LETTER FROM THE EDITOR

Last month, I discussed how medicine is always changing: how new information continues to alter our understanding of various conditions and their treatments. While ongoing developments in research and clinical practice should always be kept in mind, we should also periodically pause to consider what we have learned—even if we know it may change tomorrow. This month, therefore, I want to address a few areas in which we have seen recent improvements, as these findings will likely serve as the foundation for future advances.

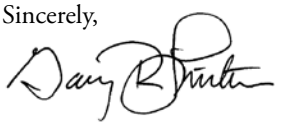
Currently, we have an array of therapeutic options to consider when selecting a treatment for inflammatory bowel disease (IBD), ranging from mesalamine therapy for ulcerative colitis to biologic agents for Crohn's disease (CD). In selecting a treatment for a particular patient, our goal is not only to find the safest agent that can adequately control the patient's current symptoms, but also to implement a drug regimen that can prevent complications and the need for future surgery. Fortunately, we now have a good predictor that can help us determine which treatments are likely to prove effective over the long term: mucosal healing.

As is discussed in the clinical roundtable monograph included in this issue, several studies have shown that patients who achieve mucosal healing in the short term are likely to remain in remission over the long term. Thus, if a particular treatment offers symptomatic relief and heals the intestinal mucosa, then patients are likely to do well if they are maintained on this medication. However, if mucosal inflammation remains despite treatment, then more aggressive therapy will likely be needed at some point, either sooner or later; in this case, promptly looking for a more effective treatment may help to prevent later complications. While we must still rely on clinical judgment to determine which medication to use for which patients, knowing that mucosal healing is a good predictor of long-term outcomes allows us to tailor our therapies more effectively.

Another success that deserves mention is the implementation of Model for End-Stage Liver Disease (MELD) scores as a guide for allocating resources in liver transplantation. As is mentioned in this month's feature by Dr. Nyingi Kemmer on page 302, implementation of MELD scores has eliminated the previously observed ethnic disparities in waiting list outcomes. According to recent studies, patients who are waiting for liver transplantation now show similar rates for pretransplantation mortality or removal from the waiting list because they are too sick for transplantation, regardless of ethnicity. While overall liver transplantation outcomes still show differences among various ethnic groups, these differences likely stem from differences in access to liver transplantation, rather than differences in transplantation rates once patients are on the waiting list. As with the finding that mucosal healing predicts long-term success in the treatment of IBD, this improvement represents an important advance that could pave the way for further success in this area.

In addition to this feature on ethnic disparities in liver transplantation, this month's issue of *Gastroenterology & Hepatology* includes a review of 5-aminosalicylic acid therapy for CD and columns on several interesting topics: irreversible electroporation as a treatment for liver cancer, management of dysphagia in stroke patients, why we should define and treat early CD, and the significance and management of nonampullary duodenal polyps. In addition, this issue includes 2 cases: a report of autoimmune cholangiopathy and high-output heart failure in a patient with Graves disease and a case of Barrett esophagus with progression to adenocarcinoma in a family with attenuated familial polyposis. I hope you find this information both clinically relevant and interesting.

Sincerely,



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