LETTER FROM THE EDITOR

Dysphagia is a symptom that may be twice as common in persons older than 50 years than in younger persons. Dysphagia is particularly common in persons residing in assisted living environments; thus, as the population ages, gastroenterologists can expect to see patients presenting with complaints of dysphagia more frequently. Dysphagia can be seen in patients with obesity or gastroesophageal reflux disease, the incidence rates of which are also increasing. Further, dysphagia is common in neurologic conditions such as tardive dyskinesia, Parkinson disease, multiple sclerosis, amyotrophic lateral sclerosis, and cerebrovascular accidents; autoimmune disorders such as Sjogren syndrome, systemic lupus erythematosus, and rheumatoid arthritis among others; and esophageal or other cancers. Dysphagia may also have a psychogenic cause. Thus, diagnosis and management of dysphagia may be a multispecialty endeavor.

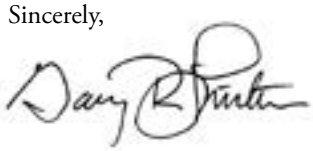
Also consider that untreated dysphagia, particularly in the elderly, takes a significant toll on healthcare resources. According to a study by a team led by Dr Kenneth W. Altman of the Mount Sinai School of Medicine in New York City and published in the August 2010 issue of *Archives of Otolaryngology–Head & Neck Surgery*, hospital stays for patients with dysphagia were nearly double that of patients without dysphagia, translating to a total estimated overall hospitalization cost of $547,307,964 per year. Altman and colleagues also pointed out that many cases of dysphagia go unidentified and, thus, recommend early identification of dysphagia in hospitalized patients, particularly elderly patients and patients dealing with stroke, dehydration, malnutrition, neurodegenerative disorders, pneumonia, and cardiac disease.

In this issue of *Gastroenterology & Hepatology,* we present a timely and informative clinical review on dysphagia in the elderly by Dr Muhammad Aslam and Dr Michael F. Vaezi of Vanderbilt University Medical Center in Nashville, Tennessee. We also present part 2 of our clinical review by Dr Francis A. Farraye, clinical director of the Section of Gastroenterology at the Boston Medical Center in Boston, Massachusetts, and colleagues of environmental influences on the onset and clinical course of Crohn's disease. This part covers the effects of infections, antibiotics, nonsteroidal anti-inflammatory drugs, and oral contraceptives.

In the wake of the recent American Association for the Study of Liver Diseases Liver Meeting 2013, which took place on November 1 to 5 in Washington, DC, we present an informative conversation about treating hepatitis C virus infection in special populations with Dr Steven L. Flamm of the Northwestern University Feinberg School of Medicine in Chicago, Illinois. In addition, Dr Florence Wong of the University of Toronto in Toronto, Canada discusses renal failure and hepatorenal syndrome in liver cirrhosis in our Advances in Hepatology column. Cryotherapy for the treatment of Barrett esophagus is covered by Dr John Dumot of the University Hospitals Ahuja Medical Center in Beachwood, Ohio in our Advances in GERD column; insights into common challenging endoscopic ultrasound scenarios are given by Dr Jorge V. Obando of Duke University School of Medicine in Durham, North Carolina in our Advances in Endoscopy column; and management of ulcerative colitis is discussed by Dr Laurent Peyrin-Biroulet of the University of Lorraine in Nancy, France in our Advances in IBD column.

I hope that the information presented by the top-notch international group of thought leaders in this issue of *Gastroenterology & Hepatology* will be of great assistance to you in your clinical practice.

Sincerely,



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