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Nuggets from the GI tract

Objectives

- Cover important topics in GI/Hepatology briefly
- Focus on Tips and tricks
- Focus on common presenting problems
- Discuss what's new
- Interact- what do you want to talk about?

Coeliac

- 1% of the population
- TTG reliable IF patient consuming gluten
- IgA deficiency now automatically tested for
- D2 biopsy is the gold standard so no GFD until then
- Main consequences are anaemia and osteoporosis
- Symptoms are protean so ALWAYS test

Coeliac 2

- What if results equivocal? HLA DQ2/8?
- ?Gluten challenge
- May be a diagnosis made on balance of probabilities
- Lymphoma is rare- low absolute risk
- Must see a dietician
- Must have a DEXA scan
- ? Rebiopsy or monitor with TTG

Barrett's (Yawn)

- Change from squamous to columnar epithelium- confers higher risk of cancer
- Newer guidelines on surveillance- less frequent- 3-5 years
- Must be on PPIs lifelong
- Surveillance is patient choice
- Surveillance isn't just for those fit for surgery (HALO & EMR now available)

Eosinophilic Oesophagitis

- Exciting new "emerging" condition
- Presents as dysphagia and sometimes reflux
- Biopsies prove it but can sometimes also look typical at endoscopy
- Commoner in atopic individuals
- Considered "asthma of the gullet"
- Treated like asthma- steroids, Monteleukast, also PPIs and allergy testing- food & pollen

Eosinophilic Oesophagitis 2

- Important to diagnose as can lead to strictures in the young
- Increasingly being recognised as the cause of unexplained dysphagia in younger patients
- Incidence probably increasing
- A diagnosis to watch…

Reflux

- Increasing as people get fatter
- A CHRONIC condition
- Distinct from dyspepsia- a different disease
- PPIs and H_2 RA antagonists are mainstay
- LIFESTYLE! DIET! STRESS!
- Step down approach to PPIs
- Fundoplication is an option and probably cost effective
- Needs pH manometry before surgery

PPIs

- A super drug if used wisely
- MHRA warnings re: low Mg and osteoporosis
- Probably overprescribed
- Implicated in C Diff & pneumonia in sick patients
- Lowest dose to control symptoms
- May need very high doses to completely abolish acid secretion
- Consider ranitidine when you can- harmless

Treatment of UGI bleeds

- Not that much has changed
- APC, argon, endoclips and adrenaline for bleeding ulcers
- Hemospray for uncontrolled bleeds
- IV PPI infusions for ulcers with stigmata
- Banding & TIPS for varices
- Gluing & TIPS for gastric varices
- Terlipressin for varices
- On call bleed service- otherwise scope within 24h

HPB Stones & HPBCancer

- Not much new
- ERCP now only for therapeutics- MRCP for everything else
- MRCP for ductal disease- EUS if still unsure
- USS is probably as good for GB disease
- Common dilemma- MR or CT first in jaundiced patient with dilated ducts on USS?

Small Bowel imaging

- BaFT now rarely used
- MRI Small bowel and CT small bowel now the standard for structural disease- age dependent
- Capsule endoscopy for subtle mucosal disease or occult bleeding
- Double Balloon Enteroscopy if treatable pathology on MR or capsule- if fit enough for GA

Liver disease Treatment

- Viral hep- constantly changing
- Autoimmune- steroids and early Azathioprine
- PBC- Urso
- PSC- Transplant
- Liver metastases- increasing success with resection as well as primary
- Alcohol- depressing!- ITU shouldn't write them off though…

Liver imaging

- USS is still first line- can do dopplers of vessels too- always ask
- CT good for metastases
- CT and ultrasound very fallible in the cirrhotic
- MR liver is optimum in cirrhotic (in conjunction with AFP)
- AFP normal in up to 20% of HCCs

"LFTs"

- True LFTs are Urea, Albumin, Bilirubin & INR
- AST/ALT are markers of hepatocyte damage- no hepatocytes to damage?- will be normal!
- Alkphos/GGT are ductal enzymes- ask for GGT separately

A word about tumour markers

- AFP OK in cirrhotics 6 monthly- also check testes
- Ca125 now all over the place
- Ca 19-9 unreliable unless diagnosis already made- numerous false positives
- Please do NOT use CEA as a screening test!
- CEA only useful once colon cancer diagnosed- for monitoring & recurrence

IBD

- Not much new
- We are quicker to escalate treatment- *top down strategy*
- Steroids are bad!
- No steroids long term- only a bridge
- Big users of Aza/MP and anti-TNF
- Avoid oral iron- use IV

Symptomatic anaemia

- Iron can be unpleasant
- Will usually make GI symptoms worse- can exacerbate IBD
- Consider IV iron- e.g Cosmofer, Venofer
- IV iron now very much safer
- Safer than blood!
- Works quickly
- PLEASE USE IT!

Colonoscopy

- Bowel Cancer Screening Program 8 years old in East & North Herts
- Sent FOBT every 2 years between 60-75
- Colonoscopy in those found positive
- 10% have cancer
- At least 40% have adenomas
- Bowel scope program last year- all aged 55 get a one-off flexi
- Not without risk- hence strict QA

Constipation- the problem

- 60% of my referrals (in the end)
- Presents in a number of ways- overflow, pain, bloating
- Opiates a major problem
- **Ondansetron** a new threat
- Referrer needs to think of the possibility
- History, History, History
- Is rarely a harbinger of cancer (Check calcium)

Constipation- The treatment

- Avoid stimulant laxatives long term- senna, bisacodyl
- Fybogel/Psyllium/Methylcellulose a good starting point
- Water intake up to a point
- Macrogol is great and safe long term
- Can "prep" someone to get them started
- Check TFT & Calcium & drugs

Newer Constipation treatments

- Prucalopride- ladies only until recently
- Linaclotide- anyone
- Lubiprostone- anyone- limited experience

- All released within last few years
- Allure of a tablet
- All approved by CCG in laxative resistant cases

IBS

- It's all in the story
- Opportunity to be a "proper doctor"
- Won't get better unless you treat psych comorbidity
- Make a positive diagnosis- not one of exclusion
- Most common GI problem you face- get good at it (BSG Guidelines are excellent)- takes time

IBS 2- Treatment

- Dietary manipulation now in vogue
- Antispasmodics a little better than placebo
- Sequential dairy & wheat avoidance
- Low insoluble fibre (bran) & maybe increase soluble fibre
- Complimentary therapies (NOT chiropractic or Homoeopathy!)
- FODMAP is super!-must be via a dietician

Diarrhoea- points to consider

- Giardia- Trial of Flagyl- all in the story- be nosey!
- Bile salt malabsorption- ?post cholecystectomy or IBD? Questran may help
- Pancreatic diarrhoea
- IBD- FH, red flags, platelets
- Cancer- FH, other symptoms- bleeding
- Drugs- Metformin
- OVERFLOW- Take a stool history

Newer tests

- Faecal calprotectin- useful for excluding IBD- high incidence of false positives. Watch the number.
- Faecal elastase- pancreatic insufficiency

Service Considerations

- We are overwhelmed with referrals!
- GPs need to know how to manage GI disease
- No QOFs in Gastro
- Need time to think
- Need time to keep up to date
- Need time to get a good story and build confidence

How to be a proper doctor in the "modern" NHS…

- Avoid "tests instead of thinking"
- A guideline is a *guideline*
- A pill for all ills? Are we poisoning our patients? Think before prescribing
- Take a proper focused history
- The person in front of you is your mum/dad etc.
- Treat the patient not the test result
- Be open- it's what you would want

Doctors- what is the patient trying to tell you?

Why men shouldn't write advice columns

Dear John,

I hope you can help me. The other day, I set off for work, leaving my husband in the house watching TV. My car stalled, and then it broke down about a mile down the road, and I had to walk back to get my husband's help. When I got home, I couldn't believe my eyes. He was in our bedroom with the neighbor's daughter!

I am 32, my husband is 34 and the neighbor's daughter is 19. We have been married for 10 years. When I confronted him, he broke down and admitted they had been having an affair for the past six months. He won't go to counseling, and I'm afraid I am a wreck and need advice urgently. Can you please help?

Sincerely, Sheila

Dear Sheila,

A car stalling after being driven a short distance can be caused by a variety of faults with the engine. Start by checking that there is no debris in the fuel line. If it is clear, check the vacuum pipes and hoses on the intake manifold and also check all grounding wires. If none of these approaches solves the problem, it could be that the fuel pump itself is faulty, causing low delivery pressure to the injectors.

I hope this helps,

John

— Forwarded by Steve Sanderson, Gilbert, S.C.