

The Role of the Lower GI Specialist Nurse

Debbie West



Roles and Responsibilities

GP perspective

- Approx 1000-1200 patients under our care
- Vet ALL lower GI open access referral from GPs
- Nurse led clinics
- Clinical Audits
- Patient education and support
- Telephone Helpline

Contact Details

- Advice line- 01226 436371
- URGENT : 01226 730000
- bleep 591

Future developments primary care related

- Virtual clinics
- Clinics in the Community
- GP Education
- Expand the telephone helpline service
- Patient forums- monthly

Open Access lower GI Referrals

- Patient on Warfarin therapy



Open Access referrals for lower GI Endoscopy

- Female referred for colonoscopy
- No bowel symptoms/ no anaemia
- Symptoms of PV bleeding
- Needed colposcopy referral not colonoscopy

Open Access Lower GI Referrals

- Patient referred for colonoscopy for change in bowel habit looser stools for only 3 days
- Referred for colonoscopy rectal bleeding on wiping non in stool
- Patient referred for flexible sigmoidoscopy indications rectal bleeding and change in bowel habits for 6 weeks or more

Lower GI open Access Referrals

- Suitability for colonoscopy i.e. severe co morbidities such as patient on oxygen therapy, severe COPD.
- Discuss with patient re suitability given risks of perforation/ finding a Colon CA
- Refer to Gastroenterology clinic for further assessment discussion and possible inpatient prep if patient wishes to proceed

The Management of Left sided colitis

- By Debbie West lower GI Nurse Specialist

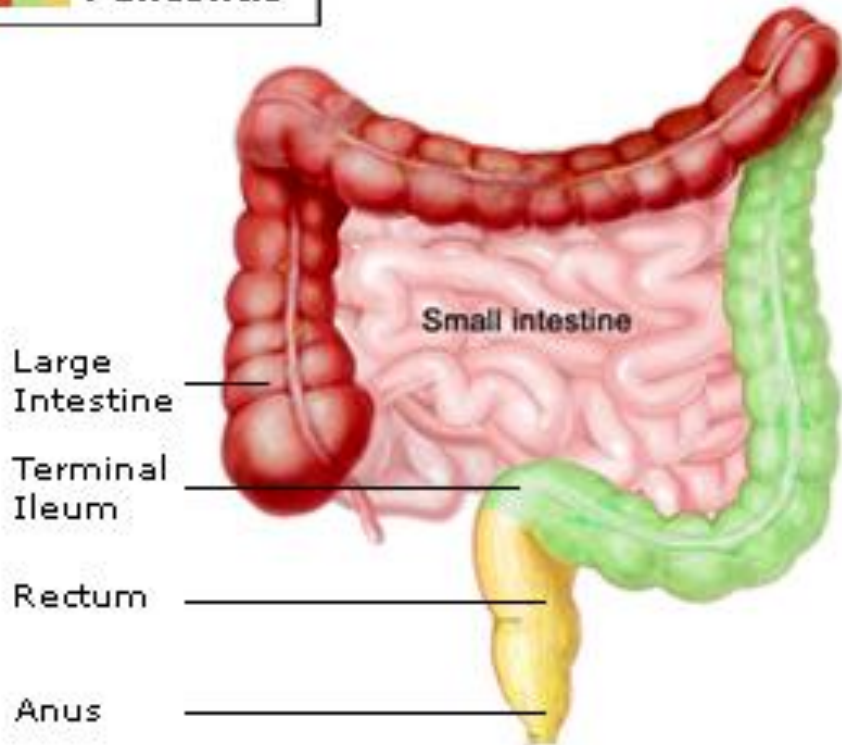
Introduction

- What is left sided colitis ?
- Clinical manifestations
- Treatment options available
- When to admit to hospital
- When to undertake surveillance
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What is left sided colitis ?



Ulcerative Colitis



- Proctosigmoiditis – Rectum and sigmoid
- Left sided or distal disease extends no further than splenic flexure
- Approximately 2/3 of patients with UC present with distal disease
- Progression to proximal disease occurs in 10% of patients at 10yrs

Left sided colitis

Clinical manifestations

- Diarrhoea
- Bleeding
- Tenesmus
- Rectal urgency
- Abdominal pain
- constipation

Treatment options

5 ASA (mesalsine) therapy for mild to moderate distal UC (2.4gm – 4.8gm)

Induction therapy for distal UC involves topical 5 ASAs
rapid effect

Proctitis – Mesalazine suppositories 1gm for inducing remission and maintaining

Distal colitis – Mesalazine foam enemas 1 gm daily reach splenic flexure for inducing and maintaining remission

predsol suppositories 5mg /
predfoam enemas 20mg

Treatment options continued

Draw backs to topical treatments burning / scolding sensation along with urgency

Young population non compliance

Oral 5 ASAs well tolerated

Side effects – diarrhoea, pancreatitis , hepatotoxicity and nephritis

U&Es checked prior to commencement then at 3 to 6 monthly intervals for 12/12 then annually.

Treatment options continued

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Topical steroids for induction therapy for Distal UC- Not to be used long

Patients with moderate to severe distal UC refractory to maximum doses of mesalazine prednisolone can be used 40mg reducing by 5 mg per week till stop

Always give Adcal D3 along with steroids

More than 2 “flare ups in 12/12 then refer to Gastro as will need step up approach to Immunomodulating therapy

When to admit to hospital

- Definition of severe colitis (Truelove & Witts)
- >6 bloody stools in 24 hours + at least 1 of:
- Fever >37.8, pulse>90/min. ESR> 30 or raised CRP
- Hb <10g/l, albumin, <35g/l

Surveillance in IBD

BSG (2009) NICE (2011)

**Colonoscopy 10 years from
onset of symptoms**

Findings



Severe inflammation/ PSC or stricturing – 1 year colonoscopy
Moderate inflammation – 3 year colonoscopy
Quiescent disease - 5 year colonoscopy

In Summary

- What left sided colitis is and treatment options, treat patients individually
- Symptoms of left sided colitis flare up
- Management of an acute flare
- Surveillance in IBD patients

Thank you for listening

