# LETTER FROM THE EDITOR

The practice of personalized medicine is a goal in many diseases, including inflammatory bowel disease (IBD). Recent research in IBD has highlighted interpatient variability in the manifestation of the disease that may lead to a more nuanced approach to management. The anti–tumor necrosis factor-α agents infliximab (Remicade, Janssen), adalimumab (Humira, AbbVie), certolizumab pegol (Cimzia, UCB), and golimumab (Simponi, Janssen) have shown great success overall, but many patients fail to achieve or maintain a response to these therapies. The reasons underlying these differences are not completely clear. The treatment of patients with IBD requires a perspective that extends beyond the gastrointestinal tract. This issue of *Gastroenterology & Hepatology* presents 3 specialized views of IBD management.

New diagnoses of IBD are increasing more quickly in adolescents than in other age groups. In one of our features, Drs Bincy P. Abraham and Stacy A. Kahn examine the important transition from pediatric care to adult care. Concerns specific to this population include anxiety about "starting over" with a new healthcare provider, resistance to differences in the management style of physicians who treat adults vs children, and fears that the disease will worsen during the transition. Parental involvement will also evolve as the patient gains autonomy. Gastroenterologists can do much to ease this transition; studies suggest that patient education and communication are key.

In another feature, Dr Veena Nannegari and colleagues review data on the group of patients who experience IBD after liver transplant. IBD in this setting is a clinical challenge because of the overlapping diagnostic possibilities and the paradox that the bowel remains inflamed even with the use of immunosuppression to prevent organ rejection. Most patients who develop IBD after solid organ transplant have undergone orthotopic transplantation for end-stage primary sclerosing cholangitis. Dr Nannegari and colleagues explore how the disease process that drives the development of IBD after liver transplant may differ from that in nontransplant patients, and they raise management issues unique to this population.

Studies are also examining the use of biomarker testing in the diagnosis of IBD. More than 160 independent IBD susceptibility loci have been identified. Many IBD patients are aware of this research and are bringing their questions to the clinic. In our Advances in IBD column, Dr Dermot McGovern discusses how the identification of genetic and molecular markers in IBD might be used to personalize management in the near future. He suggests that the disease variability observed in the clinic may be partially attributable to the molecular variation underlying the disease. A patient's particular set of biomarkers potentially could be used to assess disease severity and predict response to certain therapies, thereby refining management options.

This issue also offers insight into several other important areas in gastroenterology and hepatology. In our third feature, Drs Joseph Ahn and Robert G. Gish bring attention to the "forgotten" hepatitis D virus, and they explain why all patients with hepatitis B should undergo screening for hepatitis D. In our Nutrition column, Dr Martin H. Floch addresses the use of probiotics and prebiotics, an area of intense patient interest. In our other monthly Advances columns, Dr Santiago J. Munoz addresses the many complications of acute liver failure, Dr Mark E. Baker examines use of the barium esophagram in patients undergoing antireflux surgery, and Dr Douglas K. Rex discusses serrated polyps in the colon.

I hope this issue provides valuable information that you can put to good use in your clinical practice.

Sincerely,

Gary R. Lichtenstein, MD, AGAF, FACP, FACG