Gastroenterology Practice Review™

Making Education Easy

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In this issue:

Abbreviations used in this issue:

5-ASA = 5-aminosalicylic acid; **AGA** = American Gastroenterological Association; **AGITG ASM** = Australasian Gastro-intestinal Trials Group Annual Scientific Meeting; **AHPRA** = Australian Health Practitioner Regulation Agency; **AI** = artificial intelligence; **CD** = Crohn's disease; **CPD** = continuing professional development; **CPU** = Clinical Practice Update; **CTG** = Closing the Gap; **CVS** = cyclic vomiting syndrome; **EMR** = endoscopic mucosal resection; **ESGE** = European Society of Gastrointestinal Endoscopy; **GESA** = Gastroenterological Society of Australia; **GI** = gastrointestinal; **HELLP** = haemolysis, elevated liver enzymes, low platelet count; **HPOS** = Health Professional Online Services; **IBD** = inflammatory bowel disease; **IV** = intravenous; **PBS** = Pharmaceutical Benefits Scheme; **SSLs** = sessile serrated lesions; **TGA** = Therapeutic Goods Administration; **UC** = ulcerative colitis.

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Welcome to the 41st issue of Gastroenterology Practice Review.

This Review covers news and issues relevant to clinical practice in gastroenterology. It brings you the latest updates, both locally and from around the globe, in relation to topics such as new and updated treatment guidelines, changes to medicine reimbursement and licensing, educational, professional body news, and more. Finally, on the back cover, you will find our COVID-19 resources for Gastroenterologists and a summary of upcoming local and international educational opportunities, including workshops, webinars and conferences.

We hope you enjoy this Research Review publication and look forward to hearing your comments and feedback.

Kind Regards,

Dr Janette Tenne
Editor
janette.tenne@researchreview.com.au

Clinical Practice

AGA Clinical Practice Update: Pregnancy-related gastrointestinal and liver disease

The American Gastroenterological Association (AGA) has published a Clinical Practice Update (CPU) that provides expert guidance on managing pregnancy-related gastrointestinal (GI) and liver diseases. The authors emphasise the importance of preconception counselling and contraceptive care for reproductive-aged individuals with GI or liver conditions. They advise that necessary procedures and medications should not be withheld solely due to pregnancy, with risks and benefits carefully assessed.

For high-risk pregnancies involving complex inflammatory bowel disease (IBD), advanced cirrhosis, or liver transplants, management by a multidisciplinary team at tertiary care centres is recommended. The CPU offers stepwise treatment approaches for nausea, vomiting, and hyperemesis gravidarum, including early intervention to prevent progression. Constipation management focuses on dietary fibre, hydration, and safe laxative options.

Elective endoscopy procedures should be deferred, but necessary non-emergent procedures are ideally performed in the second trimester. For pregnant patients with cirrhosis, the authors suggest evaluating and treating oesophageal varices, with upper endoscopy recommended in the second trimester if not done within a year before conception.

The CPU stresses the importance of maintaining clinical remission in IBD before, during, and after pregnancy. It advises continuing biologic agents throughout pregnancy and postpartum, while certain medications like methotrexate must be stopped well before conception.

For liver diseases unique to pregnancy, such as intrahepatic cholestasis, pre-eclampsia, HELLP syndrome, and acute fatty liver of pregnancy, the guidance focuses on timely delivery planning and consideration of liver transplantation when necessary. The authors recommend aspirin prophylaxis for those at risk of pre-eclampsia or HELLP syndrome.

In chronic hepatitis B management, the update suggests considering antiviral treatment in the third trimester for patients with high viral loads. For those on immunosuppressive therapy for chronic liver diseases or post-liver transplantation, the guidance recommends continuing treatment at the lowest effective dose during pregnancy, except mycophenolate mofetil, which is contraindicated.

Throughout the CPU, the authors emphasise the need for individualised care, multidisciplinary collaboration, and careful risk-benefit analysis in managing GI and liver conditions during pregnancy.

https://tinyurl.com/2ck9jhe6

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AGA Clinical Practice Update: Diagnosing and managing cyclic vomiting syndrome

The AGA has published a CPU providing expert guidance on diagnosing and managing cyclic vomiting syndrome (CVS) in adults. CVS is characterised by recurrent episodes of intense nausea, vomiting, and retching, separated by symptom-free intervals. CVS remains underdiagnosed and undertreated, leading to significant healthcare utilisation and disability.

Diagnosis is based on clinical criteria, including stereotypical episodes of acute onset vomiting lasting <7 days, with at least three discrete episodes in a year. The condition has four distinct phases: inter-episodic, prodromal, emetic, and recovery. Recognising prodromal symptoms is crucial for early intervention. Common triggers include stress, sleep deprivation, and hormonal fluctuations.

Comorbidities such as mood disorders, migraines, and autonomic imbalances are frequent. A basic diagnostic workup should include blood tests and upper GI imaging to exclude other conditions. Repeated invasive testing should be avoided.

Management involves a multifaceted approach. Lifestyle modifications and addressing comorbidities are essential. Prophylactic therapy is recommended for moderate-severe CVS (≥4 episodes/year, >2 days each, requiring emergency department visits). First-line prophylaxis includes tricyclic antidepressants, with topiramate, aprepitant, zonisamide, and levetiracetam as second-line options.

Abortive therapy aims to prevent or reduce the severity of the emetic phase. Combinations of medications are often necessary, typically including sumatriptan and an antiemetic like ondansetron. Sedation can be an effective strategy. For uncontrolled episodes, emergency department management may be required, focusing on IV fluids, antiemetics, and sometimes sedation.

The update emphasises the importance of prompt recognition and individualised treatment. It highlights the need for further research to understand CVS pathophysiology and develop more targeted therapies. The authors also note racial disparities in clinical outcomes that warrant investigation.

https://tinyurl.com/aarfukz4

ESGE Guideline: Colorectal polypectomy and endoscopic mucosal resection

The European Society of Gastrointestinal Endoscopy (ESGE) has published comprehensive recommendations on colorectal polypectomy and endoscopic mucosal resection (EMR) techniques.

Key recommendations include using cold snare polypectomy for diminutive (≤5 mm) and small (6–9 mm) polyps, with a clear margin of normal tissue. Hot snare polypectomy is recommended for 10–19 mm nonpedunculated adenomatous polyps. For large (≥20 mm) nonpedunculated adenomatous polyps, conventional EMR is recommended as the standard approach.

The guideline emphasises careful lesion assessment and classification using standardised systems to predict histology and invasion depth. En-bloc resection techniques are recommended for suspected superficial invasive carcinomas. After piecemeal EMR of large polyps, thermal ablation of resection margins using snare-tip soft coagulation is advised to prevent recurrence.

Cold snare techniques are recommended regardless of size for sessile serrated lesions (SSLs) without dysplasia. However, hot snare polypectomy with en bloc excision is advised for SSLs with dysplasia.

Prophylactic clip closure is recommended after EMR of large polyps in the right colon to reduce delayed bleeding risk. The guideline also addresses the management of intraprocedural and post-procedural bleeding.

Underwater EMR is suggested as an alternative to conventional EMR for large adenomatous polyps. Endoscopic submucosal dissection may be considered for selected large polyps in high-volume centres.

The guideline emphasises the importance of complete resection, proper specimen handling, and communication between endoscopists and pathologists. It recommends that experienced endoscopists remove large or complex polyps in appropriately resourced centres.

https://tinyurl.com/bdhevhnj

Practical management of mild-to-moderate ulcerative colitis

A recent international expert consensus provides practical guidance on managing mild-to-moderate ulcerative colitis (UC). The panel recommends combination therapy with oral 5-aminosalicylic acid (5-ASA) at 2-4.8 g/day and rectal 5-ASA for eight weeks to induce remission in treatment-naive patients. The response should be monitored clinically and via faecal calprotectin, measured after 8-12 weeks of induction therapy and every 3–6 months thereafter in responders.

Therapy optimisation is advised for those with inadequate response after 2–4 weeks. In non-responders to induction therapy, budesonide MMX 9 mg/day is recommended as an 8-week add-on treatment. Endoscopic evaluation is suggested within 6-12 months of starting 5-ASA therapy.

To improve adherence, once-daily oral 5-ASA administration is recommended. Renal function should be monitored every 6 months in patients on oral 5-ASA. For patients experiencing disease flare while on maintenance 5-ASA (<4 g/day), the panel advises optimising oral 5-ASA to ≥4 g/day for 8 weeks and adding rectal 5-ASA. Before initiating steroids in non-responders to optimised 5-ASA, stool tests should be performed to exclude intestinal infections.

In patients responding to optimised oral 5-ASA (≥4 g/day) who lose response upon de-escalation, re-escalation to ≥4 g/day and maintenance at a stable dosage is recommended. Endoscopic evaluation is advised 6-12 months after therapy optimisation. The panel emphasises that oral 5-ASA should be continued as long-term maintenance therapy to reduce colorectal cancer risk.

The consensus highlights the importance of tight monitoring using faecal calprotectin and timely dose adjustments for optimal disease control. It also discusses emerging concepts like disease clearance and histological remission as potential treatment targets. The experts note that while 5-ASA remains the standard first-line therapy for mild-to-moderate UC, new formulations and delivery systems may improve its efficacy in the future.

https://tinyurl.com/ms4t4ct8

Common mistakes in managing patients with inflammatory bowel disease

A recent review article identifies common errors in managing patients with IBD, highlighting that many can be prevented in clinical practice. The authors review scientific evidence and propose appropriate recommendations.

The authors emphasise the importance of providing an accurate diagnosis, including ruling out enteric infections in patients with symptoms suggestive of IBD exacerbation. *Clostridium difficile* testing should be routine for patients with severe flares, regardless of recent antibiotic use. The article notes that discontinuous lesions do not preclude a diagnosis of UC, and complete colonoscopies in severe cases are discouraged due to the risk of complications.

The authors critique the over-reliance on corticosteroids, advocating for their limited use and the timely introduction of steroid-sparing agents. Thiopurines are acknowledged as effective for maintaining remission in UC, though their role in Crohn's disease (CD) is less clear. The combination of oral and topical 5-ASA is recommended for enhanced efficacy in treating UC, while surgery should not be unduly delayed in severe cases.

Anaemia and iron deficiency are common in patients with IBD, with screening and treatment essential for improving quality of life. Elderly patients should not be excluded from biologic therapies, as they can benefit from these treatments despite concerns about adverse effects. The article also addresses misconceptions regarding medication safety during pregnancy and breastfeeding, asserting that many IBD medications are compatible with both.

The authors call for improved adherence to clinical guidelines and ongoing education for healthcare providers to reduce variability in IBD management. They advocate for specialised units for IBD patients to ensure higher-quality care and minimise errors. The review concludes that while errors in IBD management are frequent, many can be mitigated through better education, adherence to guidelines, and focused patient care strategies.

https://tinyurl.com/znnryze8

Meeting your professional obligations when using AI in healthcare

Since artificial intelligence (AI) is becoming increasingly integrated into healthcare, the Australian Health Practitioner Regulation Agency (AHPRA) has published guidance on how clinicians can use AI tools responsibly while adhering to professional obligations. In healthcare, AI encompasses various technologies, from diagnostic tools to generative AI for administrative tasks. While some AI tools are regulated by the Therapeutic Goods Administration (TGA) as medical devices, many general-purpose tools used in clinical practice are not.

The potential benefits of AI in healthcare include improved health outcomes, enhanced diagnostics, and reduced administrative burdens. However, clinicians must be aware of the challenges and ethical considerations associated with AI use. Regardless of the technology employed, practitioners remain accountable for delivering safe, quality care and meeting professional standards outlined in their Code of Conduct.

When using AI, clinicians should understand the tool's intended use, limitations, and potential risks. This includes reviewing product information, training data, and clinical contexts where the tool may not be appropriate. Transparency with patients about AI use is crucial, mainly when it involves personal data input or recording consultations.

Informed consent is essential when using AI tools that require patient data input or for recommended diagnostic devices. Clinicians should document patient consent, especially when using AI scribing tools that employ generative AI.

Other important considerations include ensuring patient privacy and confidentiality, being aware of potential biases in AI algorithms, complying with relevant legislation and regulatory requirements, and understanding the governance arrangements established by employers or practices for AI implementation.

AHPRA will update the guidance regularly to reflect new developments in AI and share updates from other regulators.

https://tinyurl.com/yckch76v

Communication and support of patients and caregivers in chronic cancer care

The European Society for Medical Oncology has published a Clinical Practice Guideline providing recommendations on communication and support for patients and caregivers in chronic cancer care. The guideline takes a nuanced view of communication as contextual and relational rather than a set of discrete skills. It aims to equip clinicians to make informed judgments about communicating effectively with patients with cancer and their caregivers across the disease trajectory. The key recommendations are outlined below.

Clinicians should understand that communication involves more than just skills, knowledge, and attitudes that guide judgment. They should be aware of psychological factors affecting both patients and themselves that shape communication needs. Learning to communicate is an individual process requiring adaptable training formats.

The guideline discusses the psychology of being a patient with cancer, including vulnerability and attachment needs. It recommends that clinicians recognise patients' need to trust in their care while respecting patient autonomy. Clinicians should reflect on their own motivations and psychological challenges in oncology.

The guideline advises structuring conversations, using appropriate question types, and carefully managing information delivery when obtaining and providing information. When explaining options and making decisions, clinicians should assess patients' ability to participate and involve them accordingly.

Responding to emotions requires understanding their communicative functions and exploring underlying concerns before responding. Building relationships involves efficient, conscientious engagement and availability for emotional support.

The guideline addresses supporting hope, interprofessional communication, chronic cancer/survivorship care, and family meetings. It recommends communication training to increase clinicians' awareness of personal and contextual factors shaping communication.

Research recommendations include promoting qualitative studies linking communication behaviours to clinician objectives and patient experiences, as well as assessing effects on patients in real-world settings.

https://tinyurl.com/72ucdr2d

Regulatory News

Release of Stage 3 for 60-day prescriptions

The final phase of the 60-day prescription implementation commenced on September 1, 2024, marking a significant expansion in medication access for patients with stable chronic conditions. This third stage encompasses 264 medicines, representing 766 PBS items when accounting for various strengths and formulations.

Clinicians retain complete discretion over prescribing quantities, allowing for tailored patient care. While this change offers potential cost savings and convenience for patients, it necessitates vigilance in medication management. Healthcare providers should implement robust recall and review systems to ensure regular patient assessments, particularly for conditions like asthma, where ongoing monitoring is crucial.

The reform has been widely adopted, with over 10 million 60-day scripts dispensed in its first year. This change alleviates the financial burden for patients and potentially reduces unnecessary GP visits for prescription renewals. As the program reaches full implementation, clinicians should familiarise themselves with the comprehensive list of eligible medications and consider updating their prescribing practices accordingly.

https://tinyurl.com/mttzwkce

Expansion of the Closing the Gap PBS Co-Payment Program

The Closing the Gap (CTG) PBS Co-payment Program has been expanded to improve access to affordable medicines for First Nations people living with or at risk of chronic disease. From 1 July 2024, the program has included section 100 PBS medicines, in addition to section 85 medicines when dispensed by community pharmacies, approved medical practitioners, or private hospitals. Further expansion to public hospitals is planned for January 1, 2025.

This initiative addresses the significant medical cost barrier for First Nations people. Eligible patients registered in the program pay reduced co-payments or receive medicines for free, depending on their usual payment status. The program is available to First Nations people of any age who are registered with Medicare and, in the opinion of a prescriber or Aboriginal Health Practitioner, would experience setbacks in managing their condition without this assistance. Registration is a one-off process completed via the Services Australia HPOS portal.

https://tinyurl.com/2mknrx6n

Mild to moderate Crohn's disease

Budesonide (Budenofalk®; 3 mg enteric capsule) is now listed on the PBS for treating mild to moderate CD. Prescriptions for initial and continuing treatments are Authority Required (STREAMLINED).

https://tinyurl.com/4xra66ch

PBS listing: Neocate® Syneo

Amino acid formula supplemented with prebiotics, probiotics and long-chain polyunsaturated fatty acids (Neocate® Syneo; powder for oral liquid, 400 g) is now listed on the PBS for the treatment of cows' milk protein enteropathy; severe cows' milk protein enteropathy with failure to thrive; combined intolerance to cows' milk protein, soy protein and protein hydrolysate formulae; proven combined immunoglobulin mediated allergy to cows' milk protein and soy protein; cows' milk anaphylaxis; severe intestinal malabsorption including short bowel syndrome; eosinophilic oesophagitis. Authority applications for initial and continuing treatments can be made either in real-time using the Online PBS Authorities system or by telephone.

https://tinyurl.com/ycyvncnw

PBS listing: Abrilada®

Adalimumab (Abrilada®; 20 mg/0.4 mL injection, 2 x 0.4 mL syringes; 40 mg/0.8 mL injection, 2 x 0.8 mL syringes; 40 mg/0.8 mL injection, 2 x 0.8 mL pen devices) is a new biosimilar now listed on the PBS for the treatment of severe CD, moderate-to-severe UC, and complex refractory fistulising CD.

https://tinyurl.com/ycyvncnw

News in Brief

Irritable bowel syndrome toolkit

The AGA has published a toolkit that includes clinical guidelines, on-demand clinician education, and patient resources for irritable bowel syndrome.

https://tinyurl.com/xtzbejn3

Understanding liver tests

The Gastroenterological Society of Australia has developed a comprehensive overview of liver function testing, interpretation, and management for general practitioners and physicians. It covers indications for testing, liver test abnormalities patterns, fibrosis and cirrhosis assessment, and specialist referral criteria. The document emphasises the importance of non-invasive screening tools like Fibrosis-4 and aspartate aminotransferase to platelet ratio index scores. It also highlights critical considerations for various liver conditions, including metabolic-associated fatty liver disease and portal hypertension.

https://tinyurl.com/2f68adfk

COVID-19 Resources for Gastroenterologists

American Gastroenterological Association

American College of Gastroenterology

Conferences, Workshops, and CPD

Click on the links below for upcoming local and international gastroenterology meetings, workshops and CPD.

NZSG

GESA

AGITG ASM, Brisbane, 18-21 Nov 2024

World Gastroenterology Organisation – meetings and events

COMS – conferences and meetings on gastroenterology

Research Review Publications

Biologics Research Review with A/Prof Paul Bird, Dr Ian Kronborg and Dr Annika Smith

Gastroenterology Research Review with Dr Andrew Buckle and A/Prof Jonathan Segal

IBD Research Review with Associate Professors Britt Christensen, Jonathan Segal and Dr Emily Wright

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