26th Advanced Gastroenterology & Hepatology Course
Tuesday 31 of January and Wednesday 01 February 2023

Hepatocellular surveillance - who, how and for how long -Dr Tom Bird:

Q. Giving patients responsibility! On an app! Where do we stand if poor cooperation for scan and then subsequent hcc diagnosis?

A. The issue here is that there is poor engagement on both sides. The published data is more complete from the US but what is there in UK (published and anecdotal) and US suggests that dropout from screening is as much poor organisation of healthcare services as it is non-attendance/engagement by the patients themselves. Both sides need to be improved. We need better recall systems, but there is also more we can do to engage patients. There are a number of potential opportunities here, which would engage patients and give them some control/responsibility in their own screening. The system (NHS) would still keep ultimate responsibility in my opinion, but access to results, better engagement with why we do surveillance, and their current status (dates of next appointments and results) might help engagement. Also online/written resources explained what surveillance is how it works and what its limitations are would also help in my opinion. Managing expectations is key.

Regarding second point. We try to do the best for our patients. If you have had honest discussions about rationale and importance of screening with patients and they don't engage with it then they have to take that responsibility in my view. From medicolegal standpoint too I believe this is acceptable.

Taking a step back we have to accept that screening is not going to be perfect even if we apply our guidelines perfectly and all patients engage. It is an inaccurate process which does not use gold standard diagnostic methods.

Coeliac disease: clinical pathways in diagnosis and management - Dr Helen Gillett:

Q. does actual value of TTG tire has any role of diagnosis and then response to GFD ?

A. The higher the titre the more likely the diagnosis is, and hence why we feel that given the presence of symptoms a titre of >10 times the upper limit of normal is sufficient to make a diagnosis.

Lower titres exhibit much more variability – some will have entirely normal histology, but others (with the same titre) will have flat biopsies.

Titres fall with the removal of gluten from the diet. Not everyone will normalize their titre though, even with strict gluten free diet. I tend to use trends rather than absolute values; if a patient's symptoms resolve and their titre has fallen (eg >200 to 8) then I am reasonable confident that their diet is good and their disease has responded. If they then represent

with symptoms and their level comes back at 20 then it would suggest to me that gluten is slipping into their diet somewhere.

Foreign body ingestion: dos and don'ts - Professor Xavier Dray:

Q. **Wasn't the case with narcotic ingestion where bags were removed with a retriever not similar to body packing (or is the term used along with rectal/vaginal installation of substances only)?**

A. You are right. Body packing refers to patients swallowing drug-filled packets, whereas body-stuffing refers to the insertion of drug-filled packets in the rectum or vagina.

Q. What is your approach to patients who swallow foreign bodies recurrently / frequently?

A. I must confess that my team mostly proceed to foreign body extraction at night and weekends for other departments. I don't have these patients in charge afterwards. Still, recurrent "swallowers" are usually children or adult patients with psychological disorders (with or without suicidal intent) and/or prisoners who try to get admitted to the hospital to have a few days off the jail. The general comment would be that they all need psychological / psychiatric evaluation and appropriate management.

Diabetes and NAFLD - the way forward - Professor Philip Newsome:

Q. Do we have enough evidence to recommend GLP1 in all our NASH pts who have DM

A. No

Q. Timing to refer for consideration of transplantation and is treatment required for obesity required prior to that?

A. Yes

Q. can we routinely advise Via E in NASH (no DM) as low harm approach ?

A. No