.

Many patients develop refractory IBS (symptoms which remain unresponsive to pharmacological treatments and dietary or lifestyle improvements after 12 months).[1] Hypnotherapy has proven successful in several controlled trials in reducing or even eliminating IBS symptoms and improving quality of life; it is a useful option to treat refractory IBS. Professor Whorwell's team pioneered the hypnotherapeutic approach to IBS, and have published extensively (http://ibs-care.org/publications.html). Hypnotherapy is recommended for refractory IBS in British Society of Gastroenterology guidelines and NICE (National Institute for Health and Clinical Excellence) guidelines in adults.[1,3] Both guidelines advocate the diagnosis and management of IBS in primary care. Mohammed et al[4] calculated the prevalence of IBS in Sandwell to be 18%. These data formed the basis for an IBS Hypnotherapy pilot service, using Primary Care Trust (PCT) 'innovation' funding. In a telephone audit of all PCTs in February 2011, no other PCT had such a service.

Secondary care costs for IBS care are predominantly diagnostics, not treatment or symptom amelioration. Many patients feel frustrated that despite extensive and often invasive testing, no diagnosis of a 'real' disease has been made. Patients report increased concern that organic pathology has been missed, causing them further distress.

People who have received support through psychological therapies are more likely to return to work than those who have not.[5] Some IBS patients lose time from work, others are unable to work; resulting in an economic impact in addition to symptoms. NICE guidance refers to IBS as a long term condition and it is included with 'medically unexplained symptoms' which constitute 30% of primary care and 50% of secondary care appointments.[6,7]

The aims for the service were to:

- Reduce secondary care referrals and follow up appointments for IBS.
- Reduce onward referrals to other specialities.
- Reduce unnecessary tests.
- Improve patient well-being and confidence.
- Reduce demand on existing primary and secondary care services by empowering patients to self manage symptoms.
- Reduce pharmaceutical costs.
- Provide a cost effective service.

Service Delivery

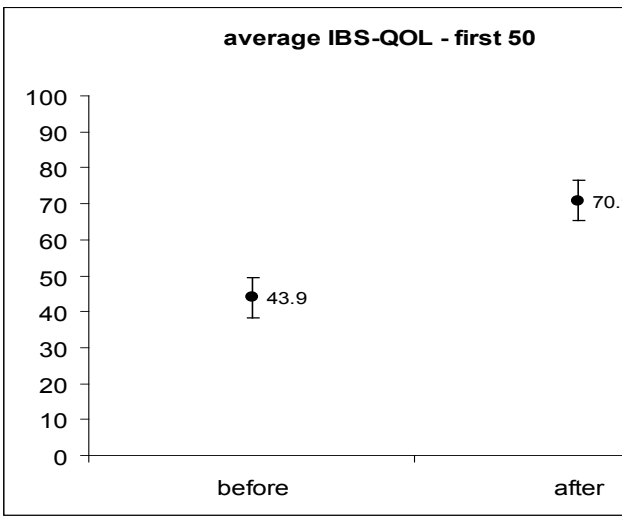
Patient referrals were accepted from general practitioners, by secondary care, and self-referrals where appropriate.

NICE guidelines for diagnosis of IBS were followed as closely as practicable, including checking results of recommended investigations for organic disease. Patients attending for hypnotherapy who presented with 'red flag' symptoms were asked to see their GP at the earliest opportunity.

Patients were given up to ten sessions of one-to-one therapy; guided by the patient's wishes and experiences between sessions.

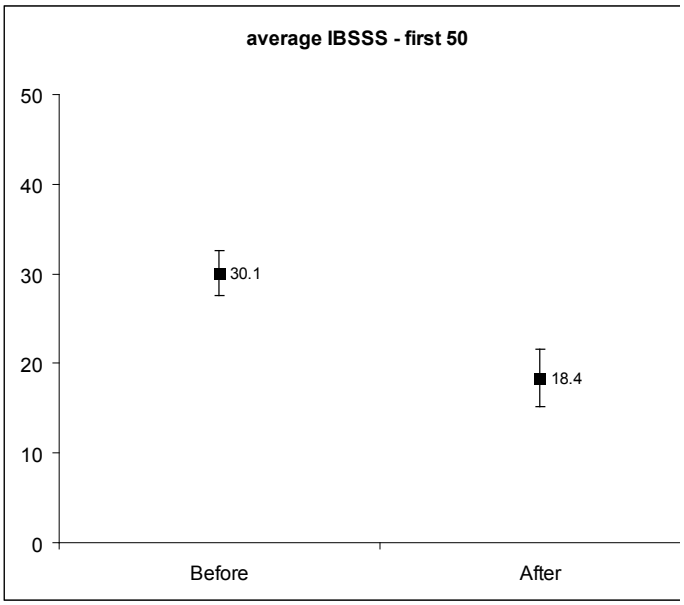
Audit data were collected at baseline, mid-point and post-therapy, using validated tools. These included an Irritable Bowel Syndrome Quality of Life Questionnaire (IBSQOL), a general health survey (MOS-36), an IBS Symptom Severity Score (IBSSSS) and a Goal Attainment Form, where patients stated their goals for therapy at assessment and reviewed them on discharge, also providing feedback on satisfaction, and an opportunity for the service to improve.

Patient Outcomes



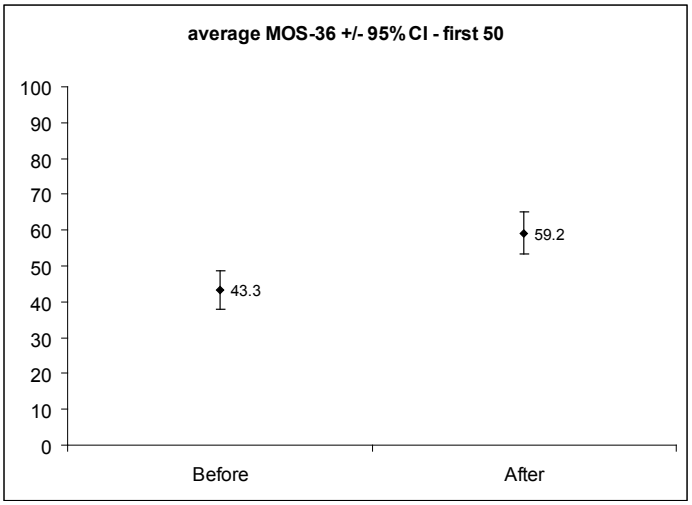
34 questions, 100 is best health. 9 categories.

IBS Quality of life questionnaire: results improved from an average of 43.9 before therapy to 70.9 after therapy.



5 questions, 0 is best health.

IBS Symptom Severity Score; of a total of 50 points. Results improved from an average of 30.1 to 18.4.



36 questions, 8 categories, 100 is best health.

RAND Medical Outcomes Score improved from an average of 43.3 to 59.2.

The effect of therapy was reviewed in 22 cases who had chosen to report back in detail. The average duration of IBS was 8 years (range 1-21 years). Medications were reduced or stopped in 12 of 22 cases (54%). Visits to healthcare professionals reduced from an average of 4.5 in the 6 months prior to therapy to 0.55 in the following 6 months.

Patients who did less well were those who had not invested time to listen to their therapy CD, and who said that they 'did not have time' to practise the techniques taught to them. Some patients struggled to accept that physical symptoms can exist in the absence of organic

disease. All patients were pleased with their treatment, and every patient would recommend it to a friend. Several commented that they were initially sceptical about hypnotherapy, and were pleasantly surprised when it was effective.

Case Examples (Patient consent obtained for disclosure)

• 37 year old female. IBS diagnosis 2008, gastrointestinal problems since school. History of dysmenorrhoea and anxiety. Scared of flying. After one session, booked a two-week foreign holiday. (One week was too long previously). After two sessions, she had been on a microlight, which showed to her that 'the sky's the limit'. Further work improved the patient's confidence, self esteem and anxiety, which in turn allowed her better symptom control, and to respond to challenges (at work, with difficult family relationships and stress) calmly and effectively.

• 53 year old female. 14 year history of IBS (bloating/ distension, pain, nausea, smelly flatus). History of clinical depression, agoraphobia (18 months), mild Parkinson's disease. She was withdrawn and quiet at the first appointment she reported being frightened to leave her home due to urgency of stool. After two appointments, she went to a regional shopping centre for the first time in years with her daughter on a Saturday. After three appointments she went to the shops, on impulse, alone (which she said would have been impossible previously). After four appointments, she had been to and enjoyed a gig at a national stadium, as her symptoms were so much better controlled.

Examples of feedback comments

"[Hypnotherapy] has helped me to believe in myself more and not to stress myself out over silly little things. And it has helped me to control my way of thinking and also my body and the way it reacts. What can I say? I came in here a broken man and now I'm fully repaired."
"I was pleasantly surprised to find my thoughts and feelings were deliberated on. I initially thought I would just be hypnotised. The whole experience has been beneficial. I feel inwardly calmer and less trauma from bowel movements; although I am not (as yet) cured. I feel this method is extremely beneficial … This approach to bowel issues seems to me to be the way forward. It has had a deep and long lasting effect on me."
"Therapy has changed the way I look at things and how I see myself. Rather than worrying that I am never good enough, I feel that if I do my best, that I am good enough. Therapy has also helped me to stop worrying about what might happen, and to enjoy what is happening now. [Therapy] has made a big difference, not only in dealing with IBS but to my life in general and to my relationships. I had been advised to have surgery because of my bowel problems, but I do not feel that this will now be necessary."
"I appreciated somewhere to talk about IBS with someone who knows what they're talking about. Brilliant! No negatives. This service should be continued for everyone, and available to everyone, not just those [in this area]"

Future Recommendations

This service has strong links with primary and secondary care clinicians; and patients are encouraged to help themselves as much as possible. Much has been achieved in 18 months. Extrapolating these results to a larger team, rather than just a one-person service suggests that many more patients could be helped, and much more money could be saved by treating IBS in Primary Care. The development of more services across the country could realise substantial financial savings for the NHS, and help patients to improve their symptoms and their quality of life.

CONCLUSION

An innovative service was established in Primary Care at low cost. Patient outcomes are comparable to published research data. Patients experienced improvements to confidence, well-being and general health, in addition to IBS symptom management. Patients presented for healthcare appointments less, and many reduced or ceased IBS medication use. The service consistently received high levels of patient satisfaction, increasing acceptance by referring clinicians, who subsequently encouraged patients to attend hypnotherapy.

Threats to the future of the service arise from NHS reorganisations and funding cuts. This is also the opportunity for hypnotherapy to further prove itself, as reducing inappropriate referrals to secondary care and reducing inappropriate testing saves money; and only a small amount of these savings are required to fund hypnotherapy. The success of this service may pave the way for further IBS hypnotherapy services.

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IBS: A Matter of Food and Mood

Professor Nick Read, Director and Medical Adviser of The IBS Network www.theibsnetwork.org outlines his perspective on the enigma that is IBS.

Irritable Bowel Syndrome (IBS) is one of the most common illnesses, yet one of the least understood. As many as 20% of people suffer from chronic or intermittent abdominal pain, or bloating and a disturbance in bowel habit, yet, for most, there is no clear pathological basis. Tests for organic disease are frequently negative and so, in the absence of anything more definite, they are diagnosed with IBS.

IBS is a disease invented by committee to explain the inexplicable, define the indefinite and account for the unaccountable: the James Dean of the gut, a rebel without cause or cure. It is one of an increasing number of 'functional' or 'medically unexplained' illnesses that frequently coexist to plague doctors' surgeries and hospital consulting rooms.

There is extensive overlap between IBS and other unexplained disorders, up to 60% with functional dyspepsia and around 30% with chronic fatigue syndrome or fibromyalgia. Patients with IBS suffer from headaches, backaches, irritable bladder, lassitude and aches and pains in many parts of the body.[1] All are probably part and parcel of an overarching state of dysphoria involving the mind and body. Depression and anxiety are common in IBS and exacerbations are often instigated by life events or situations.[1]

In the past, such conditions were grouped together under terms such as hysteria, hypochondriasis, melancholia, the vapours, the spleen, neurasthenia and irritable weakness. Fashion has moved on. Medicine has become more specialised and scientific and so an irritable boundary has been drawn around unexplained bowel symptoms in the hope that this will focus research and lead to the discovery of a cause or a cure. It hasn't....yet!

That's not to say that causes of irritated bowel do not exist. Bloating, abdominal cramps, frustrated defaecation, pains relieved by defaecation and inconsistent bowel habit are all non-specific indicators of bowel irritation and may be found in any condition that affects the bowel: inflammatory bowel disease, infection, cancer, dietary indiscretion, malabsorption.

Diagnosing IBS

It therefore behoves doctors working in primary care to take a careful history to identify red-flag symptoms of serious organic disease (rectal bleeding, fevers, weight loss and altered bowel habit commencing later in life with no obvious cause), take note of family history of ovarian or bowel cancer and screen out coeliac disease, inflammatory bowel disease and cancer by simple and inexpensive tests of blood and faeces.[1]

In the absence of red-flags or positive screening tests, patients with putative IBS do not need to be referred to hospital; NICE's 2008 guidelines suggest that they can be just as effectively diagnosed and managed in primary care.[1] But IBS need not take up the already restricted time of the busy GP. There is no reason why IBS cannot be diagnosed and managed by specially trained practice nurses, dietitians or counsellors and monitored by the GP with telephone/email access to specialists in secondary care, if required.

Informed self care is the new sound-bite for most long-term medical conditions. Patients need to be informed, advised and supported in how to manage their own illness in whatever way is best for them. This can be best done by healthcare professionals working within primary care, but in conjunction with the resources of the charities sector.

The IBS Network is the national charity for people with IBS. It publishes a monthly newsletter, quarterly magazine and issues "Can't wait" cards for instant access to toilets. Its 12-module self-management programme can be downloaded and worked through in practice-based self-help groups. Advice to individual patients can be obtained via a telephone helpline, staffed by IBS trained nurses, and by email responses from medical specialists.

Managing IBS

The management of IBS changes with fashion and doctors and nurses need to be kept up to date with recent trends. While 30 years ago, specialists were advocating coarse wheat bran for everything, in particular IBS, it now seems that the wheels have fallen off the bran wagon. Dietary fibre needs to be taken advisedly.[1] The NICE guidelines suggest that soluble fibre, such as oats and linseeds, would be more soothing for wind and bloating than wheat bran which may

make symptoms worse.[1] Since then, some studies have suggested that some fermentable oligosaccharides (FODMAPS) may make symptoms of pain and bloating worse,[2, 3] although there is evidence that 'prebiotic' galacto-oligosaccharides can improve these symptoms.[4]

It is all very confusing and, despite the guidelines, there is no definite rule except that some components or varieties of dietary fibre help some of the people some of the time. It is a matter of informing the patient and then encouraging them to find what suits them. Some patients with constipation can benefit from more fruit 'n' fibre.[5] Prunes can be an effective laxative.[6] Some patients with diarrhoea-predominant symptoms fare better on a low-residue diet, but it depends on the individual patient.

The same rule applies to probiotics. In general, it seems, according to NICE, some probiotics are beneficial for IBS and those patients who choose probiotics should be advised to take them for at least four weeks, while monitoring the effect.[1] Taking the good bugs to get rid of the bad is supported by clinical evidence but some strains seem better than others.[7] The Map of Medicine cites specific strains, such as Bifidobacterium lactis DN-173 010 and Bifidobacterium infantis 35624, as having clinical evidence for reducing bloating and other IBS symptoms.[8] All this, while other studies claim that treatment with the poorly absorbed broad spectrum antibiotic, Rifamixin, causes a global reduction in IBS symptoms by suppressing the bacteria that ferment carbohydrate.[9]

Food and mood

In IBS, as with many other 'unexplained' conditions, it is better to understand the patient than the illness. Two factors tend to instigate symptoms of IBS; these are food and mood, and they work together. Despite popular belief, food allergy is responsible for no more than about 2% of cases of IBS and biochemical evidence of specific food intolerance is also uncommon (<6%). Lactose, fructose and wheat intolerance may be more to do with changes in bowel transit and sensitivity to gaseous distension than any specific effect of the food.

Physiological tests indicate that the most frequent finding in patients with IBS is sensitivity to distension.[10] This might be due to mild inflammation caused by previous infection, but is most likely related to emotional tension. Even when IBS has been instigated by an attack of gastroenteritis, it is anxiety, depression and life events that predict the persistence of symptoms.[11] Food intolerance is not a life sentence; many patients report that it comes and goes according to how they are feeling. It's often more useful to direct therapy to calming the gut than avoiding specific foods.

My clinical work with people who suffer with IBS (as both a gastroenterologist and a psychotherapist) has revealed that not only the symptoms of IBS, but also the foods that cause these symptoms may re-enact the dominant themes in a person's life. Helping people with IBS may be not so much a matter of selecting the right medicine or diet, but finding out what the symptoms represent. One of my patients could never eat a meal of fish since her fiancé abandoned her over a special meal in a fish restaurant. Connotations about food are established by experience and enhanced by fashion and the media. How many of our convictions about food are established in childhood? Where did our feelings about meat, shellfish, smelly cheese, milk and chocolate come from? I like it, but it doesn't like me. If certain foods create emotional tension (fear or guilt), those feelings will frequently go to the gut and only serve to consolidate the belief about that particular food.

IBS, like many illnesses, does not have a single cause; it is the interaction of several factors: a previous infection, diet, lifestyle (too busy, rushed), stress, memory and meaning. Symptomatic treatment with drugs that reduce intestinal spasm and regulate bowel action may help,[1] but rarely cure. However the introduction this year of a new prokinetic agent (prucalopride) may offer a significant advance in the treatment of constipation in women.[12] What patients often need is that confidence, belief and control that may be brought about, at least in part, by a combination of judicious medication, dietary and lifestyle advice, insight and meaningful counselling. But nobody else can make a patient better; they can only guide them in the right direction.

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BARRETT'S OESOPHAGUS – AN UPDATE

Dr Adeel Saleem, Dr Ian Penman

Barrett's oesophagus (BO) is the main recognised precursor for the development of oesophageal adenocarcinoma and it occurs as a result of chronic, pathological reflux of gastro-duodenal contents into the oesophagus.

Histologically, BO is a metaplastic change in the distal oesophageal lining from normal squamous epithelium to columnar epithelium that usually contains intestinal metaplasia (IM) although this is not a prerequisite for the diagnosis of BO .The diagnosis is made by endoscopy with biopsy and BO is classified histologically as columnar lined oesophagus that may be negative for dysplasia, have findings that are indeterminate for dysplasia or contain areas of either low-grade or high-grade dysplasia.

Current British Society of Gastroenterology (BSG) guidelines define BO as any portion of the normal squamous lining replaced by a metaplastic columnar epithelium, which is visible macroscopically.

Incidence and prevalence

In 2009, 7,966 people were diagnosed with oesophageal cancer (OC) in the UK, males being affected almost twice as often as females.

OC is the ninth most common cancer in the UK. The risk of developing the disease increases with age: only 53 cases were diagnosed in the UK in 2009 in people underless than 40 years of age.

It has been estimated that the lifetime risk of developing oesophageal carcinoma is 1 in 64 for men and 1in 116 for women in UK.

The majority of cases (80-85%) are diagnosed in developing countries whereas it is the fourth most common cancer in men. Within the UK, the highest rates are recorded in Scotland. Scotland also currently has some of the highest rate in the Europe.

Barrett's Oesophagus and Oesophageal

Adenocarcinoma (OAC):

Patients with BO have an increased risk of developing oesophageal adenocarcinoma, the relative risk being 30 to 125 times higher than patients without this condition. OAC is one of the deadliest cancers with the fifth lowest 5 year survival rate of only 15.4%. Progression from BO to cancer occurs in approximately one patient per 200 each year (0.5%).

GORD and Barrett's oesophagus

Barrett's oesophagus is detected in approximately 10-15% of patients with GORD. Approximately up to 13% of Caucasian men over the age of 50, who have chronic reflux, will develop BO. It's currently not possible on the basis of clinical presentation to distinguish GORD patients with BO from those in whom BO is not present.

Why Treat BO?

BO is premalignant condition that can lead to the development of high-grade dysplasia and oesophageal adenocarcinoma.

Diagnosis	% Risk in 4 years	% Risk per year
Intestinal metaplasia advancing to low-grade dysplasia	16.1%	4.3%
Intestinal metaplasia advancing to High-grade dysplasia	3.6%	0.9%
Oesophageal adenocarcinoma	2.0%	0.5%

Patients with intestinal metaplasia have a combined 1.4% risk per year of progressing to high-grade dysplasia or cancer.

Endoscopic Grading System for BO ¬ The Prague C And M Criteria

Diagnosing and classifying BO can be difficult especially when there is a hiatal hernia and / or the segment is short. The Prague (C&M) criteria were developed by a subgroup of the International Working Group for the Classification of Oesophagitis (IWGCO). The criteria are easy to apply, reliable and have been internally and externally validated.

Prior to their development, there was no standardised, validated, clinically relevant classification for the endoscopic description of BO. Instead, endoscopists had been utilising unreliable, ad-hoc grading systems, with confusing terminologies such as 'short', 'ultra-short', or 'long' BO That lacked any proven clinical relevance.

Practice Points

- The initial step in diagnosing BO requires an accurate endoscopic recognition of the columnar lined oesophagus.
- A reliable diagnosis of BO depends on accurate endoscopic recognition of the key anatomic landmark - the gastro oesophageal junction.

- The proximal margin of the gastric mucosal folds is considered the most practical anatomic landmark of the gastroesophageal junction.

- The Prague C&M criteria is a standardised approach to the endoscopic description of the BO according to its circumferential extent (the C value) and the maximum extent (the M value) above the gastro oesophageal junction in centimetres. Thus 'C2M4' would describe 2cm of circumferential BO with a further 2cm of tongues or islands proximal to this.

Surveillance for BO

While there is no strong evidence to demonstrate the survival benefits or cost-effectiveness of regular endoscopic surveillance, most experts agree that BO should be regularly monitored by surveillance endoscopy, to detect dysplasia or early cancer allowing curative interventions. The time intervals for surveillance are different for different histological results and are the same irrespective of segment length:

- No dysplasia - 2 to 3 years

- Low grade dysplasia - 6 months, if stable then yearly

- Indeterminate for dysplasia – repeat after high dose PPI (ongoing reflux may lead to reactive atypia or inflammatory changes that make interpretation of biopsies more difficult)

- High grade dysplasia or carcinoma in situ – repeat within 3 months & review by second expert GI pathologist

- Confirmed HGD or cancer- requires staging investigations and discussion at an upper GI multidisciplinary team meeting

The ASPECT TRIAL (Chemoprevention)

The incidence of Barrett's ACC is on the rise and when it presents with 'alarm' symptoms it is usually at an advanced stage and carries a poor prognosis despite advances in surgical techniques, chemotherapy and radiotherapy in recent years. It is not known whether it is possible to prevent BO progressing to cancer.

The AspECT trial (Aspirin Esomeprazole Chemoprevention Trial) is the biggest, multicentre, randomised controlled chemoprevention trial in the UK looking at the long term chemoprevention effect of esomeprazole with or without aspirin. The primary aim for the trial is to prevent conversion to cancer in patients with BO. The interventions evaluated are high versus standard dose PPI therapy with or without aspirin.

The Trial can be summarised as follows:

ARM A:20mg esomeprazole **symptomatic treatment only=standard therapy control ARM** 2 yearly surveillance	**ARM B:80mg** esomeprazole **stringent acid suppression ARM** 2 yearly surveillance	**No Aspirin (A+B)**
ARM C: 20mg esomeprazole **symptomatic treatment and low dose aspirin ARM** 2 yearly surveillance	**ARM D**:80mg esomeprazole **Stringent acid suppression and Low dose aspirin ARM** 2 yearly surveillance	**Aspirin (C+D)**
Low dose PPI (A+C)	**High dose PPI (B+D)**	

Why Esomeprazole?

Esomeprazole is a highly effective PPI for GORD. Esomeprazole 20mg/day is sufficient for symptom relief but higher doses for more profound levels of gastric acid suppression may be necessary to suppress reflux profoundly and impede Barrett's progression.

Why Aspirin?

Aspirin may be effective chemoprotective agent for a number of cancers for the gastrointestinal tract. There is some epidemiological data demonstrating that it may be associated with a decreased incidence of oesophageal adenocarcinoma.

AspECT has recruited 2500 patients who have now been on treatment and under careful clinical and endoscopic follow up for up to 4 years,years; although another 6-8 years of follow up are necessary before final results are anticipated.

Endoscopic therapy for early Barrett's neoplasia.

Improvements in endoscopic imaging – high definition scopes, enhanced imaging techniques, magnification and chromoendoscopy – have allowed more frequent detection of subtle abnormalities containing dysplasia or early cancer and has driven the development of less invasive therapies than surgical resection. Two complementary endoscopic approaches have become commonplace for selected patients, after full MDT discussion of treatment options:

(a) Endoscopic mucosal resection (EMR)

There are various ways of undertaking this but most commonly, the visible abnormal area is marked and then sucked into a cap fitted on to the endoscope tip. It can then be grasped with a snare and resected just as a colonic polyp would. Larger lesions can also be

resected in a piecemeal fashion, and complications such as bleeding or perforation are rare. The tissue is examined for vertical depth of invasion as involvement of the submucosa carries risks of lymphatic spread and is usually an indication to proceed to surgery. For dysplasia or mucosal cancer, EMR is usually curative, but leaves behind a large vulnerable surface area of BO with risk of metachronous tumour development.

(b) Radiofrequency ablation(RFA, 'HALO')

Randomised trial data have proven the efficacy and safety of a system of RFA for flat dysplasia or early cancer.

Primary circumferential ablation ° is performed using a balloon-based bipolar electrode, and allows long segments of Barrett's to be treated quickly.

Secondary treatment of residual islands or short tongues of Barrett's epithelium is performed using an endoscope mounted plate electrode. Recent studies suggest that this ablation technique is highly effective removing Barrett's mucosa and its associated dysplasia safely without the known side-effects of photodynamic therapy or laser photocoagulation, such as oesophageal stenosis. Barrett `s epithelium is approximately 500µm in thickness and the RFA system is designed to achieve a uniform, superficial depth of ablation of ~ 1,000 µm. Medium term follow up data have shown that it can eradicate dysplasia in up to90% of cases and that this response is durable up to at least 3 years. Ongoing trials are studying whether this is an effective and safe option for permanent ablation of non-dysplastic Barrett's.

The implementation of the IBS NICE Guidelines and the GPSI.

This article is written from the perspective of a GP with a specialist interest in diagnostic endoscopy providing community diagnostic gastroscopy and flexible sigmoidoscopy services. Those of us in such a position are probably all too familiar with presenting symptoms such as abdominal pain, change in bowel habit, a feeling of abdominal distension with ease of satiety as well as altered bowel habit with a feeling of tenesmus. Such is the spectrum of symptoms which are often referred into community services such as ours. Such symptoms, however, also typify those experienced by sufferers of Irritable Bowel Syndrome (IBS).

It seems fitting therefore to consider what role we may have in helping our GP colleagues in the diagnosis and management of IBS. In preparing this article references are largely taken from the NICE guidelines regarding IBS. The detailed guidance exceeds 550 pages! Attempting to read through an extract relevant pieces of information certainly seem to exacerbate my hitherto quiescent symptoms of IBS.

NICE reports that 10% of the population have symptoms such as abdominal pain, change in bowel habit and distension each year. Up to 50% of these patients will present to their GP. It has long been held that IBS is a diagnosis by exclusion but how does one attempt to differentiate between the various causes of such general symptoms such as these? Differential diagnosis is wide embracing and could include such conditions as coeliac disease, non-ulcer dyspepsia, gallbladder disease, colitis, thyroid disease, lactose intolerance, gastrointestinal infection and even malignancy.

It has been widely acknowledged that there is no gold-standard reference for the diagnosis of IBS. Various attempts have been made to draw together symptoms considered to be characteristic of this condition. Thus, various attempts have been made to try and define the gold-standard for the diagnosis of IBS. NICE quotes such specialists in the field as Manning and Kruis as attempting to draw up such criteria in the early-90's. A pan European panel of experts were then involved in drawing up the Rome criteria which has now developed to Rome III. The Rome III criteria assesses ten characteristics associated with irritable bowel. These include frequency of abdominal pain, relationship to menses in women, duration of the pain, relation to bowel movements, relation to the increased frequency of stools or, indeed, reduced frequency of stools, relationship to looseness of stools as well as hardness of stools together with a frequency of hard stools in the last three months and the frequency of loose stools.

Certainly for those of us in General Practice, making such detailed assessments is often not feasible. Certainly there seems to be poor awareness in primary care of the Rome criteria or indeed those of Manning and Kruis. It would appear we are not alone as even specialists in secondary care are not always familiar with the detail of the criteria.

Whilst it is generally true that irritable bowel syndrome affects mainly the 20 – 30 year old age group, with a predominance of females to males, it can also affect older people in which other gastrointestinal conditions with similar symptoms need to be considered more carefully. Certainly in considering the differential diagnosis list given previously, one could make a case for a wide spectrum of investigations. After all if IBS is a diagnosis by exclusion, then it would appear natural to want to try and exclude other more serious pathology. Relevant investigations would therefore seemingly include routine blood screen to include full blood count, urea and electrolytes, LFT's, TFT's, inflammatory markers together with, EMA or TTG antibody levels. Stools could be checked for microscopy; one could refer for a lactose tolerance testing and indeed refer for endoscopic assessment.

Manning and Kruis's attempts to characterise IBS do not necessarily discriminate between inflammatory bowel disease (three or more of the Manning criteria where frequent in patients with ulcerative colitis in remission), or from other organic GI disease. It appears that more

than 50% of patients with irritable bowel syndrome may be referred to secondary care for diagnosis confirmation, patient reassurance or indeed at the patient's request. Clearly referrals to secondary care with wide ranging investigations carry a cost.

NICE attempts to carry out analysis on the cost effectiveness of the various investigations required to help formulate a diagnosis of irritable bowel syndrome. They conclude that cost effective investigations include, full blood count, inflammatory markers such as ESR and CRP and also checking for EMA or TTG antibody levels. All other investigations including ultrasound scan, sigmoidoscopy, barium enema, thyroid function tests, stool microscopy, faecal occult bloods and hydrogen breath tests were considered to **not** be cost effective. NICE accepts, however, that the presence or otherwise of red flag symptoms will clearly affect the choice of investigation. Indeed, it is recognised that those with red flag symptoms or those not meeting the IBS diagnostic criteria, do merit early and appropriate investigation.

NICE thus makes the following recommendations:-

1. Healthcare professionals should consider assessment for IBS if patients present with the following symptoms for greater than six months – abdominal pain/ discomfort (which is eased by defaecation), bloating, with a change in bowel habit.

2. All patients with suspected IBS should be actively asked for red flag symptoms such as unintentional or unexplained weight loss, rectal bleeding, a family history of bowel or ovarian cancer or a change in bowel habit to loose or more frequent stools for more than six weeks in aged over 60 years. If there is the presence of red flag symptoms then referral to secondary care should be made.

3. All patients presenting with suspected IBS should be assessed and clinically examined for the following red flag indicators and referred to second care if present, such as anaemia, abdominal or rectal masses, or raised inflammatory markers suggestive of inflammatory bowel disease.

4. The recommended diagnostic criteria for irritable bowel syndrome is only if the abdominal pain or discomfort is relieved by defaecation or is associated with altered bowel frequency or stool form with at least two of the following symptoms: –

- altered stool passage (straining, urgency, tenesmus).
- abdominal bloating, distension, tension or hardness.
- symptoms that are worse with eating.
- the passage of mucus.

5. Recommendations for investigations are for full blood count, ESR, CRP, EMA or TTG's .

6. The following investigations are not necessary to confirm the diagnosis in people who meet the IBS diagnostic criteria. These investigations include ultrasound scanning, sigmoidoscopy, colonoscopy, assessment of thyroid function, assessment of stools for microscopy or faecal occult blood and hydrogen breath tests.

Thus, NICE seem very clear regarding the need for careful history taking and examination of patients with suspected IBS to see if they meet the diagnostic criteria as typified by the Rome III criteria. Furthermore, NICE is very clear that the only relevant investigations that are required would be full blood count, ESR, CRP, EMA or TTG's. NICE is also very clear about the non-cost effectiveness of such diagnostic tests such as endoscopy. There is the caveat, however, that patients need to be actively screened for red flag symptoms or signs and if these are present to be referred on for appropriate investigation.

I would conclude this article therefore, by suggesting that those of us providing diagnostic endoscopy services in the community setting can assist our colleagues in primary care where patients do not sit neatly within the NICE recommendations and in whom we, as GP's, feel somewhat uneasy to label as having IBS without some further investigative process. As ever it is a fine line for us in Primary Care to balance the roles of "Gate-Keeper" and "Holders of the Purse Strings" whilst ensuring that we do not disadvantage our patients by not following our clinical intuition when we feel that all is not as it should be.

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The diagnosis and management of chronic constipation in primary care

Chronic constipation is a much more complicated condition that it might first appear to be. Perceptively, amongst professionals and the general public, chronic primary constipation is thought to be a functional problem that can be dealt with increasing fibre in the diet, drinking more fluid and going for a brisk walk. In fact there is very little evidence that any of these strategies will make any real difference to constipation symptoms but they are good health practices. It is popularly thought that the pathophysiology of chronic constipation is a 'lazy' bowel resulting in the slow passage of faecal material through the lumen of the bowel resulting in the excessive recovery of liquid by the bowel, producing a dry solid stool that is difficult to expel. Although this might account for some causes of constipation there are a number of other conditions that need to be considered.

There is little doubt that chronic constipation affects a person's quality of life and also that chronic constipation also poses a financial burden on the NHS. It is estimated that 80% UK community nurses spend up to half a day per week treating constipation[1] and in the US the mean cost of care per annum per constipated nursing home resident was estimated to be $2253 [~€1600] – including labour, the cost of medication and its administration[2]. Therefore this problem is not inconsiderable and needs a new understanding and a fresh approach to tackle this condition.

The first question is: what is chronic constipation? The 'gold' standard is the ROME III criteria but a more pragmatic approach would be the patient's self reported symptoms (see figure 1). In other words, constipation is, whatever the patient says it is. A study in the US of patients who reported constipation showed that the most frequent self-reported was straining with infrequent bowel motions 5th (the generally accepted definition of constipation), after flatulence, hard stool and abdominal discomfort[3].

Chronic constipation is either primary or secondary (see figure 2), this article focuses the primary causes as secondary causes are treated in accordance with the underlying condition. Differentiating between primary and secondary chronic constipation is illustrated in the algorithm produced by the EPCSG – the European consensus guidelines for the diagnosis and management of chronic constipation (see figure 3). This provides a logical and safe diagnostic pathway for a diagnosis of chronic constipation.

Further enquiry will determine into which the category constipation lays and accordingly, a broader view of primary chronic constipation is discussed below.

Primary chronic constipation comprises of four overlapping categories:

- *Slow transit constipation*
- *Pelvic floor disorders*
- *IBS-C (normal transit)*
- *Normal transit constipation*

The key messages are that these categories exist and that they overlap. These categories are reflected in the common conditions that cause constipation.

These are:

Slow transit constipation

IBS-C

Rectocoele and enterocoele

Dyssynergic constipation

Megacolon and megarectum

To differentiate between these various conditions, it is worthwhile considering symptom patterns as these can define the types of chronic constipation. Generic symptoms of chronic constipation are shown in figure 4. Therefore, constipation symptoms, response to treatment, patient history and physical examination indicate the cause of constipation and examples of the symptom pattern in each of the four conditions is shown in figures 5a to 5e.

At this point, I would like to draw your attention to vaginal and rectal manual manipulation. This question is not often asked in the assessment of constipation but it is very important in the diagnosis of two frequently overlooked causes of constipation – rectocoele and enterocoele, and dyssynergic constipation.

A rectocoele or enterocoele may cause obstructive defaecation in women (see figure 6) and the key characteristic of this is that vaginal manual manipulation will assist the passage of the stool. Rectocoeles are surprisingly common; this was found in 17 of 21 healthy volunteers who had defaecography[4]. Clinically, the presence of a rectocele/enterocoele can be confirmed by bimanual examination of the rectum and vagina.

The other common but often overlooked cause of chronic constipation is dyssyngeric defaecation. This occurs when there is an inability to coordinate the normal pattern of increased abdominal pressure with the relaxation of the pelvic floor and the internal and external sphincters. This is illustrated in figure 7. The typical symptom pattern of unsuccessful straining with a feeling of incomplete evacuation and rectal manual manipulation, without abdominal pain and normal structural anatomy is typical of dyssynergic defaecation. This condition may be caused by a history of suppressed defaecation.

Other possible causes of constipation, such as IBS-C and slow transit constipation are suggested by the symptoms patterns as shown in figure 5. Slow transit constipation may be confirmed by transit studies. This is a fairly straightforward test and available in most DGHs. The patient takes three differently shaped small plastic radio-opaque markers on three successive days. The positioning of these markers shown by a plain abdominal X-ray on day 5 indicates the rate of transit through the patient's large bowel.

The treatment algorithm for chronic constipation shown in figure 9 was also produced by the EPCSG advisory broad. This is a generic treatment pathway that provides a logic approach to constipation treatment. In addition, this algorithm may be refined at Stage 3 by tailoring the treatment according to the specific symptoms and constipation type (see figure 8).

However by applying the symptom patterns shown in figure 5a to 5e, it is possible to determine the underlying cause. This is particularly useful when dealing with treatment failure. For example, obstructed constipation due to a rectocele may well respond to the escalating doses and types of laxatives, or 5-HT_4 agonists but surgery may be required in resistant cases. Dyssynergic defaecation may respond to biofeedback and IBS-C to talking therapy or hypnotherapy.

This overview of chronic constipation highlights the categories and causes of chronic constipation. Furthermore, the concept of rectal and vaginal manual manipulation by the patient to relieve their constipation is important in determining common, but often overlooked, causes of chronic constipation, namely a rectocoele and enterocoele and dyssyngeric constipation. By considering these conditions targeted and appropriate treatments may be offered. Also, with the launch of a prokinetic for the treatment of chronic constipation, there are more therapeutic opportunities for the treatment of this condition.

Dr Jamie Dalrymple.

This article was prepared with support from Shire Pharmaceuticals

ROME III criteria for the diagnosis of chronic constipation	Pragmatic descriptors for chronic constipation
Symptom onset ≥6 months prior to diagnosis ≥2 of the following, for the last 3 months, in 25% defaecations: Straining Lumpy or hard stools Sensation of incomplete evacuation Sensation of anorectal obstruction /blockage Manual manoeuvres needed <3 bowel movements per week For IBS-C diagnosis additional symptoms are required	Depends on perception of normal bowel habit Including expected frequency Patients with self-reported constipation are most bothered by symptoms e.g. Straining Abdominal discomfort Sensation of incomplete evacuation Symptoms typically present for onset ≥6 months

Figure 1 ROME III and pragmatic diagnostic features of chronic constipation

Primary constipation	Secondary constipation
• Functional constipation • Irritable bowel syndrome with chronic constipation (IBS-C) • Pelvic floor disorders • Structural or functional • Idiopathic megacolon/ megarectum Rarely: Hirschsprung's disease Chronic intestinal pseudo-obstruction	Medication Opiates, iron supplements, TCAs, Diuretics, antipsychotics etc. Metabolic/endocrine Hypercalcaemia, hypothyroidism, hypokalaemia, Pheochromocytoma, etc. Neurological Multiple sclerosis, Parkinson's disease, spinal cord injury, etc. Psychological Depression, eating disorders, abuse, etc Intrinsic Colorectal cancer, Diverticular disease etc.

Figure 2 Primary and secondary constipation

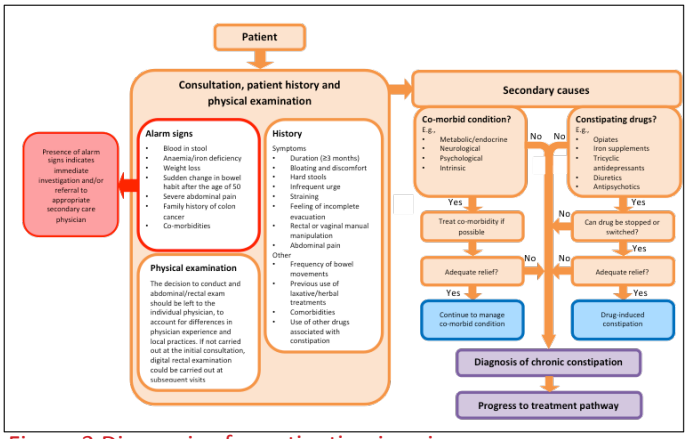


Figure 3 Diagnosis of constipation in primary care

Constipation symptoms Bloating and discomfort Hard stools Infrequent urge Straining Feeling of incomplete evacuation Need for rectal manual manipulation Need for vaginal manual manipulation Abdominal pain	Response to laxatives, diet Patient history Physical examination

Figure 4 Common symptoms of constipation

Constipation symptoms **Bloating and discomfort** **Hard stools** **Infrequent urge** **Straining** Feeling of incomplete evacuation Need for rectal manual manipulation Need for vaginal manual manipulation Abdominal pain	**Response to laxatives, diet** **High fibre or bran can worsen constipation** **Laxatives rarely produce diarrhoea unless overloaded** **Patient history** **Predominately women often presents in puberty** **Triggers: past history of urge avoidance** Physical examination

Figure 5a Symptom pattern for slow transit constipation

Constipation symptoms **Bloating and discomfort** **Hard stools** **Infrequent urge** **Straining** **Feeling of incomplete evacuation** Need for rectal manual manipulation Need for vaginal manual manipulation Abdominal pain Other: passage of mucus	**Response to laxatives, diet** **Variable** **Fibre exacerbates pain/ bloating** **Patient history** **Stress induced symptoms pattern** **Female >> Male** Physical examination

Figure 5b Symptom pattern IBS-C

Constipation symptoms Bloating and discomfort Hard stools Infrequent urge **Straining** **Feeling of incomplete evacuation** Need for rectal manual manipulation **Need for vaginal manual manipulation** **Anterior – enterocoele** **Posterior - rectocele** Abdominal pain	**Response to laxatives, diet** **Suppositories may help** **Patient history** **Mainly women** **History of difficult childbirths** **Physical examination** **Moderate-sized rectocoele via bimanual exam** **Enterocoele identified by palpable descent of small bowel on straining via bimanual exam**

Figure 5c Symptom pattern Rectocoele and enterocoele

Constipation symptoms **Bloating and discomfort** Hard stools **Infrequent urge** **Straining** **Feeling of incomplete evacuation** **Need for rectal manual manipulation** Need for vaginal manual manipulation Abdominal pain	**Response to laxatives, diet** **Suppositories can be successful** **Difficulty expelling enema fluid** **Patient history** **Much more common in women** **?related to delayed defaecation** **Can be any age, not related to parity** **Physical examination** **Contraction of puborectalis**

Figure 5d Symptom pattern Dysynergic constipation

Constipation symptoms **Bloating and discomfort** **Hard stools** **Infrequent urge** **Straining** **Feeling of incomplete evacuation** Need for rectal manual manipulation Need for vaginal manual manipulation **Abdominal pain** **Bloating and discomfort**	**Response to laxatives, diet** **Best with osmotic laxatives** **Fibre exacerbates bloating** **Patient history** **Affects men and women equally** **Lifelong symptoms** **Starts in childhood or early adulthood** **Physical examination** **May feel rectum arising from the pelvis** **Full rectum** **Perianal soiling**

Figure 5e Symptom pattern Mega rectum and mega colon

Rectocoele: herniation of rectum through rectovaginal defects

Enterocoele: small intestine pushes down into vagina

Complications of childbirth are the most significant risk factor

Research indicates large proportion of women may have undiscovered rectocoele

Rectocoele / enterocoele should be considered in women with chronic constipation

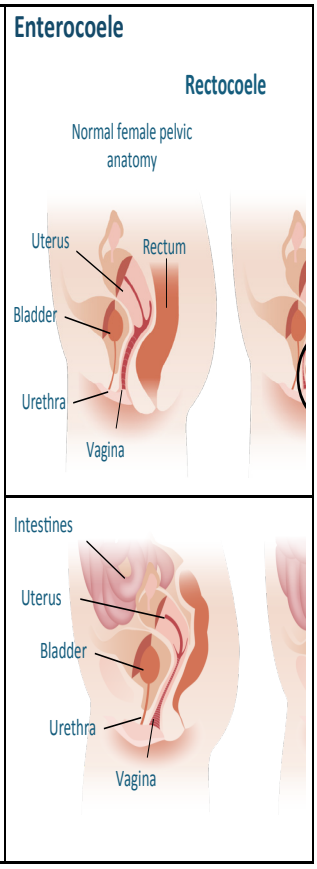


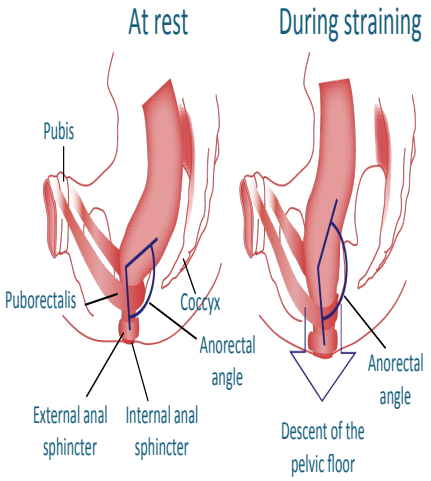
Figure 6 Rectocoele and Enterocoele

Normal pattern for defaecation

Increased intrarectal pressure

Simultaneous relaxation of anal sphincters

Descent of pelvic floor



Dyssynergic defaecation*

Failure to coordinate abdominal musculature and pelvic floor

Failure to coordinate pelvic floor and anal sphincters

*Also termed: Anismus, Paradoxical anal contraction, Pelvic Floor Dyssynergia, Obstructed constipation, Functional outlet obstruction.

Figure 7 Dysynergic defaecation

Episodic reduced frequency	→	Stimulant laxative[8]	If no improvent: Increase dose[8]
Slow transit constipation	→	Osmotic laxative[8]	
Difficulty evacuating	→	Glycerine or stimulant	Rational combination e.g. Stool softener and stimulant laxative[9, 10] or bulking agent[1]
Megarectum or megacolon	→	Osmotic laxative[11]	

Figure 9 Tailoring laxative treatments to the patient, symptoms and type of chronic constipation

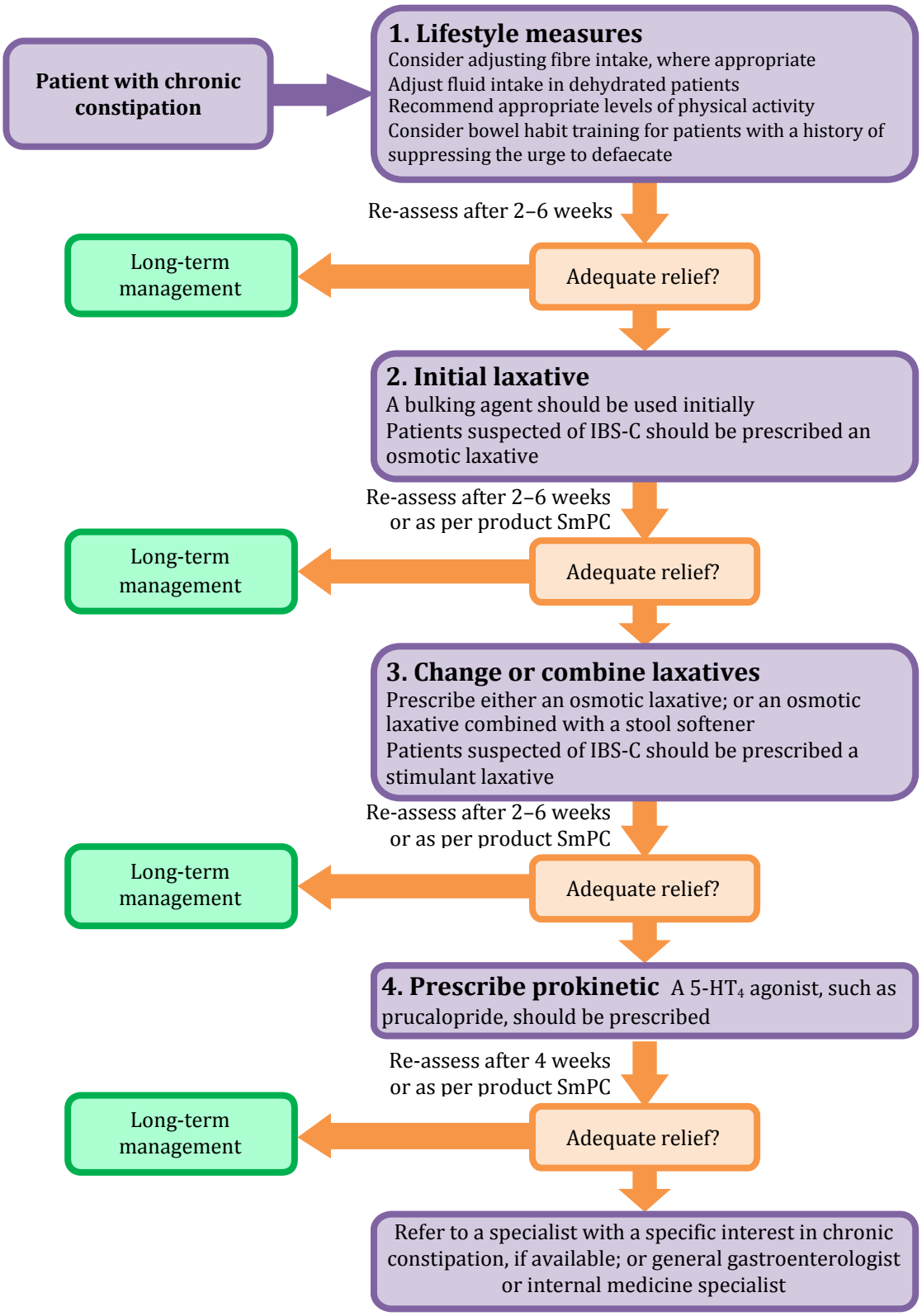


Figure 8 ESPCG Treatment algorithm for chronic constipation

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Tables and diagrams courtesy of Shire Pharmaceuticals

Journal Watch

Gastroprotection; have we got it right yet?

It has long been recognised that some patients are of increased risk of ulceration due to concomitant medication such as NSAIDs and other factors. However, there remains confusion as to who should receive PPI protection and the advent of PPI/NSAID formulations further complicates matters. This Italian study highlights an increasing problem of blanket prescribing of PPIs with NSAIDs with little if any assessment of risk.

Morini S, Zullo A, Oliveti D, Chiriatti A, Marmo R, Chiuri DA, et al. A Very High Rate of Inappropriate Use of Gastroprotection for Nonsteroidal Anti-inflammatory Drug Therapy in Primary Care: A Cross-Sectional Study. J Clin Gastroenterol. 2011 Oct;45(9):780-4.

Liver and the gut.

The association between ulcerative colitis and primary sclerosing cholangitis is well known. However, as this study shows, the more severe PSC is, the less active the associated UC is. Could PSC have a protective role in UC activity?

Marelli L, Xirouchakis E, Kalambokis G, Cholongitas E, Hamilton MI, Burroughs AK. Does the severity of primary sclerosing cholangitis influence the clinical course of associated ulcerative colitis? Gut. 2011 September 1, 2011;60(9):1224-8

NAFLD in childhood

When one thinks of NAFLD, we often think in terms of the adult disease but it si now one of the most common reasons for chronic liver diease and adolescemts in the Western world. This fascinating articles outlines the causes in childhood and also the similarities and differences from adult NAFLD.

Cheung CRLH, Kelly DA. Non-alcoholic fatty liver disease in children. BMJ. 2011 July 18, 2011;343

NAFLD

This short review is an excellent primer outlining the challenges created by NAFLD. The irritating part is that it is a condition which ideally requires a integrated response from primary and secondary care but, sadly, remains below the radar for many commissioners.

Anstee QM, McPherson S, Day CP. How big a problem is non-alcoholic fatty liver disease? BMJ. 2011 July 18, 2011;343

Autoimmune hepatitis

There are probably far more patients in the average practice than you would think with AIH. Nevertheless, those of you working in a secondary care setting will probably see far more. The gist of these latest guidelines show that little progress has been made in the past few decades and many questions remain unanswered but in the future????

Gleeson D, Heneghan MA. British Society of Gastroenterology (BSG) guidelines for management of autoimmune hepatitis. Gut. 2011 July 13, 2011

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