# Availability of lab-based investigations for children with inflammatory bowel disease

**Sir,**

Early diagnosis, classification and implementation of an individualized treatment plan is key to reducing morbidity and complications and ensuring good quality of life in children with inflammatory bowel disease (Levine et al, 2014; Oliveira and Monteiro, 2017). There were variations in the availability of laboratory-based investigations for paediatric inflammatory bowel disease in south-west England, and the authors anticipated similar issues elsewhere in England.

A national telephone survey was conducted in 2017 covering all laboratories in England ($n$=139) which provided investigations for paediatric inflammatory bowel disease. Three centres responded via email. The study was approved as an external student selected component project by the University of Bristol. Respondents were asked about provision of testing for inflammatory markers (erythrocyte sedimentation rate, plasma viscosity, orosomucoid), serological markers (anti-*Saccharomyces cerevisiae* antibodies, antineutrophil cytoplasmic antibodies), faecal calprotectin, thiopurine methyltransferase, 6-thioguanine levels, levels of infliximab in the blood and antibodies to infliximab.

Responses were obtained from all 139 laboratories. Tests for inflammatory markers which were most widely available were erythrocyte sedimentation rate (98%), plasma viscosity (71%) and orosomucoid (48%). Faecal calprotectin was offered by 89% of laboratories; 16% of these ($n$=20) only responded to requests for faecal calprotectin from senior clinicians. On-site testing for faecal calprotectin was available from 40% of laboratories.

*Figure 1* shows the availability of specialist blood investigations. Extensive regional heterogeneity was seen among English laboratories. Limited on-site testing is likely to add significantly to the time lag for the results to become available and a management decision to be taken based on those results.

National guidelines should include standards for investigations required and provide information on cost effectiveness to allow at least the regional paediatric gastroenterology units to access these tests promptly. This is likely to improve the management of paediatric inflammatory bowel disease. Results from this national survey are likely to indicate similar issues for practice for adult gastroenterology teams in England.

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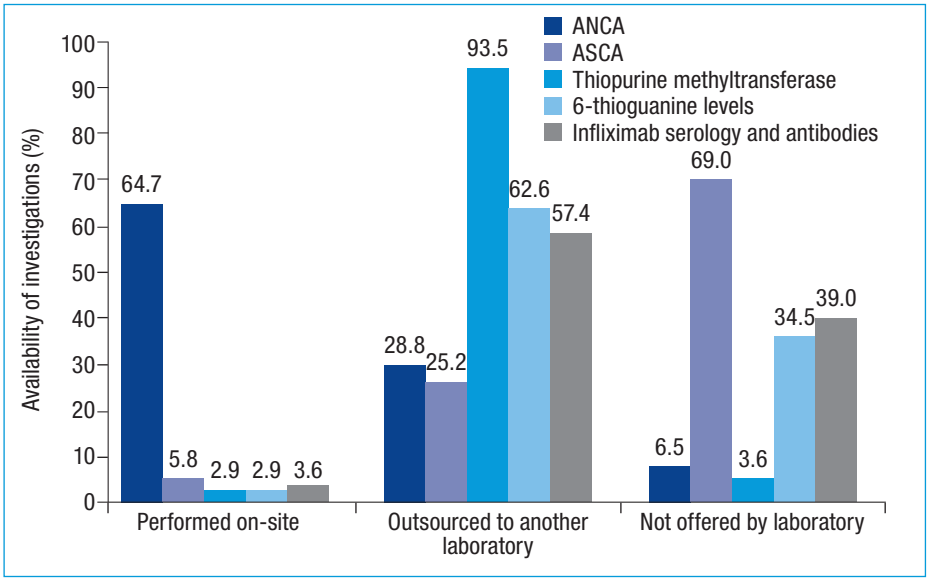
Levine A, Koletzko S, Turner D et al; European Society of Pediatric Gastroenterology, Hepatology, and Nutrition. ESPGHAN revised porto criteria for the diagnosis of inflammatory bowel disease in children and adolescents. J Pediatr Gastroenterol Nutr. 2014 Jun;58(6):795–806. https://doi.org/10.1097/MPG.0000000000000239

Oliveira SB, Monteiro IM. Diagnosis and management of inflammatory bowel disease in children. BMJ. 2017 May 31;357:j2083. https://doi.org/10.1136/bmj.j2083

Figure 1. Responses regarding availability of various specialist investigations. ANCA = antineutrophil cytoplasmic antibodies; ASCA = anti-*Saccharomyces cerevisiae* antibodies.




## Erratum

The article *Performing and interpreting a lumbar puncture* (vol 79(12), 2018, p. C183; https://doi.org/10.12968/hmed.2018.79.12.C183) contained an error in *Table 1* under the contraindications section.

The low molecular weight heparin treatment dose should have read <24 hours (not <12 hours) before lumbar puncture, and the low molecular weight heparin prophylactic dose should have read <12 hours before lumbar puncture, rather than <24 hours. We apologise for any confusion caused.