REFERRAL GUIDELINES: GASTROENTEROLOGY II

Document purpose
- To ensure patients are referred as appropriately as possible
- To support GPs in risk management of possible gastroenterology cancer
- To clarify the care pathway for patients with suspected gastroenterology cancer
- To take account of national guidance from NICE and Oxfordshire CCG’s local commissioning policies.

Contents
(Control and Click to jump to section)
1. General considerations
2. Investigating the large bowel
3. Iron-deficiency anaemia
4. Change in bowel habit
5. Diarrhoea

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Notes
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1. General considerations

In assessing those with GI symptoms causing concern:
- FBC and ferritin are required to diagnose iron deficiency (see section 3)
- Endomyosal antibodies should be tested to exclude Coeliac Disease (see guidelines: 238 Referral Guidelines Coeliac Disease Adults June 2010) in anyone with continuing GI symptoms
- Be aware of the types of large bowel investigation available and the indications for these investigations (see section 2)

Risk management
- Refer to guidelines on assessment of family history of GI cancer (http://www.bsg.org.uk) so as not to over-estimate an individual’s risk or embark on investigations needlessly.
- At present, there is no evidence that faecal occult blood testing has any role in the evaluation of those with GI symptoms (unlike screening in an asymptomatic population)
- Direct access to upper GI endoscopy and sigmoidoscopy/CT colon or CT colonoscopy allows GPs to exclude GI cancer but needs to be used in accordance with these guidelines to prevent over-stretching capacity to provide these services.
- Constipation alone is not a useful predictor of GI cancer at any age and diarrhoea should be distinguished from a change in bowel habit (see section 4)
### 2. Investigating the large bowel

#### DIAGNOSIS
- **CT colon** (also known as ‘minimal prep CT colon’ or ‘long prep’). Involves oral contrast preparation for 3 days prior to the procedure and no laxative, so easier in frail patients and those over the age of 80. It is as reliable as a barium enema for detecting cancer and usually detects polyps >1cm.
- **CT colonography** (also known as virtual colonoscopy, CT pneumocolon). Laxative bowel preparation ie Picolax has now been replaced by oral Gastrografin for CT colonography

#### CT colon
- Change in bowel habit or iron deficiency anaemia in patients >80 years or who are frail or have limited mobility.
- Requested through radiology and does not require patient to take laxative bowel preparation

#### CT colonography or virtual colonoscopy
- Change in bowel habit or iron deficiency in patients >55-80yrs. This is not a test for diarrhoea (see Section 5 for management of diarrhoea)
- Requires that a patient is fit for bowel preparation (which can be associated with hyponatraemia in patients on diuretics/renal failure), so patients must be stated as ‘fit for bowel prep’ by the requesting clinician.
- Requested through radiology and currently requires patient to take laxative bowel preparation
- Laxative bowel preparation ie Picolax has now been replaced by oral Gastrografin for CT colonography

#### Colonoscopy
- Investigation of choice for watery/non-bloody diarrhoea, or iron deficiency anaemia when age <55 years.
- Requires bowel preparation and currently not available as open access, owing to risk of perforation, or incomplete procedure and lack of capacity

#### Flexible sigmoidoscopy (directly available through Choose and Book)
- Readily available and simple procedure
- Investigation of choice for isolated rectal bleeding (refer through 2WW)
- Refer through cancer 2-week wait system if age >50 or mass on PR examination or rectosigmoid lesion identified by CT colon(ography)/colonoscopy
- Other indications include
  - Bloody diarrhoea not due to infection
  - For watery or nocturnal diarrhoea (to exclude most cases of microscopic colitis and to manage the demand for colonoscopy)

### 3. Iron deficiency Anaemia

#### DIAGNOSIS
- Low haemoglobin defined as Hb <12g/L in males and <11g/L in females AND serum ferritin <50
- The pathway of investigation/referral depends on: degree of anaemia/gender/postmenopausal status
- Colonic investigations needed depend on age/comorbidity.

#### MANAGEMENT and REFFERAL
- **Pre-menopausal female**
  - If age <50 and no GI symptoms, treat with iron and ensure haemoglobin returns to normal.
  - If associated with upper GI symptoms, refer for upper GI endoscopy and duodenal biopsy and associated with lower GI symptoms refer to routine gastroenterology for colonoscopy
  - Age >50 and associated with lower GI symptoms, arrange CT colonography
- **Post-menopausal female and males**
  - Bear in mind cancer very uncommon age <50. If there is another explanation for the anaemia, address this first. If there is no explanation and no GI symptoms, arrange routine
### 4. Change in bowel habit

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<thead>
<tr>
<th>DIAGNOSIS</th>
<th>MANAGEMENT</th>
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<tr>
<td><strong>An increase in bowel frequency or change in consistency to looser stools persisting for at least 6 weeks</strong></td>
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<tr>
<td><strong>Constipation or harder stools are far less likely to indicate colorectal cancer</strong></td>
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<tr>
<td><strong>Distinguish from diarrhoea (see Section 5)</strong></td>
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<tr>
<td><strong>Colorectal cancer may be the cause in 15%, especially if associated with visible rectal bleeding (distinguish this from bloody diarrhoea)</strong></td>
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<td><strong>Check full blood count, thyroid function, CRP</strong></td>
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<td><strong>Do NOT check FOBs, since this will not change management</strong></td>
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<tr>
<td><strong>If age &gt;50, refer 2WW cancer. Discretion appropriate if age &lt;50, since cancer is so uncommon at this age</strong></td>
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<tr>
<th>Constipation</th>
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<tr>
<td>Most unlikely to be due to colorectal cancer unless associated with overt features of obstruction</td>
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<tr>
<td><strong>Check full blood count, thyroid function, calcium</strong></td>
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<tr>
<td><strong>Do NOT check FOBs, since this will not change management</strong></td>
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<td><strong>Consider drug causes particularly in the elderly</strong></td>
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<td><strong>Therapeutic trial of golden linseed supplements (good source of water soluble fibre), or an osmotic laxative (lactulose or ispaghula)</strong></td>
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<td><strong>Refer if a suspected defaecation disorder (difficulty in initiating evacuation) suspected or slow transit (interval between evacuations &gt;1 week)</strong></td>
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<thead>
<tr>
<th>Alternating diarrhoea and constipation</th>
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<tr>
<td>Generally due to Irritable Bowel Syndrome (IBS), especially if associated with abdominal pain and bloating, without weight loss</td>
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<td><strong>Check full blood count, endomyseal antibody serology, thyroid function and CRP</strong></td>
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<tr>
<td><strong>If these are normal, organic disease is most unlikely</strong></td>
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<tr>
<td><strong>Mouth ulcers, weight loss, or nocturnal bowel action make IBS unlikely</strong></td>
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<tr>
<td><strong>Do NOT check FOBs, since this will not change management</strong></td>
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<tr>
<td><strong>Follow dietary modification and therapeutic advice for managing IBS</strong></td>
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<tr>
<th>REFER ONLY</th>
<th>Routine</th>
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<tr>
<td><strong>Symptoms persist despite all dietary modification and therapeutic measures in IBS management guidelines (see Gastro Referral Guideline)</strong></td>
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<th>2WW Cancer</th>
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<td>Age over 50 if looser or more frequent stools for more than 6 weeks (not watery diarrhoea)</td>
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<td>Change in bowel habit with iron-deficiency anaemia (Hb &lt;12 in males, &lt;11 in females) in any age group.</td>
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### 5. Diarrhoea

#### DIAGNOSIS
- Defined as loose, frequent stools, which may be bloody or non-bloody
- Nocturnal diarrhoea usually has an organic cause
- Diarrhoea >6/day is not usually due to cancer and should be distinguished from a change in bowel habit with looser stools (when cancer should be considered)
- Common causes include macroscopic or microscopic colitis, malabsorption or irritable bowel syndrome (unless nocturnal), assuming that infection has been excluded. Consider drugs.
- Distinguish bloody diarrhoea from rectal bleeding with an increase in bowel frequency
- Consider diabetic autonomic neuropathy as a potential cause in established diabetics with no other features of concern.

#### MANAGEMENT
- Bloody diarrhoea merits urgent referral to exclude acute colitis, unless infection is likely (duration <1 week)
- Non-bloody diarrhoea merits urgent referral if chronic (duration >3 weeks), associated with weight loss, if anaemic, or inflammatory markers (CRP) are elevated
- Check stool culture if duration >1 week and Clostridium difficile toxin (CDT) assay if recently in hospital or on antibiotics
- Check full blood count, electrolytes, thyroid function and CRP if chronic (>3 weeks)
- Check endomyseal antibody serology, ferritin and folate and B12 if anaemic or associated weight loss
- Morning diarrhoea with bloating and abdominal pain, without weight loss or abnormal blood tests is almost always due to IBS (see IBS referral and treatment guidelines: Gastro Referral Guideline)

#### REFER ONLY
- Chronic diarrhoea (>3 weeks), especially if nocturnal with raised inflammatory markers. Ensure any potential drug causes addressed before referral.

**Routine**
(Choose and book)

**Urgent OPD (not 2WW)**
Fax to GI unit
- Bloody diarrhoea >1 week duration
- Nocturnal diarrhoea with weight loss or anaemia
- 01865 228763

#### ADDITIONAL INFORMATION
Drugs, bile salt malabsorption, bacterial overgrowth, pancreatic insufficiency and a variety of less common causes should be considered in patients with nocturnal diarrhoea. Faecal elastase can help diagnose pancreatic malabsorption allowing treatment with creon.

British Society of Gastroenterology: [http://www.bsg.org.uk](http://www.bsg.org.uk)