Progressing pancreaticobiliary medicine in the UK

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THE SPECIALITY AND WHY THERE IS A NEED

This issue of *Frontline Gastroenterology* gives an overview of the rapidly developing field of pancreaticobiliary medicine in the UK. Currently, most hospitals in this country do not have gastroenterologists with a subspecialty interest in this area and there is not yet a defined curriculum in the field for training. These deficiencies now need to be addressed urgently to effectively manage the many patients who are increasingly being identified and diagnosed with pancreaticobiliary diseases. A career in pancreaticobiliary medicine is attractive to gastroenterologists, as it combines a range of skills to manage complex benign and malignant disease, including diagnostic and therapeutic endoscopic interventions and working in multidisciplinary teams. Over the last few years, evidence for endoscopic treatment in complex pancreaticobiliary conditions has been accumulating and, thanks to technological advances in equipment, endoscopy is complementing and competing with traditional surgical and radiological approaches. In several areas, such as treating patients with pancreatic cancer, the role of the physician can be expanded. Furthermore, the opportunities for service development and research are significant.

Components of the speciality

The seven papers in this series review the broad range of conditions in pancreaticobiliary medicine in which clinicians require expertise.^{1–7} These discuss the diagnosis and management of—plus recent advances in—acute and chronic pancreatitis, immunoglobulin (Ig)G4-related disease, pancreatic cysts, pancreatic cancer, pancreatic neuroendocrine tumours and cholangiopathies. The papers would form the basis of developing the training curriculum for junior gastroenterologists interested in the subspecialty. There is an increasing need for the involvement of physicians in managing patients with acute and chronic pancreatitis, particularly related to identifying aetiologies and the endoscopic treatment of sequelae. Acute pancreatitis has traditionally been managed by surgical colleagues, but there is now an increasing

trend for a joint medical and surgical approach. Endoscopic management of pancreatic fluid collections and infected pancreatic necrosis has become part of the mainstay of treatment in complicated cases in many centres. For patients with chronic pancreatitis, physicians can offer and coordinate all aspects of the multiple components of care including managing nutrition, pain relief and psychological aspects. For benign conditions, such as IgG4-related disease, the diagnostic algorithm and treatment strategies are rapidly developing. Gastroenterologists are well placed to do this following experience in managing other autoimmune conditions such as inflammatory bowel disease and autoimmune hepatitis. Experience is required in the appropriate use of invasive tests, such as pancreatic biopsy, biliary stenting and also of powerful medications including immunosuppressive drugs and biologics. Endoscopic management of biliary disease has advanced over the last few years with endoscopic ultrasound and digital cholangioscopy for diagnosis of indeterminate strictures and management of complex biliary stone disease with electrohydraulic lithotripsy and laser. Pancreatic cysts are increasingly being detected on axial imaging, in patients with symptoms due to other pathologies or in surveillance programmes for other cancers, such as colorectal adenocarcinoma. Appropriate surveillance and management strategies are essential. This is so those at particular risk are treated before incurable malignancy develops, but also so that the system is not overwhelmed by monitoring those in whom surveillance is either inappropriate for medical reasons or pathological progression is extremely unlikely. For patients with pancreatic cancer, physicians should have an active role in follow-up to manage medical complications including malnutrition, diabetes, depression, pain and obstructive jaundice. Effectively addressing these areas helps ensure patients with pancreatic cancer achieve a better performance status such that they are more able to tolerate primary treatments including chemotherapy and surgery. The medical pancreaticatologist can actively work with palliative care physicians to deliver endoscopic

ultrasound-guided coeliac plexus neurolysis, when conventional opiate-based analgesia has failed or resulted in intolerable side effects. Pancreatic neuroendocrine tumours are often diagnosed by gastroenterologists and their management can be continued in liaison with oncologists and endocrinologists. Overall, the management of patients with both benign and malignant pancreaticobiliary diseases requires a multidisciplinary approach where physicians work closely with surgeons, oncologists, radiologists, nutritionist specialists, pathologists, cancer nurse specialists and dieticians.

Training and infrastructure

The authors of the reviews hope this issue of *Frontline Gastroenterology* will serve as a useful overview of key topics in pancreaticobiliary medicine for trainees and consultants and raise the profile of the subspecialty in the UK. All gastroenterologists should be confident to have a working knowledge of the topics outlined in this edition. There is also an argument for a subspecialty curriculum in Medical Pancreatobiliary medicine to be defined to support trainees seeking particular expertise in the subspecialty, alongside training in ERCP and EUS. The duration of this training would be at least 2 years and the number of these training posts should meet the workforce requirements in the UK. Junior doctors in the specialty should be actively encouraged to pursue research projects in the subspecialty, for which there is a diverse range of topics.

The future

A future aim of medical gastroenterology should be to have an accredited subspecialty curriculum in medical pancreatology and for every hospital to employ a physician with such an interest. Although all hospitals will not be able to provide all diagnostic and therapeutic services, availability of a physician to provide the essential services for such patients and coordinate referrals is desirable. In larger centres, physicians in pancreaticobiliary medicine can be expected to be intimately involved in managing all areas of these complex diseases, including being at the cutting-edge of endoscopic technology

and delivering minimally invasive care to a large population. We believe this approach can bring great benefit to patients with pancreaticobiliary disease. We welcome your comments and feedback on the seven articles in this series. Thank you.

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