As stated in the editorial by Drs Banerjee and Gearry, the main result of the present study is the finding of an increased risk of cancer and mortality in paediatric onset inflammatory bowel disease in Denmark and Finland during a 23-year period: a population-based study. Aliment Pharmacol Ther. 2019;50:33-39.

In contrast to the adult literature on this subject, the paediatric literature almost unambiguously reports an increased risk of cancer in pIBD and the main question is no longer if there’s an increased risk but why. To better understand this subject, we need large cohort studies with follow-up times of more than 10 years, mapping both exposure to different immunomodulators and biologic therapies and, perhaps more challenging, the disease activity. Only in this way will we understand the impact of a chronic, often insufficiently treated, inflammatory state of the gastrointestinal tract on the risk of adenocarcinomas. This is of interest, as it has been hypothesised that pIBD constitutes a more aggressive disease state than adult onset IBD, which would explain the increased risk of colorectal cancer. However, to date this hypothesis remains unproven.

The most surprising result of our study is the increased risk of death due to suicide, most of which occurred after transition into adult care. Adolescent patients with IBD face different challenges as pre-puberty and puberty are vulnerable periods of life with great inherent cognitive and physical challenges. Adolescents with IBD have increased school absence both due to symptoms and to medical appointments or hospitalisations. Consequently, the combination of a severe disease and adherence to medical and even surgical treatment, absence from school and an already difficult time of life means that they experience serious deteriorations in their health-related quality of life, as also stated in the editorial.

Adolescents with IBD face the challenging and complex task of transitioning from paediatric to adult care. The transfer to a setting with increased demands can be challenging for young patients and lead to relapse of disease during the first year after transfer. While the importance of a formal transition program is internationally accepted, the transfer to adult care should be viewed as a process including transition preparation at the paediatric department, coordinated transfer and a consolidation phase after transfer. This process will acknowledge that the emerging adult patient is continuously building his/her managing skills. This approach will require the paediatric and adult care to join forces and develop a closer inter-departmental cooperation. It is our belief that such a collaborative and gradual transition might reduce the risk for suicides seen in our study.

In summary, the worrisome results of the present study raise additional questions and unveil serious concerns. Our incomplete knowledge of the impact of different exposures (chronic inflammation and medical therapy) on the risk of cancer is problematic as is the lack of knowledge of the difference in disease course between paediatric and adult onset IBD, which might help explain the different risk profiles found in the present study. However, more concerningly, this study emphasises the importance of not only a holistic care in the pre- and post-transfer setting but also the
imperative role of the paediatricians in securing sufficient disease monitoring and thereby not undertreating the paediatric or adolescent patient with IBD.

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LINKED CONTENT
This article is linked to Malham et al and Banerjee and Gearry papers. To view these articles, visit https://doi.org/10.1111/apt.15258 and https://doi.org/10.1111/apt.15299.

REFERENCES

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Editorial: faecal gluten immunogenic peptides in coeliac children

For patients with coeliac disease, a strict gluten-free diet (GFD), that is eating less than 50 mg per day of gluten,¹ is by no means an easy task. How do we make sure our patients do follow a GFD? Available tools are as follows: (1) a skilled dietitian assessment of the diet; (2) monitoring clinical response; (3) measuring serum coeliac-specific antibodies (tissue transglutaminase—TTG and deamidated gliadin peptides—DGP); and (4) checking duodenal mucosal histopathology.

While the fourth is the most accurate, it is clear that it cannot be used in every patient, and, especially in children, repeating a biopsy can and should be avoided in the vast majority of cases.²

As for the role of dietitian, this is well known and the recommendations of several academic bodies, including, ESPGHAN³ and NASPGHAN,⁴ call for their input. However, even a thorough review of eating habits may fail to reveal ingestions of minute traces of gluten, which can cause a lack of response in some coeliac patients.⁵