

Transitional care with Patrizia Burra & Jorge Amil Dias

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Podcast Episode

Paediatrics

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Two European gastroenterology experts discuss the science and practice of transitioning young patients with chronic digestive diseases from paediatric to adult care, emphasising that unstructured handovers lead to worse outcomes, treatment non-adherence, and loss to follow-up.

KEY POINTS

- Structured transition programmes are essential because without them patients with chronic gastroenterological conditions drop out of care, stop treatment, and return later with worse prognosis, according to the speakers.
- The transition process should begin at age 12 to 14 with family discussion, continue through age 16 to 18, and culminate around age 18, taking more than a year and requiring patients to be in a stable disease phase rather than acutely unwell.
- A dedicated transition coordinator, typically a nurse, is described as crucial to monitor patient and family readiness, coordinate between teams, and ensure continuity of care so families feel safe rather than abandoned.
- Adult gastroenterologists need to avoid immediately changing treatment protocols established in paediatric care, as abrupt changes make patients anxious and erode trust in the new physician, while paediatricians must progressively empower adolescents to speak for themselves and manage their own disease.
- The speakers argue that all chronic gastroenterological diseases require transition care, including inflammatory bowel disease, liver disease, transplant patients, coeliac disease, and paediatric-specific conditions like short bowel syndrome, with transplant patients facing particularly high rejection risk if treatment adherence fails.
- A 2018 position paper established the first agreed pathways for transition in digestive health, but the speakers note that training on transition care is still missing from most medical school curricula and that interdisciplinary communication remains inadequate at the European level.

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