Treating the Whole Patient

The good physician treats the disease; the great physician treats the patient who has the disease.

—Sir William Osler

The patients we treat for gastrointestinal (GI) disorders are likely to have additional medical conditions that could affect the management plan. A patient might present with significant comorbidities, or concurrent use of therapeutic agents could lead to drug-drug interactions. The quotation from Sir William Osler serves as a reminder that a patient's GI health can be influenced by apparently disparate conditions. This issue of *Gastroenterology & Hepatology* features research elucidating the connections between common GI disorders and conditions most often managed by specialists in other fields.

In a feature article, Drs Fehmi Ates and Michael F. Vaezi examine the relationship between gastroesophageal reflux disease (GERD) and asthma. These diseases often occur together, although diagnosis can be challenging because patients with asthma may not exhibit the classic symptoms of GERD. GERD may increase asthmatic symptoms, and asthma may trigger or worsen GERD. Drs Ates and Vaezi explore the many mechanisms by which asthma and GERD can interact, and they discuss how asthma medications can exacerbate GERD symptoms.

In our Advances in IBD column, Dr Tauseef Ali explores sleep and inflammatory bowel disease (IBD). Dr Ali reviews his experience in managing IBD patients with sleep problems and describes the latest research. Data suggest that sleep deprivation can activate cytokines such as interleukin-1, interleukin-6, and tumor necrosis factor–α, which play important roles in the immune pathology related to IBD. Many patients report that disease flares appear to be associated with inadequate sleep. Some steroid treatments may impair sleep quality. Dr Ali provides an algorithm for evaluating sleep disturbances in clinical practice, and he offers tips on how patients can improve their sleep hygiene.

Up to 30% of patients infected with HIV are coinfected with hepatitis C virus (HCV). HCV-related liver disease is now a major cause of death in patients with HIV. In a feature article, Dr Bevin Hearn and colleagues examine important considerations that arise in the management of patients with both infections. Patients with HIV/HCV coinfection have lower rates of spontaneous acute HCV clearance, more rapid progression to cirrhosis, and increased risk of hepatocellular carcinoma. Rates of spontaneous HCV clearance in HIV-positive patients are lower than those reported in patients with HCV monoinfection. Patients with HIV can be successfully treated for HCV; coinfected patients have the same treatment outcomes and rates of adverse events as patients with HCV monoinfection. Dr Hearn and colleagues outline the latest treatment options.

In another feature article, Dr Michael J. Bartel and colleagues discuss why small-bowel endoscopy has become an essential diagnostic tool for patients with suspected small-bowel disorders. The optimal approach to surveillance for hepatocellular carcinoma is reviewed by Dr Sammy Saab in our Advances in Hepatology column. In our Advances in GERD column, Dr Evan S. Dellon examines patients with esophageal eosinophilia who respond to proton pump inhibitors. Dr Steven J. Heitman discusses his cohort study showing a decrease in mortality associated with acute biliary diseases that require endoscopic retrograde cholangiopancreatography in our Advances in Endoscopy column.

I hope you find this issue's content interesting and informative.

Sincerely,

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