or adolescence in a significant proportion of cases.¹ Even those patients who remain in remission with an uncomplicated course in paediatric services need to progress to adult services in anticipation of the natural disease course and for surveillance of associated complications. Evidence from other chronic diseases tells us that morbidity and mortality often increase in young people in the early years following transfer to adult services.²

Many patients with paediatric IBD (PIBD) have spent a significant amount of time in paediatric services and had prolonged contact with a particular multidisciplinary team, such that the prospect of moving on from familiar surroundings and care providers, with the additional challenge of taking on more responsibility for their own disease management, can be daunting for both patients and their families. It can also be difficult for the receiving adult gastroenterologist to get a handle on complex history and management and to build a rapport with the patient and carers. It therefore follows that this step requires planning and preparation and needs more than just a referral letter and a handshake; continuity of care is essential to ensure the optimum outcome for patient, family and staff. Transition is a process, while the final move is better considered a formal 'transfer event'. The importance of planned transition is highlighted in both North American and British IBD guidelines,^{3,4} and there have been many proposed ways of organising the process, but the majority of this is based on personal experience

and expert opinion, with seemingly little actual data published.

The systematic review of transition from adolescent to adult services in PIBD presented in this issue of *Frontline Gastroenterology* is therefore a welcome addition to the literature and clearly highlights the need for further data. Clarke and Lusher found just six papers of relevance, three of which investigated the views of gastroenterologists, while the others looked at resource utilisation and parent and patient perspectives; all studies were retrospective. The data here highlight that those diagnosed in childhood have more extensive involvement than those with adult-onset disease, as has been clearly shown in other studies.⁵ This chronic burden of complex disease has implications not only for growth (which may not always be completed prior to transition) but also for further education, employment and psychosocial welfare. Three of the papers recommend joint clinic visits, with both paediatric and adult professionals in attendance, to address the relevant issues and coordinate the evolving care. While not essential for every young person, a designated transition clinic can be an effective way of focusing all parties on the task at hand—readiness for care in adult services. The review indicates that paediatric gastroenterologists, adult gastroenterologists, patients and their families each have different ideas about what factors are important in preparing for transition; joint clinics are one way to highlight gaps, build relationships and ensure everyone's

Transition of patients with paediatric IBD to adult services

Inflammatory bowel disease (IBD) is a chronic, relapsing-remitting disease which presents in childhood

needs are met. They also facilitate multidisciplinary working and the pivotal role of the IBD nurse specialist in the transition process. Assessing readiness for transition is challenging (there are no validated scales),⁶ but especially so if nobody can agree on what readiness entails!

Two things are clear from this review: first, there is no recognised standard for transition of young people with IBD to adult services and practice varies widely. Although some evidence is beginning to emerge from specialist PIBD centres,⁷ other specialties are further ahead in terms of research in this field. Of particular interest is the work by a group of UK-based health professionals who have introduced a generic transition programme for any young person with a chronic disease aged 11+ years.² It is structured but adaptable for all subspecialties; the underlying principle being empowerment of young people to take control of their lives and their illness by equipping them with the skills and knowledge to manage their own healthcare in paediatric and adult services. Initial feedback after 3 years of use is extremely positive. Second, there remains a significant gap in IBD

transition research—patient outcomes, including relapse and remission rates, surgery and service use, are not known and the longer term impact of transition has not been measured. There is much work to be done before we can be confident we are doing the best for these patients.

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Contributors VMM and PH contributed equally to the writing of the manuscript.

Competing interests None declared.

Provenance and peer review

Commissioned; internally peer reviewed.

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To cite Merrick VM, Henderson P. *Frontline Gastroenterology* 2016;**7**:333–334.

Received 12 August 2015

Accepted 15 August 2015

Published Online First 04 September 2015

Frontline Gastroenterol 2016;**7**:333–334.

doi:10.1136/flgastro-2015-100640

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