Practical approach to GI tract problems

GP CME 2014
Sat 2 and 3pm 55 mins

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Overview

• 6 Case based examples
  – Nausea
  – GORD
    • Barrett's
  – Dyspepsia
    • H pylori
  – IBS
  – Bowel cancer
  – IBD

• Interaction please!!
Case 1

• 18 year old European lady
  – Comes with her mother
  – 6 month history of ‘feeling sick’
  – Started occurring occasionally but now all the time

• What other questions would you ask?
• What is important from her past history?
• Is there anything important on examination?
Case 1- Key learning point 1

• Take a detailed HISTORY of what ‘sick’ means

• Definition of nausea
  – Unpleasant sensation of being about to vomit
    • May occur alone or with vomiting
      – Can be associated with dyspepsia or other GI tract symptoms

• Regurgitation is different
  – Return of oesophageal contents into hypopharynx with little effort- NOT VOMITING

• Functional Dyspepsia
  – Rome 3 criteria
Regurgitation

• Is a symptom of GORD
  – Perception of flow into mouth
    • May be acidic and contain undigested food

• Different to water-brash
  – Hypersalivation in response to reflux
    • Can be up to 10mls of saliva per minute
Regurgitation

• Diagnosis of reflux
  – Meta analysis of PPI challenge vs Impedance
    • Sensitivity 0.78 (0.66-0.86)
    • Specificity 0.54 (0.44-0.65)
      » Ann Int med 2004

• pH/Impedance
• BRAVO
Nausea

- Unpleasant sensation of being about to vomit
Pathophysiology of nausea

- Abnormal gastric motility or compliance
  - Vection studies (rotating drum)
    - More than half get tachygastria on EGG
- Visceral hypersensitivity
  - Gastric distension studies
    - More awareness in nausea patients
- H pylori inflammation
- Altered gut microbiome
- Psychosocial dysfunction
  - Child abuse
  - Anxiety and depression
Work up for nausea- History

• Acute onset
  – Considered less than a month
    • Pregnancy
    • Drugs
    • Gastroenteritis

• Associated symptoms
  – Abdominal pain
    • Organic cause likely e.g. Cholelithiasis, bowel obstruction
Work up for nausea

• Associated symptoms
  – Tinnitus, deafness and vertigo
    • Inner ear E.g. BPPV, vestibular neuronitis
  – Dental erosion, parotid enlargement, psyc
    • Bulimia
  – Heartburn
    • GORD
  – Neurogenic
    • Positional, projectile, other signs
      – Brain tumour

• All chronic (over a month) should consider OGD
### Differential diagnosis of nausea and vomiting

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<td>Miscellaneous causes</td>
<td>Starvation</td>
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| Ethanol abuse                    | Radiation therapy to the upper abdomen and lower chest |}

Specific disorders

- Common causes
  - Drugs
  - GORD
  - H pylori

- Less common causes
  - Gastroparesis
  - Cyclic vomiting syndrome
  - Rumination syndrome
Drugs

• Almost anything
  – Do not forget natural and OTC medications
  – History is key
    • Timing of onset of symptoms
  – Trial of discontinuation
Less common causes: Gastropresis

• Objectively delayed gastric emptying in the absence of mechanical obstruction
  – All need a gastroscopy

• Symptoms
  – Nausea (93%)
  – Vomiting (46-90%)
  – Early satiety (60-86%)
  – Bloating (76%)
  – Abdominal pain (18%)
Investigation - Gastroparesis

- Gastroscopy
- Gastric emptying scintiscan
  - Egg sandwich
  - >10% at four hours
- Smart pill
  - pH
  - Temperature
  - Pressure
  - Images
Gastroparesis

- **Idiopathic**
  - Most common
  - ?post viral
    - Better prognosis, most improve in 1 year
- **Diabetic**
  - 11-18% of diabetics have some evidence
  - Severe disease
    - More than five years and autonomic neuropathy
  - Difficult to control sugars
- **Post surgical (vagus nerve damage)**
  - Fundoplication
- **Neurological disease**
  - Stroke, Parkinsonism etc
- **Autoimmune and paraneoplastic (small cell lung)**
Treatment- Gastroparesis

- Lifestyle changes
- Pro-motility agents
  - Domperidone
  - Erythromycin
    - Motilin agonist
- PEG feeding
- Gastric pacing
  - 50% effective
Cyclic Vomiting Syndrome

• Idiopathic disorder
  – Three or more recurrent discrete episodes of vomiting
  – Varying intervals of normal interval health
  – Stereotypical episodes
    • Timing (often start early am)
    • Duration
    • Symptoms (can have prodrome)
Cyclic Vomiting Syndrome

- Pathogenesis
  - Unknown and not well understood
    - Association between CVS and migraine
    - Linked to food allergy
    - Mitochondrial disorders
      - In childhood form
    - Metabolic and endocrine disorders
Cyclic Vomiting Syndrome

- Average length of episodes
  - 6 days (1-21)
- Average length between attacks
  - 3 months (0.5-6 months)
- Some can have nausea between episodes
- Can get abdo pain
CVS- Treatment

• Supportive care
  – Fluids and anti-emetics

• If family history of migraine trail of anti-migraine meds

• Amitriptyline

• Carnitine, Co-enzyme Q10
  – No good trials but many case reports
Rules of Thumb: Treatment of nausea

• Look for consequences
  – Dehydration, hypokalaemia

• Look for and treat cause if possible
  – H pylori
    – Associated symptoms may give clue

• Trial of PPI
Treatment of nausea

- Anti-emetics and pro-kinetics
  - Prochlorperazine (Stemitil, Antinaus, Buccastem)
    - Phenothiazine. Also an anti-psychotic
      - Hypotension and EPS effects
  - Metoclopramide (Maxalon)
    - Dopamine agonist
      - Also has prokinetic effect
      - Anxiety and dystonia
  - Domperidone (Motilium)
    - Dopamine agonist but poorly cross BBB
      - Less side effects
  - Cisapride
    - Serotonin 5HT4 agonist
      - QT prolongation
  - Ondansetron
    - Serotonin 5HT3 antagonist
    - Very effective
    - QT prolongation
Treatment of nausea

• Address psycho-social factors
  – Antidepressants

• Surgical options if desperate
  – Gastrectomy
  – Gastrostomy
  – Jejunostomy
When asked what she meant by ‘sick’
  – After she eats food just comes back into her mouth
  – No effort
  – Not vomiting and not acidic tasting
Rumination syndrome

• Behavioural disorder
  – Daily, effortless regurg of undigested food within minutes of starting a meal or at end
    • No associated retching, nausea and heartburn like with vomiting
    • Not sour or acidic
  – Thought to be trauma induced
    • Not deliberate
  – Adaptation of belch reflex
  – Treated by diaphragmatic breathing
    – 86% success (30% cure)
Case 2

- 55 year old European businessman
  - Work is ‘busy’
  - Burning pain in epigastrium getting worse
    - Takes OTC Losec and Gaviscon

- What other questions would you ask?
Case 2 continued

• 10 year history of burning epigastric pain
  – Worse after wine
  – Smoker

• Examination
  – BMI 30

• What other questions would you ask?

• What would you do?
GORD

• Some degree of reflux is physiological
  – 48 episodes per day
  – Usually post prandial, short lived, asymptomatic and rare during sleep

• Pathological reflux
  – Reflux of stomach contents causes troublesome symptoms and/or complications
  – Two or more days per week
    • Montreal definition
• Typical symptoms
  – Heartburn
  – Regurgitation
  – Dysphagia
• Atypical symptoms
  – Chest pain
  – Waterbrash
  – Globus
  – Asthma
  – Nausea
Investigations- GORD

- Gastroscopy
  - In PPI era often normal
- pH study
  - pH/Impedance
  - BRAVO
pH/Impedance study

• Catheter placed via nose to 5cm above LOS

• Measures pH over 24 hour period

• Event recorder that patient can activate to correlate symptoms with reflux
  – ZepHer
Impedance Technology Fundamentals

![Graph showing impedance changes over time with annotations for Bolus Entry, Bolus Exit, and Bolus Present.](image-url)
Impedance – pH Catheter

Adult Model

6 impedance channels
1 pH channel
Bravo capsule
BRAVO advantages

• Increase yield by 50% with 48 hour recording
• >90% carry on with normal activities
• Patients much prefer this option
  – 82% would have repeat test (cf 7%)
GORD: treatment

• Options
  – Lifestyle modification
    • Weight loss and elevation of head of the bed
      – Some evidence
    • Tight clothing, food triggers, ETOH and smoking
      – Limited evidence but physiological logic
  – Treat initially with PPI

• Surgical options
  – Lotus trial
    • Laproscopic Nissen v esomeprazole 5 year FU
Figure 1. Patient Flow in the LOTUS Trial

626 Patients assessed for eligibility

72 Excluded (withdrew from study during run-in period)

554 Randomized

288 Randomized to undergo LARS
   248 Underwent LARS
   40 Did not undergo LARS
   29 Withdrew consent or refused surgery
   4 Ineligible for surgery
   2 Not operated on within time window after randomization
   2 Lost to follow-up
   1 Pregnancy
   1 Serious adverse event while waiting for surgery
   1 Death in family

266 Randomized to receive esomeprazole
   266 Received esomeprazole
   0 Did not receive esomeprazole

180 Completed 5 years of follow-up
   68 Discontinued study
   20 Lost to follow-up
   21 Lack of treatment response
   2 Adverse events
   11 Unwilling to continue
   14 Other reasons

192 Completed 5 years of follow-up
   74 Discontinued study
   8 Lost to follow-up
   16 Lack of treatment response
   15 Adverse events
   2 Not eligible
   1 Had surgery
   3 Nonadherent
   24 Unwilling to continue
   5 Other reasons

288 Included in analysis

266 Included in analysis

LARS indicates laparoscopic antireflux surgery.
Primary outcome: Do you have sufficient control of symptoms?

Surgery not better at 5 years!!
Back to Case 2

• 55 year old
  – White
  – Smoker
  – Fat

• Would you be concerned about Barretts?
• Would you screen for it?
Barrett's oesophagus
Why are most Barrett’s oesophagus cases missed?

- GORD symptoms may be mild.
  - Oesophageal sensitivity to acid perfusion may be impaired in many Barrett’s patients. At least 25% have no oesophageal complaints.

- Most patients with chronic GORD symptoms aren't screened for Barretts.
Risk factors for Barrett’s Oesophagus

- Male gender 3 times > female gender
- White race >> Blacks & Asians
- Abdominal adiposity (obesity)
- Genetic factors suspected in some patients/families
- Chronic reflux symptoms for > 5-10 years
- Age >40-50 years; mean age at diagnosis = 55 yrs
Case 2- Key learning point

Prevalence of endoscopic Barrett's esophagus (%)

Duration of symptoms (years)

- <1
- 1–5
- 5–10
- >10
Adenocarcinoma from Barretts

Risk is 0.5% per year. Dramatic increase when dysplasia found.
Case 2 - Key learning point 2

- Who I Investigate
  - Make sure is GORD - Non responders
  - Male gender 3 times > female gender
  - White race >> Blacks & Asians
  - Abdominal adiposity (obesity)
  - Genetic factors suspected in some patients/families
  - Chronic reflux symptoms for > 5-10 years
  - Age >40-50 years; mean age at diagnosis = 55 yrs
Key learning point 3
- There are new options for treatment
Endoscopic Mucosal Resection
Endoscopic Mucosal Resection
Endoscopic Mucosal Resection
Radiofrequency Ablation- Halo

- Topical focal application of radiofrequency ablation.
- Superficial uniform thermal therapy over wide-field
- Application by 360 or 90 degree delivery system
- Most frequent complication: chest pain
- Stricture rate: 0-8%
# Radiofrequency Ablation

### Shaheen et al

**NEJM 2009**

- Evaluation of BARRX therapy for eradication of Barretts dysplasia
- 127 patients randomized to RFA vs sham
- 81% vs 19% total eradication of HGD
- 1.2% vs 9.3% development of cancer
- 6% stricture

### Ganz et al

**Gastointest Endosc 2006**

- 22 patients w/ RFA for HGD
- 73% complete eradication
- No stricture or serious adverse effects
Case 3

• 62 year old Indian lady who feels ‘sick all the time’
  – Otherwise well
  – No medical problems

• What else would you ask?

• Full when she eats and nausea afterwards
• What else would you ask?
Functional Dyspepsia

• Rome 3 criteria
  – Presence for 6 months of one or more:
    • Post prandial fullness
    • Early Satiation
    • Epigastric pain/burning
  – No evidence of structural disease
    • Upper Endoscopy
Primary Care Management Of Dyspepsia

**"ALARMS"**
(Refer promptly for gastroscopy)
- Anemia
- Weight loss
- Dysphagia
- Abdominal Mass
- Jaundice
- Persistent Vomiting
- Haematemesis
- Melena
- NSAID, Steroid or Anticoagulant Use
- Serious Co-morbidity eg severe CORD, Ischaemic Heart Disease, Cardiac Failure etc.

**Age ≥ 45:**
Consider gastroscopy with persistent troublesome dyspepsia, especially if symptoms are of recent onset

**Alarm Features:** (see table page 2)

**Symptoms of Gastro-Oesophageal Reflux**
- Predominant symptom(s) burning pain in the upper abdomen radiating up towards the neck +/- acid regurgitation into the mouth (see page 2 for discussion)

**Test for H. Pylori**
- with Urea Breath Test or Serology
  - **-ve**
  - **+ve**

**Ulcer-like dyspepsia:**
- Epigastric pain main symptom: Anti-secretory therapy
  - 1. PPI (omeprazole 20mg or lanosorazole 30mg or pantoprazole 40mg once or twice daily)
  - 2. H2 antagonist (ranitidine 150-300mg or famotidine 20-40mg or nizatidine 150-300mg daily)
- CSP (Clavulanic Acid) or regular use to control symptoms

**Dysmotility-like dyspepsia:**
- Discomfort with bloating, nausea, fullness in the epigastrium
- Clarithromycin 500mg bd, amoxicillin 1000mg bd, metronidazole 400mg bd, clarithromycin 500mg bd all for 7 days
- Note: confirmation of eradication not necessary if symptoms resolved

**Triple Therapy**
- OAT (KlacidHP or LosecHP)
- 2.H2 antagonist (ranitidine 150-300mg or famotidine 20-40mg or nizatidine 150-300mg daily)
- 3. Lifestyle measures - this includes PRN anacid use, weight loss, stopping smoking, avoiding offending foods, smaller meals etc

**Treatment Successful?**
- Yes
  - No further treatment necessary
  - Continue with PRN or regular use to control symptoms

**Gastroenterology referral**
- for assessment and gastroscopy

Placebo 20-60%
Case 3- Key learning point

• H pylori incidence important to know
  – NZ European 6%
  – Maori 19%
  – Pacific Islanders 30%
  – Indian 19%
  – Oriental 14%

» Patrick et al NZMJ 2013
Case 3- Key learning point

• Options to test for H pylori
  – Serum antibodies
    • Good if never treated
    • Sensitivity 90%, specificity 85%
      – Accuracy in low prevalence population is therefore poor
  – Stool antigen
    • Good for current treatment
    • Sensitivity 94%, specificity 92%
      – 20% false negative if on PPI
  – OGD has best sensitivity and specificity
Case 3 - Key learning point

140 treatment naïve H. pylori infected patients:
- 100 antibiotic resistance testing cohort
- 40 random patients from prevalence cohort

13 patients excluded:
- 8 metastatic cancer
- 5 died (non GI cause)

127 patients in total

22 patients lost to follow-up

105 patients with follow up stool antigen data:
- 89 patients successfully treated
- 16 patients failed treatment

Treatment prescribed and overall eradication rate (per protocol)

- **OAC**
  - 92 treated
  - 82 cured
  - 10 failed
  - 89.1%

- **OCM**
  - 9 treated
  - 4 cured
  - 5 failed
  - 44.4%

- **OAM**
  - 4 treated
  - 3 cured
  - 1 failed
  - 75%

Patrick et al NZMJ 2013
Case 3- Key learning point

• Following treatment a stool antigen is required to check clearance
  – Do at 6 weeks
  – 4 weeks off a PPI
Other treatment for FD

• Antidepressants
  – Low dose tri-cyclics if no PI response in 8 weeks
  – No evidence yet for SSRI
    • Trials are underway

• Prokinetics- Domperidone
  – Meta-analysis of 19 trials (3100 patients)
    • 33% reduction in symptoms (18-45%)
      » Moayyedi et al Cochrane 2006
      – QT prolongation
      – Effect small and may be publication bias
Other treatment for FD

• Fundic relaxation medication
  – Buspirone in very small studies helpful
    » Tack et al 2012

• Alternate medicine
  – Limited evidence (acupuncture etc)
  – Peppermint oil may work
    » Koretz et al 2004

• Limited evidence for dietary modification
Case 4

- Miss AC 33 year old European receptionist
  - Normal bowel function until aged 24
  - Sudden onset
    - Diarrhoea 7X/day with urgency
    - Gripey abdominal pain relieved with defecation
    - Reflux / dyspepsia
    - Days with no BM but abdominal discomfort

- What else would you ask?
  - A lot more information from past 9 years
Miss AC - Further history

Investigations
- Routine blood tests
- Faecal cultures
- Colonoscopy X 3
- Small bowel follow through
- CT abdomen
- Gynaecological review

Treatment trials
- Metamucil / fibre supplement
- Aloe vera, slippery elm, peppermint oil, probiotics
- Gluten, dairy, meat free, Atkin’s and Liver cleansing diets
- Loperamide
- Sulfasalazine

Referred to me for a second opinion – IBS referred for breath testing
# Red Flags in Gastroenterology

## General Red Flags

- Unexplained weight loss
- Onset in older patients (>50)
- Family history of CRC/IBD
- Severe unremitting symptoms
- Rectal bleeding
- Nocturnal symptoms

## IBD Red Flags

- Mouth ulcers
- Peri-anal disease
- Relationship of onset to smoking
- Extra-intestinal manifestations
Usefulness of red flags

• IBS vs Organic lower GI disease
  – Age 50 years at onset: OR 2.65 (1.4-5.0)
  – Blood in/on motions: OR 2.7 (1.4-5.1)
  – Pooled sensitivity of alarm features is poor
    • 5-64%

• Dark red blood and abdominal mass
  – Sensitivity >95%

• Family history slight help

Hammer et al Gut 2004
Rome III Criteria* – Irritable Bowel Syndrome

Recurrent abdominal pain or discomfort at least 3 days/month
In the last 3 months associated with 2 or more:

- Improvement with defecation
- Onset associated with a change in frequency of stool
- Onset associated with a change in form (appearance) of stool

*Criteria fulfilled for the last 3 months with symptom onset at least 6 months prior to diagnosis.
Recurrent abdominal pain and disordered bowel habit

Medical and psychosocial history + physical exam

Alarm features

Yes

Urgent GI referral

No

Limited screening tests

IBS

Normal

Abnormal

Use Bristol stool chart to determine type of IBS
What are appropriate limited screening tests?

• There is insufficient evidence for any tests!
• BUT
  – FOB
  – FBC, iron studies, TFT, CRP
  – Coeliac serology (Europeans)
  – If suspicion consider US
  – If severe symptoms or an older patient consider referral
What about faecal calprotectin?

- Is pretty good inflammatory marker for GI tract
- Very stable molecule
  - Lasts 7 days
- For cutoff over 150
  - Sensitivity 95%, specificity 91%
  - NPV 96% in primary care
    - 4.8 year FU
  » Turvil Front Gastro 2011
Types of IBS

Longstreath et al Gastro 2006, 130 (5) 1480

- (Antidepressants NNT 4)
IBS-C

- Trial of simple laxatives
  - Generally risks of serious pathology low
  - Usually no colonoscopy

- What about fiber?

Ford BMJ 2008
IBS-D and IBS-M

- Food plays a greater role than genetics in shaping human microbiota

Wu et al, Science Sept 2011
How diet can effect IBS symptoms

• By changing microflora over time in the gut
  – This is probably why probiotics work at least in the short term
  – Microflora thought to return to baseline when stop treatment

• By acutely changing GI tract function
  – Food intolerance and the FODMAPs
IBS Pathophysiology

"Causes"
- Stress
- Ψ Factors
- Infection

"Triggers"
- Fluid
- Gas
- Stress
What about gluten?

• Gluten is a non absorbed protein that appears in foods that are processed from wheat and related species

• Mechanism is not known
Gluten sensitivity

• Double blind, placebo re-challenge trial
• Coeliac excluded
• 2 slices of bread and a muffin
• 6 week study

»Biesiekierski et al: Am J gastro 2011
FODMAPs

- A group of previously un-grouped short chain carbohydrates that share properties:
  - Poorly absorbed in small intestine
  - Small and osmotically active
  - Rapidly fermented by bacteria
What are FODMAPs?

Fermentable

**Oligosaccharides**

**Disaccharides**

**Monosaccharides**

And

**Polyols**
What are FODMAPs?

F 
Oligosaccharides fructans, galactans 
D 
M 
A 
P
What are FODMAPs?

- Disaccharides: lactose
What are FODMAPs?

- **F** Fructose (in excess of glucose)
- **O** Oligosaccharides
- **D** Disaccharides
- **M** Monosaccharides
  - fructose
  - (in excess of glucose)
- **A** Alternan-1,2-pentadecahexaose
- **P** Polyols
What are FODMAPs?

FODMAPs:
- Fructose
- Oligosaccharides
- Disaccharides
- Monosaccharides
- Polyols (e.g., sorbitol)
The FODMAP hypothesis

Diet
- Fructose
- Fructans
- Lactose
- Galactans
- Polyols

Physiological effects
- Osmotically active
  - ↑ water delivery
- Rapidly fermented
  - ↑ gas production

Symptom induction
- Motility changes
- Bloating
- Pain/discomfort
- Wind

Luminal distension
FODMAPs

Small bowel

Colon

Luminal distension

gas

fluid

Bloating

Diarrhoea

Wind

Pain
Low FODMAP diet in IBS

- n = 25
- 23-60 years, 4 male
- IBS (Rome II)
- FM +ve breath test
- Previous symptom improvement on low FODMAP diet

- Reduced symptoms in 2/3 cases
Case 5

• 62 year old Maori man
  – Obese, smoker
  – Passing blood for past 6 months

• What other questions would you ask?
NZ screening program update

• Been running for 2.5 years (4 year pilot) since Oct 2011
  – Aged 50-75 in WDHB area
  – Government funded $31 million
NZ screening program update

• Data from first 15 months:
  – 72,228 invited
  • 39,482 participated (55% uptake)
  • 2067 colonoscopies (50 colonoscopies per week)
    – 75 cancers
      » 60% stage 1 or 2
    – 58% adenomas
      » 34% advanced adenomas
NZ screening program update

• Number needed to be scoped:
  – 5% of those who actually participate
  – 3% of those asked

• 777 advanced lesions found from 39482
  – NNS is 20 (Italian study was 44)

  – This is likely to fall in the second round
NZ screening program update

• Summary
  – Finding a large number of significant lesions
    • Need better participation rates
    • I think there will be an announcement next year
  – There are significant resource issues
    – Each DHB could require 1 full time endoscopy theatre to meet demand
    – But 3000 cases per year and 1200 deaths in NZ
Other screening technologies

• Colon capsule

• Check-cap

• Stool tests
  – Are getting better
  – Stool DNA
11.6 x 31.5mm capsule with 172 degree image from each end
Adaptive frame rate 35/s-4/s
Clear liquid diet plus senna and 4L PEG plus boosts
Mixture of patients

TABLE 2. Accuracy characteristics for detection of patients with at least one lesion ≥ 6 mm or ≥ 10 mm

<table>
<thead>
<tr>
<th>Polyp size, mm</th>
<th>Prevalence, no. (%)</th>
<th>Sensitivity, % (95% CI)</th>
<th>Specificity, % (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥6 mm</td>
<td>45 (41)</td>
<td>84 (74-95)</td>
<td>64 (52-76)</td>
</tr>
<tr>
<td>≥10 mm</td>
<td>32 (29)</td>
<td>88 (76-99)</td>
<td>95 (90-100)</td>
</tr>
</tbody>
</table>

Cl, Confidence interval.

88% egestion rate
My concerns regarding CTC
My concerns regarding CTC

- Flat proximal serrated lesions
  - Can they be reliably seen on CT?
    - We now know that endoscopy has missed these important lesions in the past
      - Slower withdrawal
      - Better bowel preparation/washing at time
      - Training
      - NBI and other techniques
Case 5- Key learning point 1

- Symptoms suggestive of bowel cancer
  - Diarrhea not constipation
  - Altered blood or mixed in stool
    - Not outlet
  - Weight loss
  - Abdominal pain
- Iron deficiency very important
- 1/20 on MMH waiting list have cancer
Case 5- Key learning point 2

• Options for screening
  – FOB
  – CTC
  – Colonoscopy

• What would you do for this case?
Case 6

• 26 year old European lady
  – Past history of Crohn's disease
  – Diarrhea and abdominal pain
  – On Pentasa 3g daily only

• What other questions would you ask?
  – Smoking, compliance, last endoscopy

• What tests would you order?
Case 6- Key learning point 1

- Overlap between IBS and IBD
  - Fecal calprotectin
  - Bloods
    - Ferritin, CRP, FBC
Case 6- Key learning point 2

• Treatment options
  – Increase 5 Asa
  – Prednisone
  – Refer all patients with flare!
SUMMARY

• Nausea
  – Take a full history to get the diagnosis
  – Chronic symptoms often need a Gastroscopy

• Barretts
  – Remember fat, white, middle aged smokers

• Functional dyspepsia
  – Remember H pyori

• IBS
  – Calprotectin and FODMAPS
SUMMARY

• Bowel cancer
  – Diarrhoea not constipation
  – We need screening!
• Inflammatory bowel disease
  – Remember IBS overlap
  – Increase 5 asa and refer
Thanks

Feel free to take my business card and call if you have questions!
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- 1 Hepatologist
- Upper and Lower GI surgeons
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- CT colonography

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