Quiz- Dec 2015

Answers

Q1. what is the most powerful muscle in the body?

Chewing muscles, buccinator- masseter

80kg

enamel

Q2. how many times a day do we swallow ?

600-2000

1litre

Night time less!

Q3. how many muscles are used in swallowing?

20 pairs

CVA- SALT

MND

Cf hand

Q4. what is opiorphin?

Stronger than morphine.

Sore throat after eating

In the morning

Q5. how long is the small intestine ?

Q6.If we had no villi, how long would the small intestine have to be ?

Q5. how long is the small intestine ?
3m

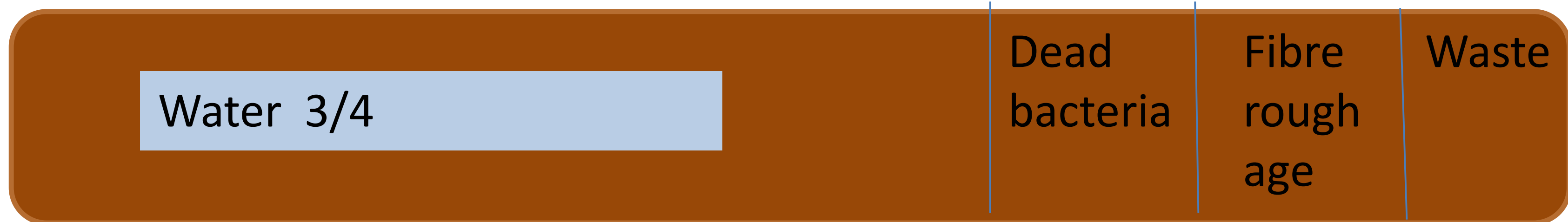
Q6.If we had no villi, how long would the small intestine have to be ?
18m

Q7. What is the Biological content of Faeces?

In what proportions?

Q7. What is the Biological content of Faeces?

In what proportions?



BRISTOL STOOL CHART

	Type 1	Separate hard lumps	Very constipated
	Type 2	Lumpy and sausage like	Slightly constipated
	Type 3	A sausage shape with cracks in the surface	Normal
	Type 4	Like a smooth, soft sausage or snake	Normal
	Type 5	Soft blobs with clear-cut edges	Lacking fibre
	Type 6	Mushy consistency with ragged edges	Inflammation
	Type 7	Liquid consistency with no solid pieces	Inflammation

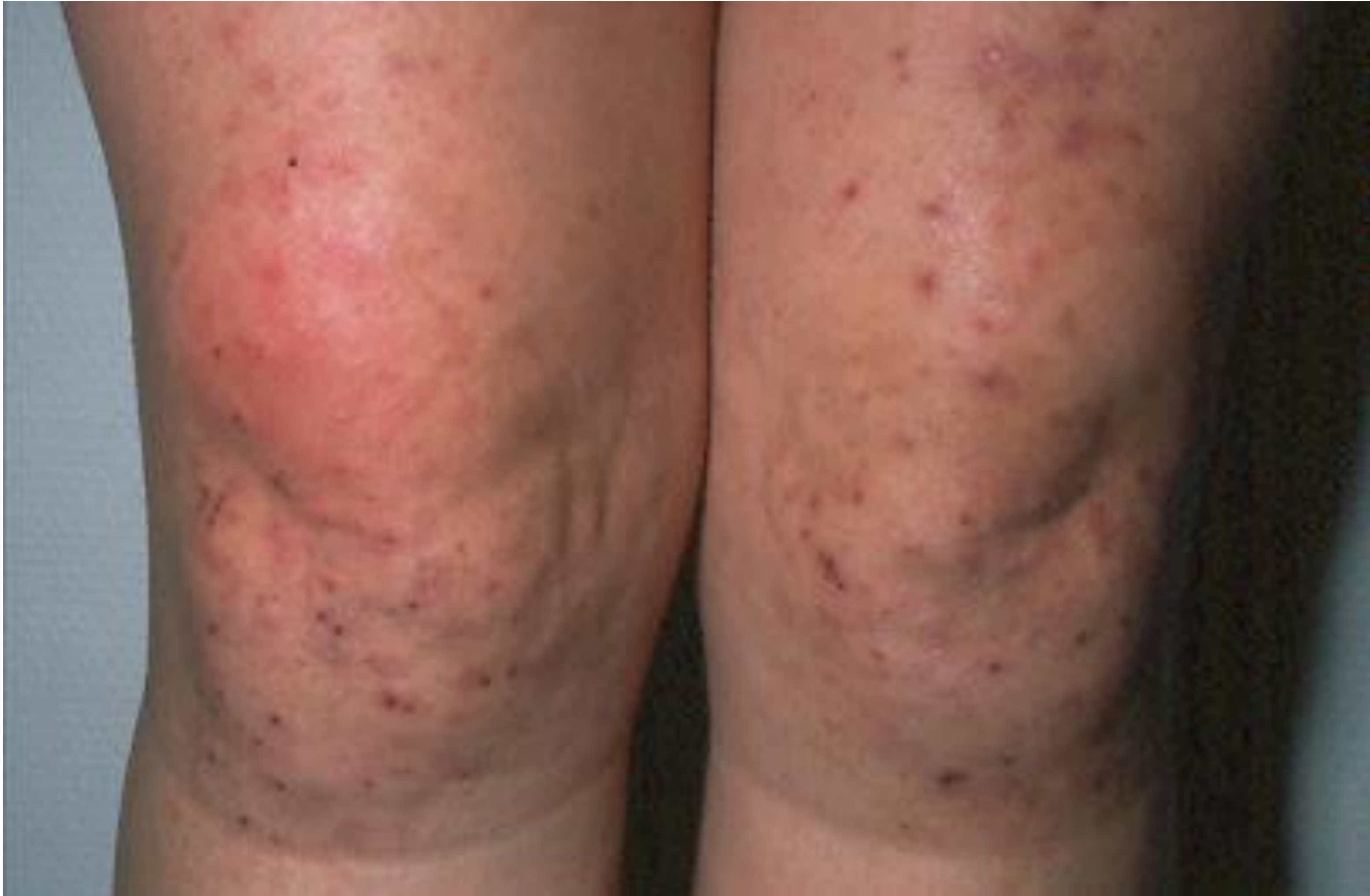
Q8. In BSS Type 1 stool, how long does it take the digestive remains to pass through the gut ?

Q8. In BSS Type 1 stool, how long does it take the digestive remains to pass through the gut ?

Type 1 – 10 days !

Type 7 – 10 hours !

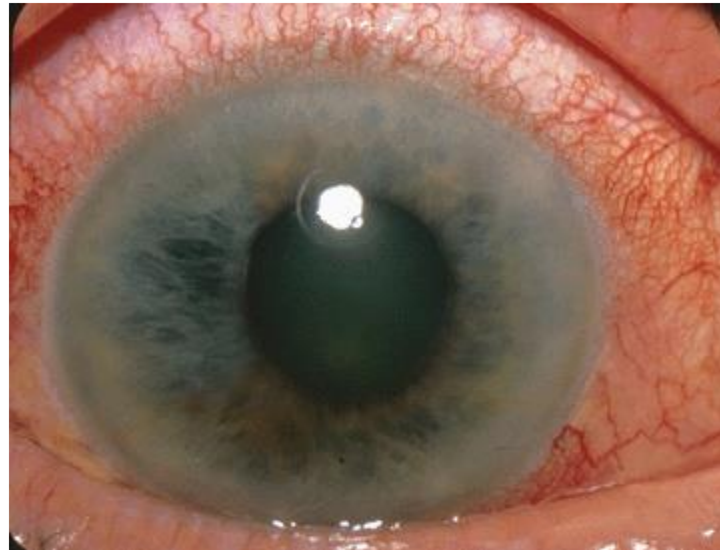
Q9 . What is this itchy rash ? What test might you want to do?



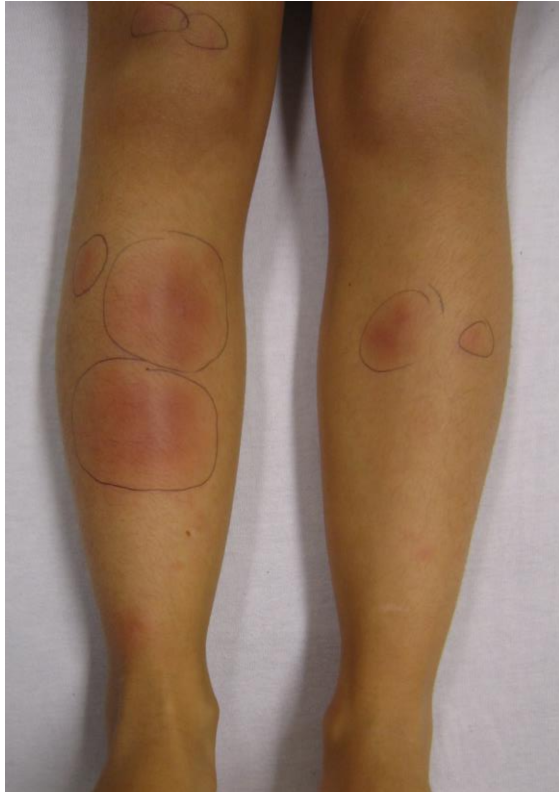
Dermatitis herpetiformis…

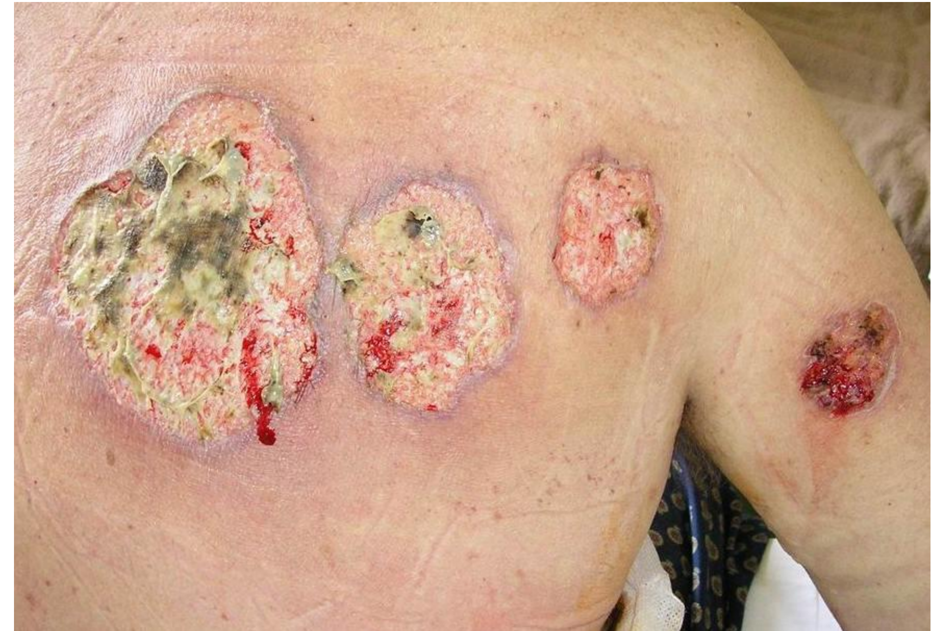
Q10. List 5 Extra GI manifestations of Inflammatory Bowel Disease   ?

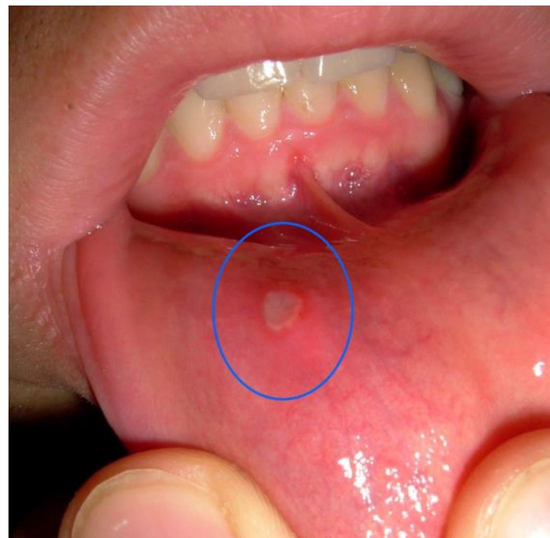
eyes



skin







Joints

sero neagative arthropathy
Sacroilitis
mono/poly arthritis

10 yrs before ..

Kidneys

stones

amyloid

Hepatobiliary

sclerosing cholangitis- jaundice

gallstones..

PRIZE

Clinical Cases

Dr Dominic Bullas

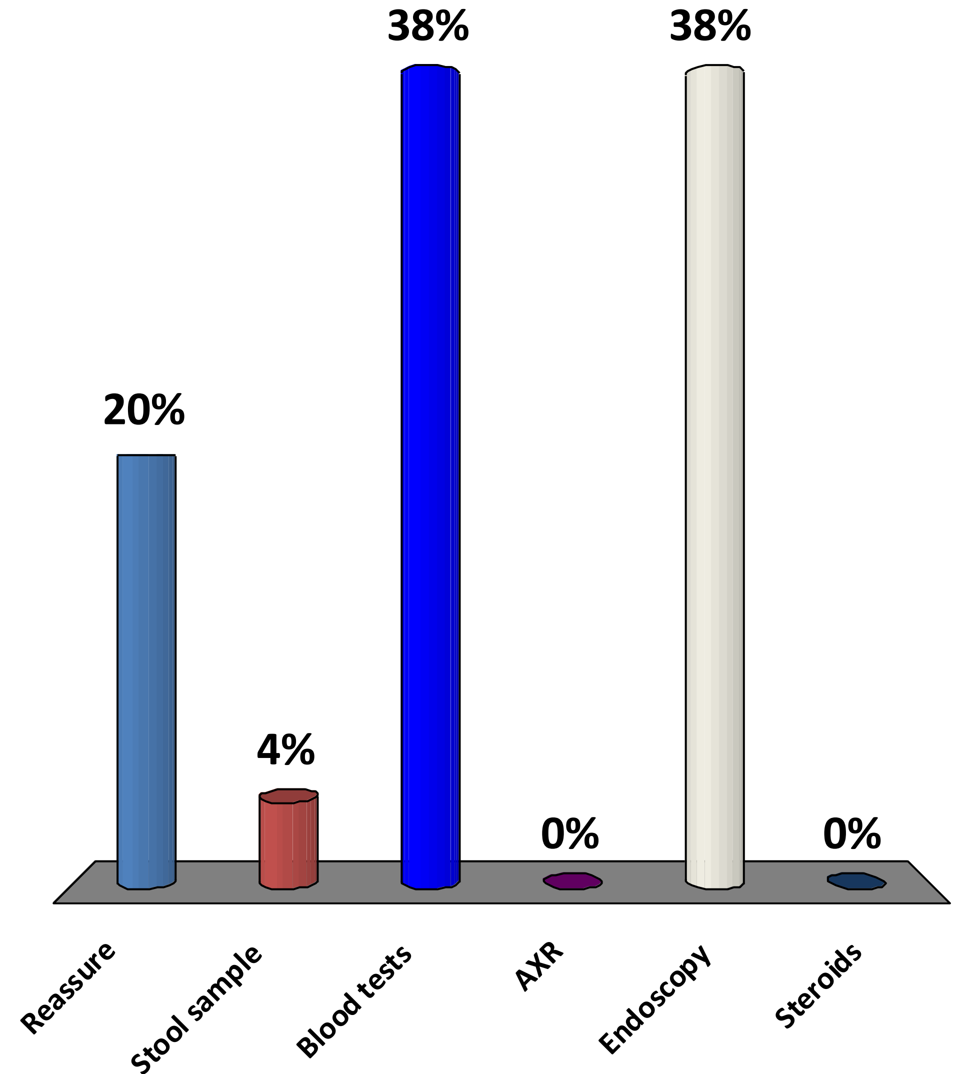
BHFT

PC

- 25 F
- 1/12: PR bleeding
  Painful defaecation
- PMH: IBS
- Dad: "We just want to get to the bottom of it"
- Diagnosis: ? Anal fissure
  ? Haemorrhoids

What would you do next?

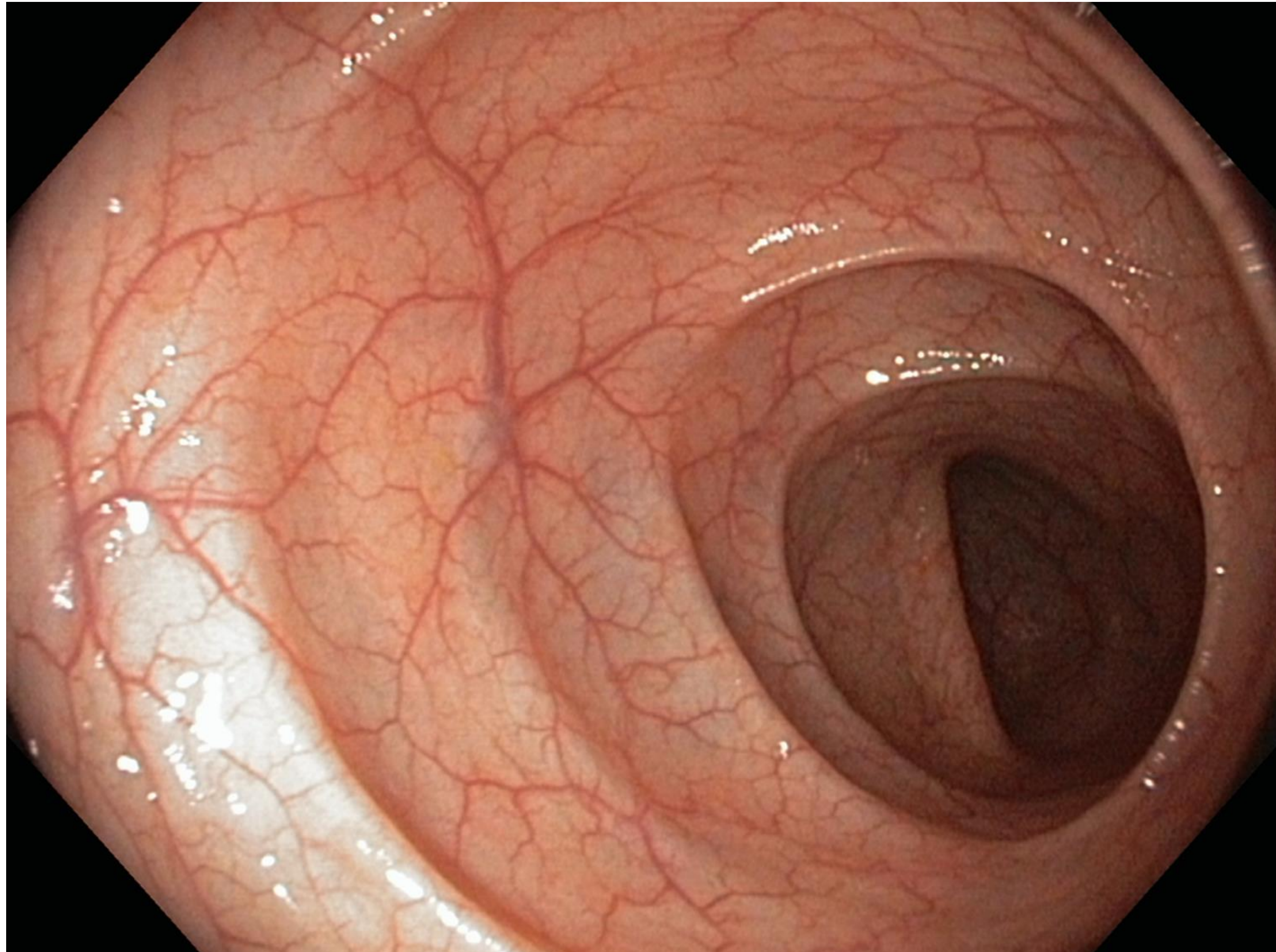
A. Reassure
B. Stool sample
C. Blood tests
D. AXR
E. Endoscopy
F. Steroids



What To Do Next?

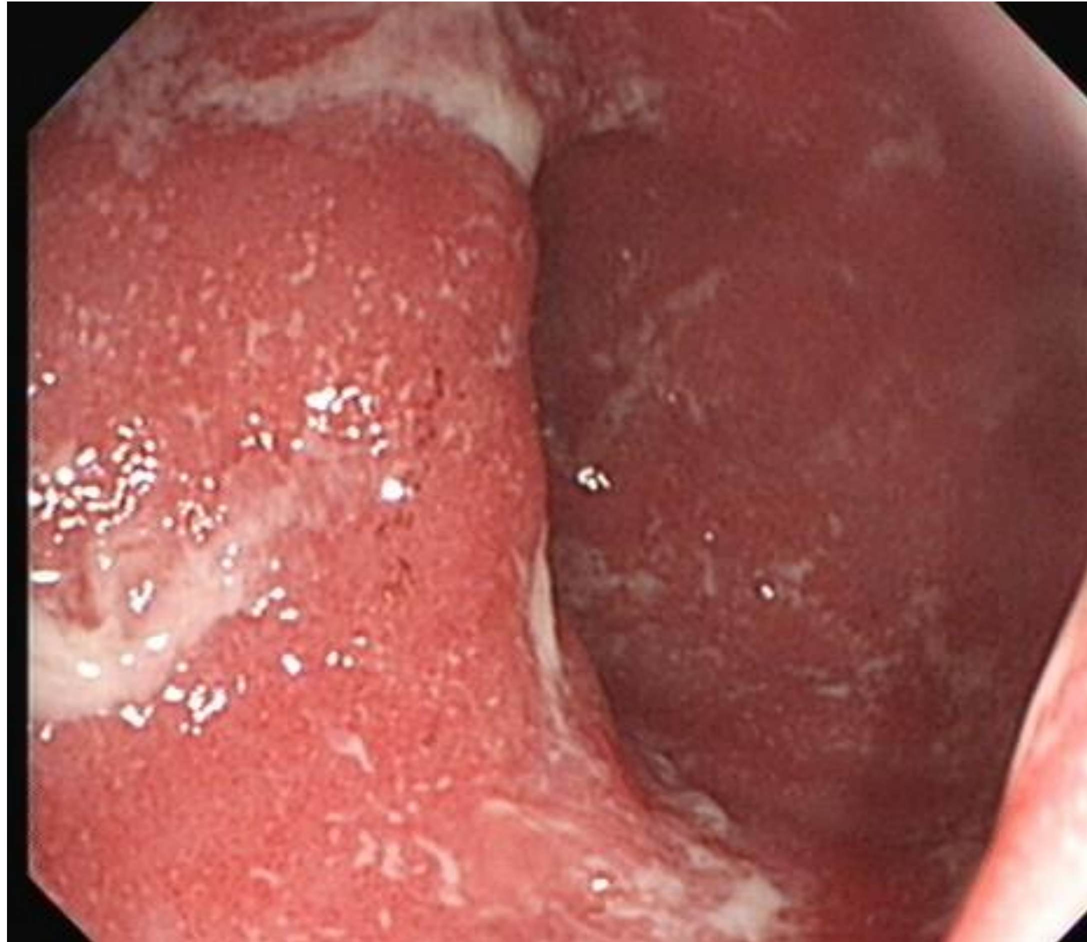
- Reassure
- Stool samples
- Blood tests
- AXR
- Endoscopy ✓
- Steroids

Normal Colon

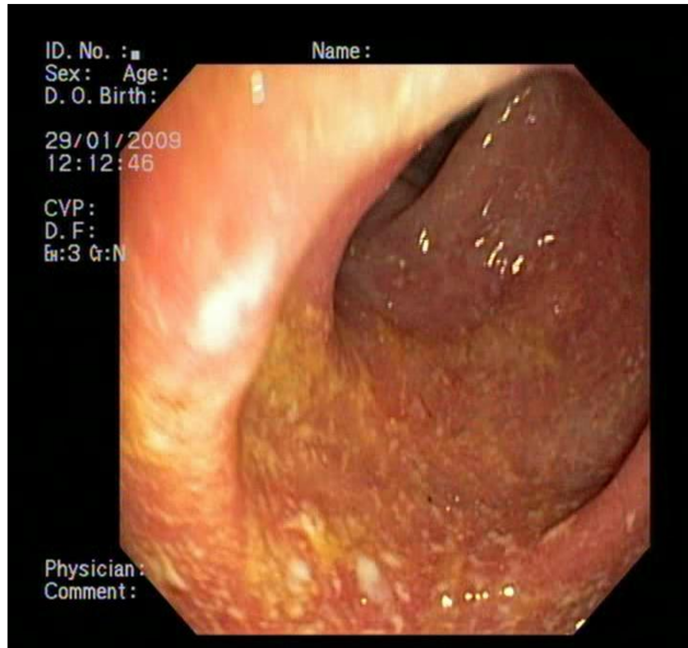


Colonoscopy

- Barons 2 inflammation to 25cm



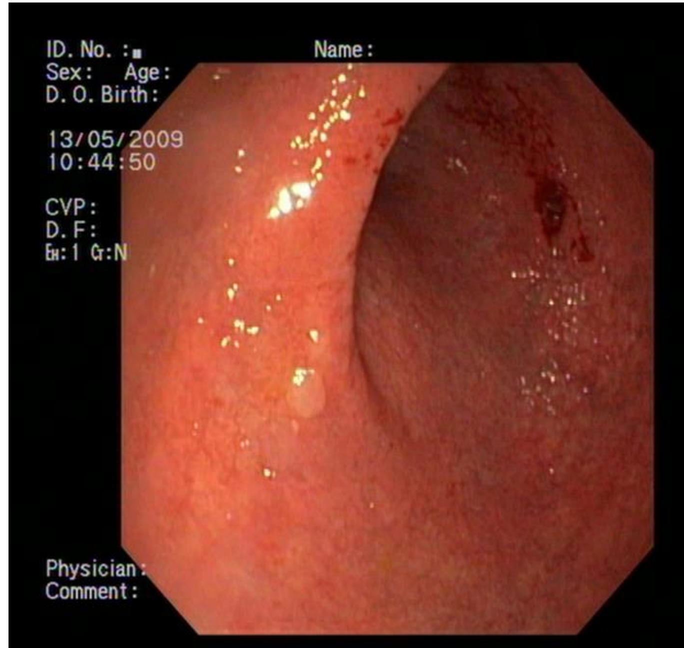
Baron's Score



1

Abnormal, but non-haemorrhagic

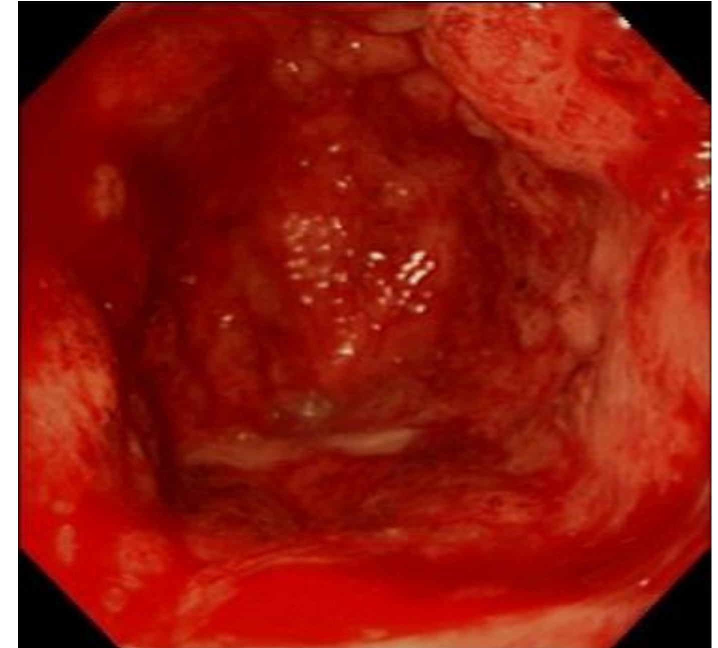
Appearances between 0 and 2



2

Moderately haemorrhagic

Bleeding to light touch, but no spontaneous bleeding seen ahead of the instrument on initial inspection



3

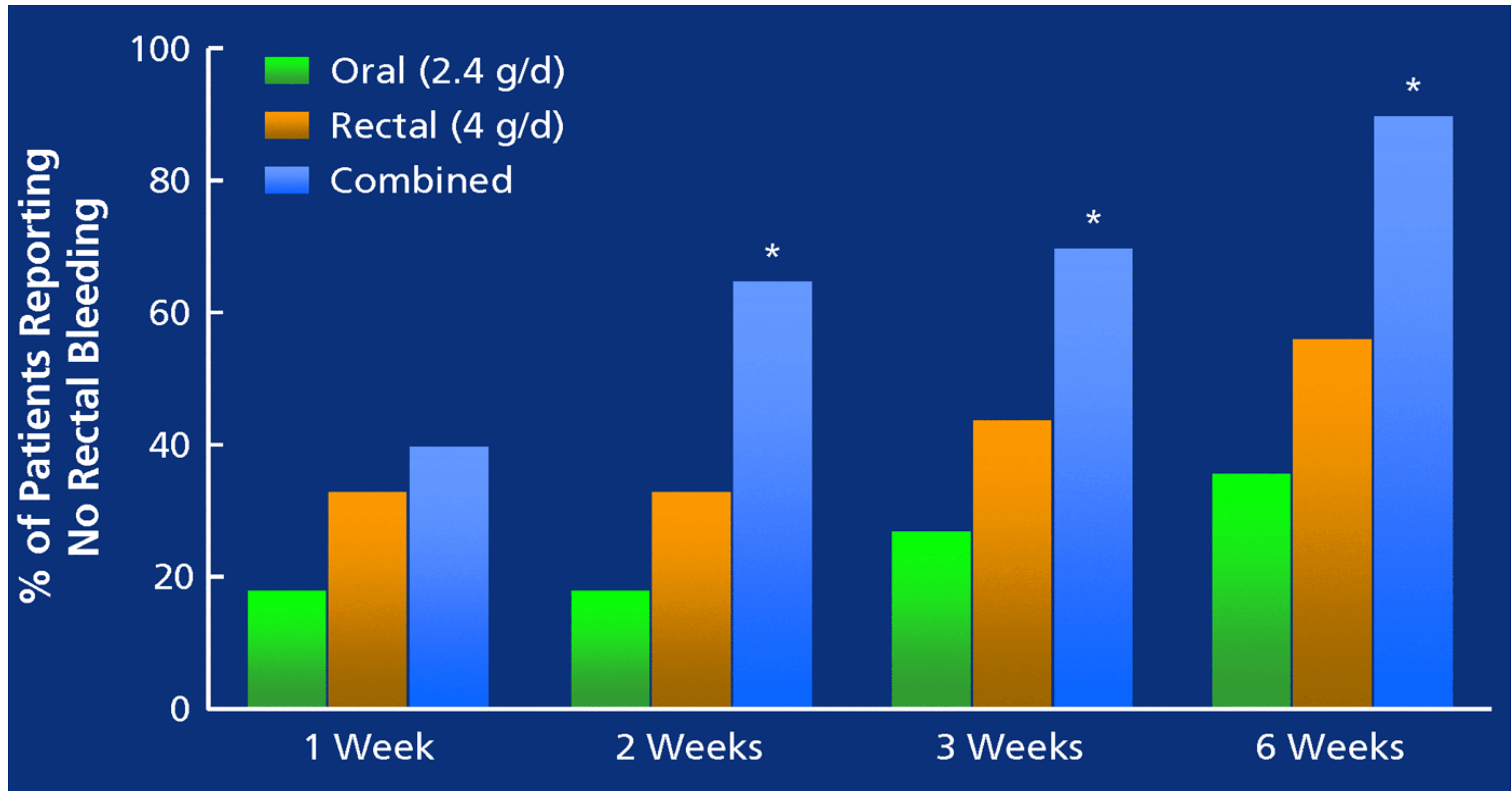
Severely haemorrhagic

Spontaneous bleeding seen ahead of instrument at initial inspection and bleeds to light touch

Rx

- Oral Asacol
- Asacol foam enemas

Why dual 5ASA therapy?



A double-blind comparison of oral versus rectal mesalamine versus combination therapy in the treatment of distal ulcerative colitis.

Safdi et al., [Am J Gastroenterol.](#) 1997 Oct;92(10):1867-71.

Rx

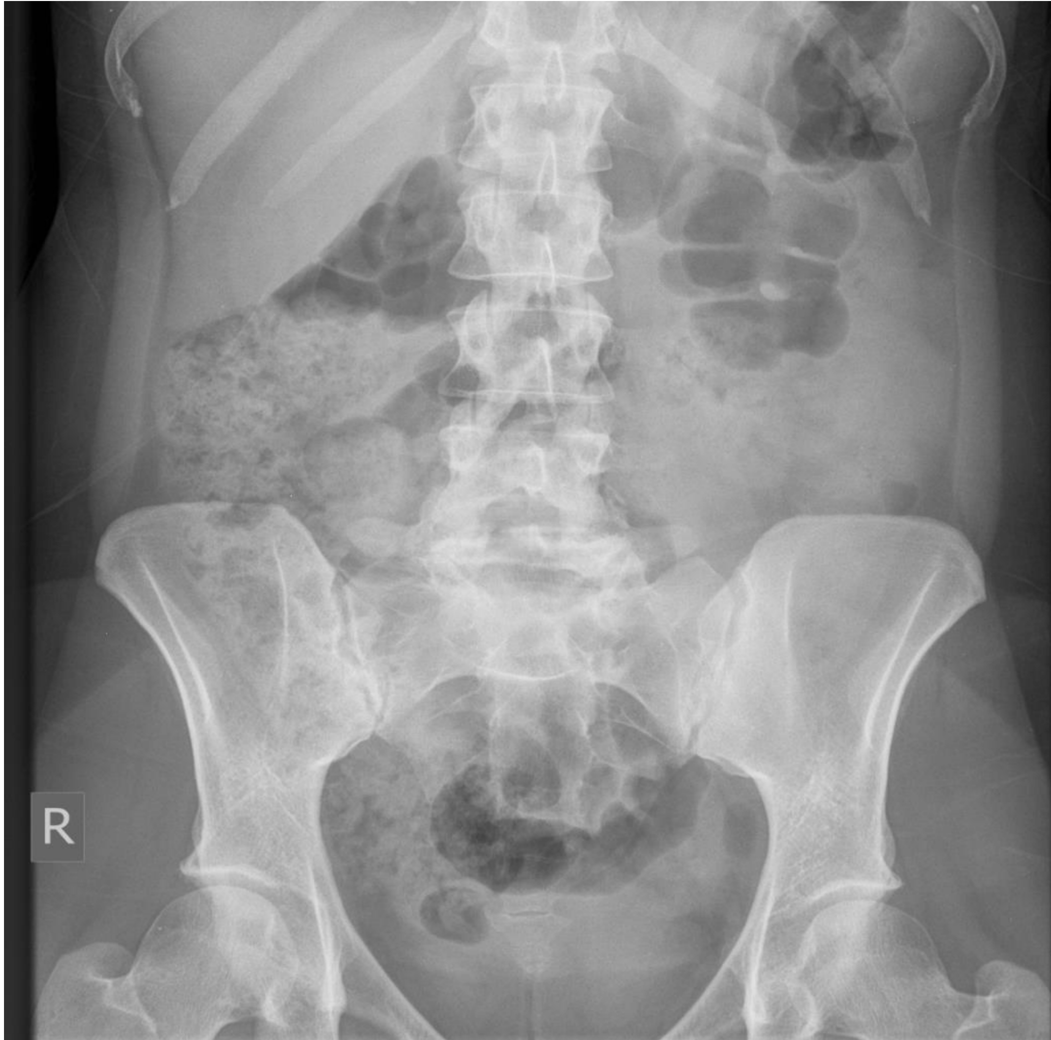
- Oral Asacol
- Asacol foam enemas
- Gastro OPA
- IBD Nurse Helpline

- Histology favouring UC
- Settled with Rx

01/2015

- BO x 5 to x 10, Bristol 3 to 7
- Constipation
- Abdominal pain, PR bleeding, PR mucus
- Nocturnal symptoms

AXR

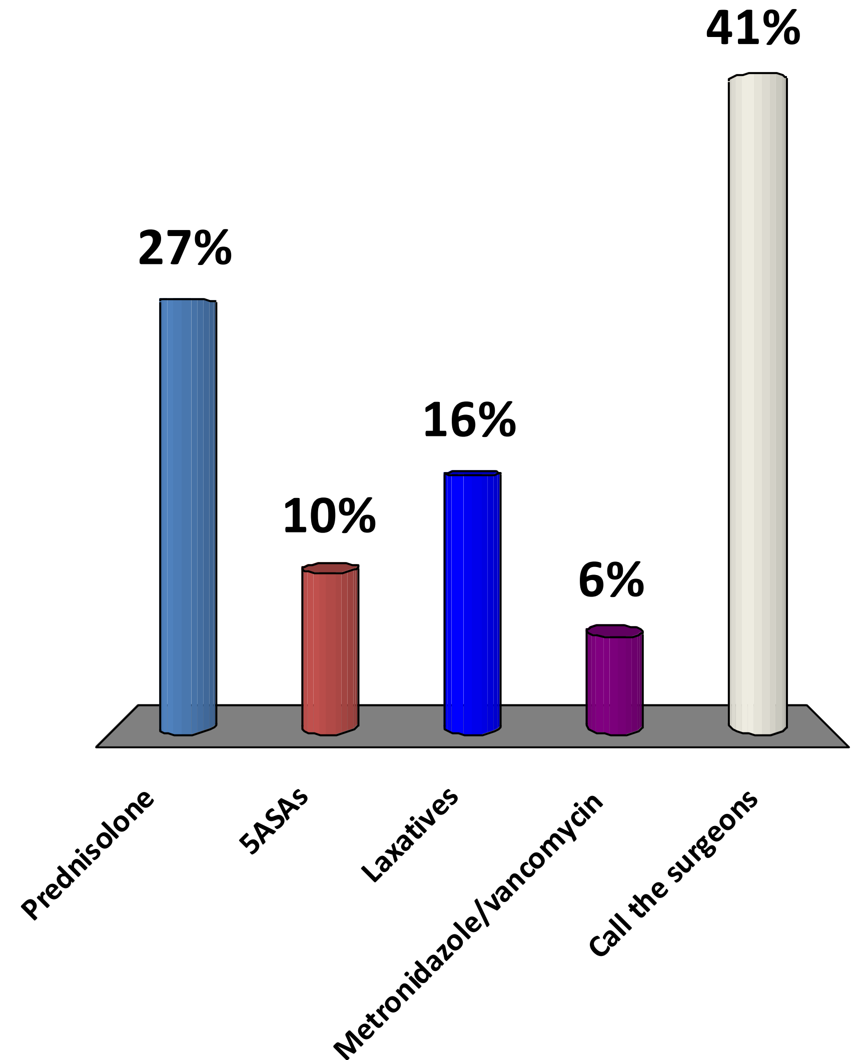


What Treatment?

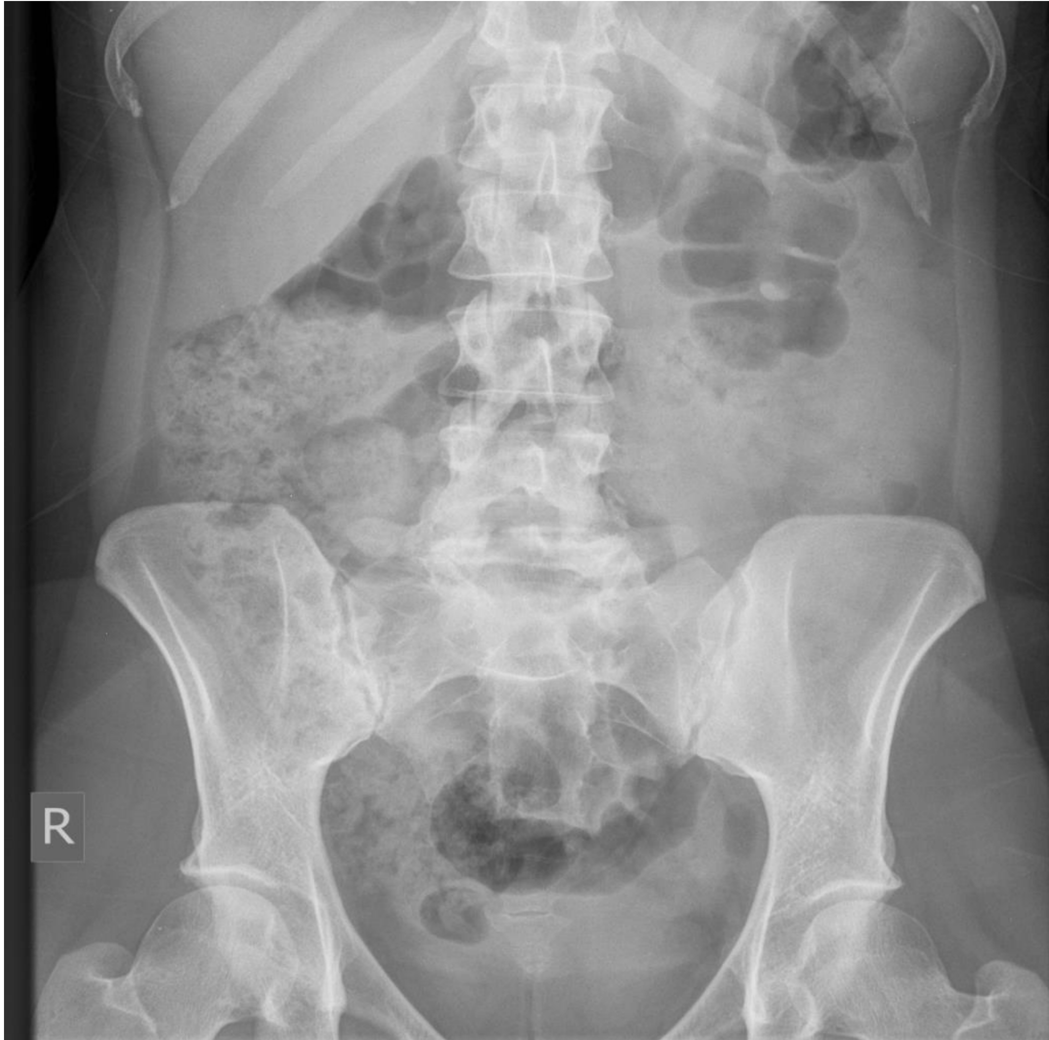
- Prednisolone
- 5ASAs
- Laxatives
- Metronidazole/Vancomycin
- Call the surgeons?

What treatment next?

A. Prednisolone
B. 5ASAs
C. Laxatives
D. Metronidazole/ vancomycin
E. Call the surgeons



AXR



What Treatment?

- Prednisolone
- 5ASAs
- Laxatives ✓
- Metronidazole/Vancomycin
- Call the surgeons?

01/2015

- BO x 5 to x 10, Bristol 3 to 7
- Constipation
- Abdominal pain, PR bleeding, PR mucus
- Nocturnal symptoms

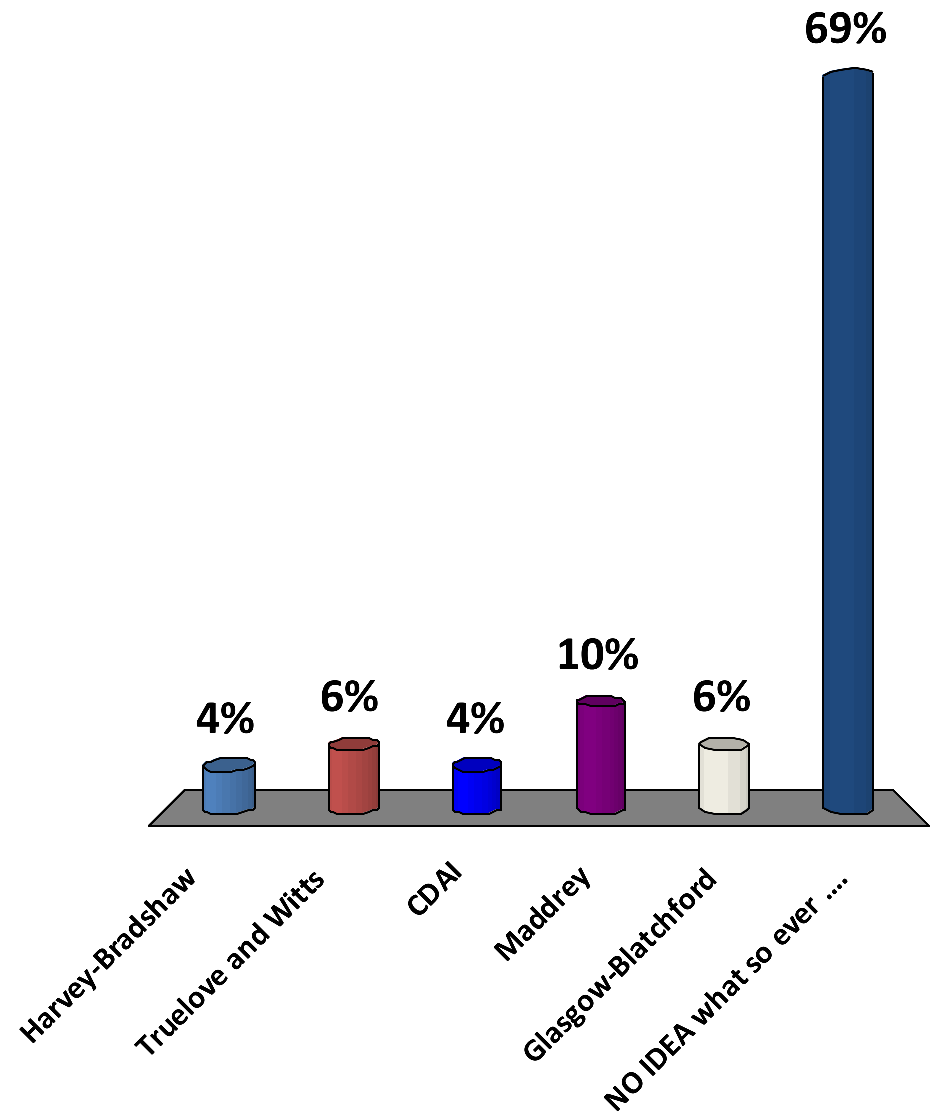
- Maintenance Asacol
- 5ASA suppositories… Prednisolone suppositories
- Fybogel

04/2015

- BO x8, PR bleeding, Urgency
- Hb 152, ESR 5, T 37°C, HR 90

Which Clinical Scoring System ?

A. Harvey-Bradshaw
B. Truelove and Witts
C. CDAI
D. Maddrey
E. Glasgow-Blatchford
F. NO IDEA what so ever ….



Which Clinical Scoring System?

- Harvey-Bradshaw
- Truelove and Witts ✓
- CDAI
- Maddrey
- Glasgow-Blatchford

Truelove & Witts Severity Index

	Mild	Moderate	Severe
Nº stools per day	< 4	4-6	> 6
Blood in the stools	No more than small amounts of blood	Between mild and severe	Visible blood
Temperature	Afebrile	Intermediate	> 37.8
Heart Rate	Normal	Intermediate	> 90
Haemoglobin (g/dl)	> 11	10.5-11.0	< 10.5
ESR	< 20	20-30	> 30

t on a
75–8.

Truelove & Witts Severity Index

	Mild	Moderate	Severe
Nº stools per day	< 4	4-6	> 6
Blood in the stools	No more than small amounts of blood	Between mild and severe	Visible blood
Temperature	Afebrile	Intermediate	> 37.8
Heart Rate	Normal	Intermediate	> 90
Haemoglobin (g/dl)	> 11	10.5-11.0	< 10.5
ESR	< 20	20-30	> 30

t on a
75–8.

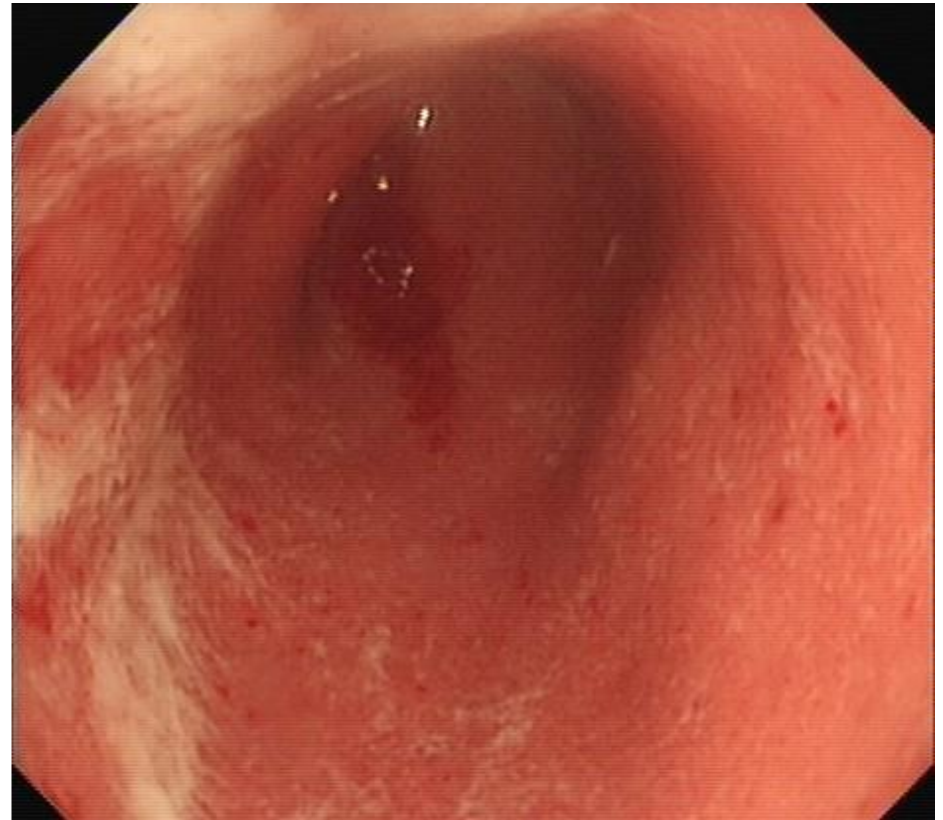
04/2015

- BO x8, PR bleeding, Urgency
- Hb 152, ESR 5, T 37°C, HR 90

- FS: Diffuse areas of inflammation in the rectum, normal sigmoid

- Rx: Prednisolone

- Admitted to BHFT
- Rx: Hydrocortisone



05/2015

- BO x2, Bristol 4, no PR bleeding (Pred. 25mg, Asacol 2.4g)
- Viral screen, TPMT

06/2015

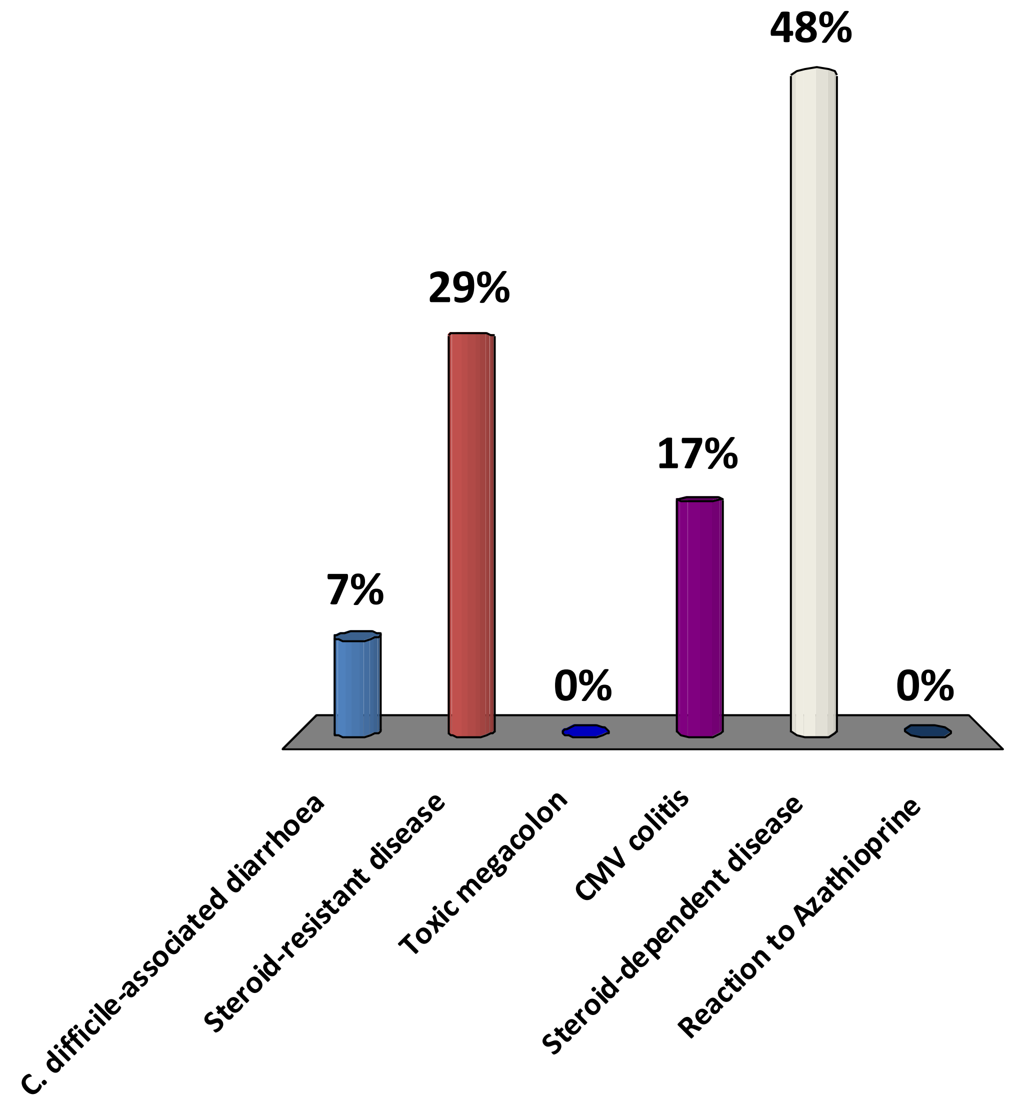
- BO x3, Bristol 4 to 5, slight PR bleeding, urgency (Pred. 10mg, ↑Asacol 4.8g)

07/2015

- BO x3 to x4, Bristol 4 to 7, PR bleeding (Asacol 4.8g)
- Prednisolone + Azathioprine

Why is she more symptomatic?

A. C. difficile-associated diarrhoea
B. Steroid-resistant disease
C. Toxic megacolon
D. CMV colitis
E. Steroid-dependent disease
F. Reaction to Azathioprine

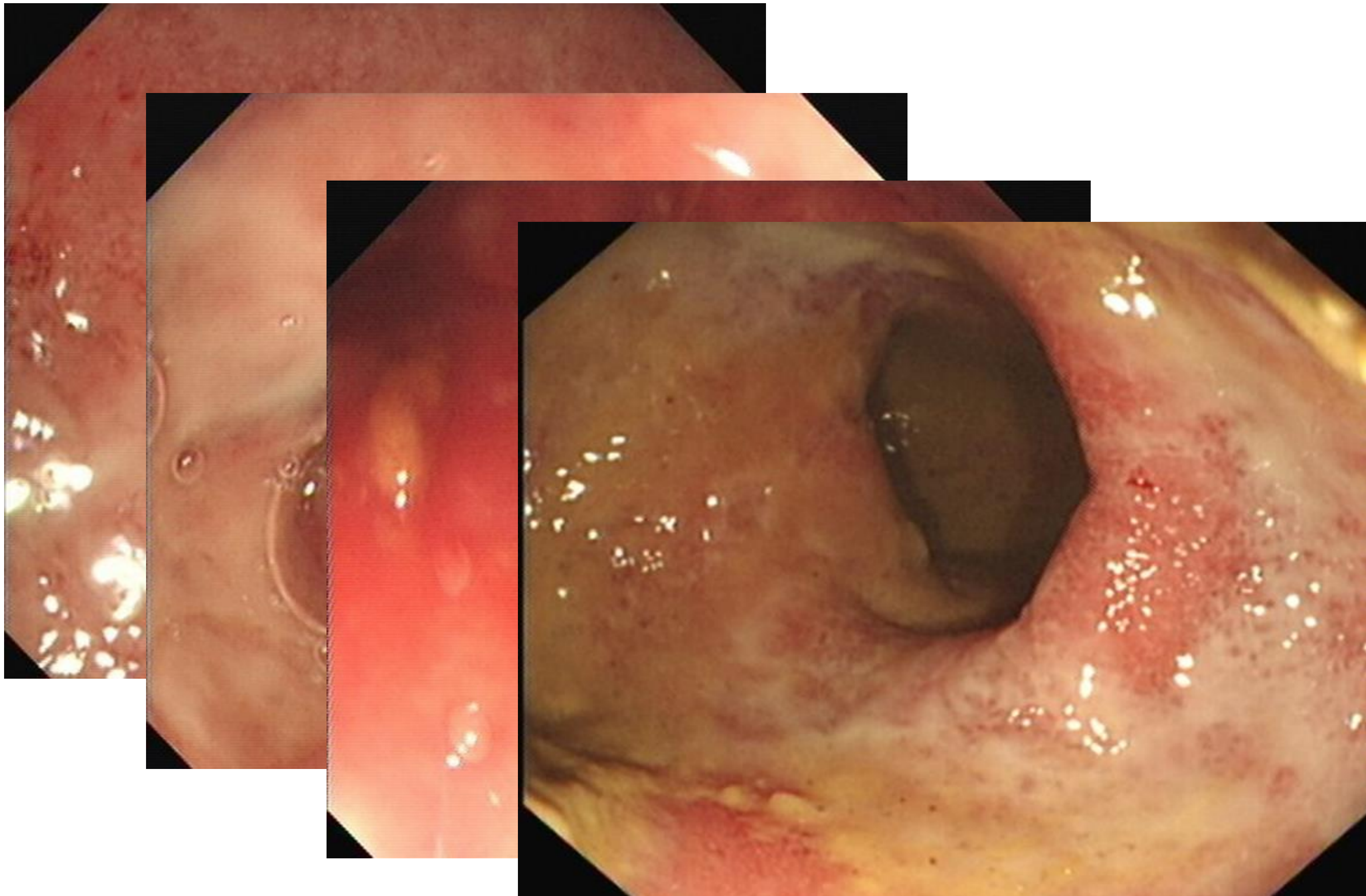


Why is she more symptomatic?

- C. difficile-associated diarrhoea
- Steroid-resistant disease
- Toxic megacolon
- CMV colitis
- Steroid-dependent disease ✓
- Reaction to Azathioprine

07/2015

- IP admission, FS x2
- Iv Hydrocortisone
- Infliximab 5mg/kg

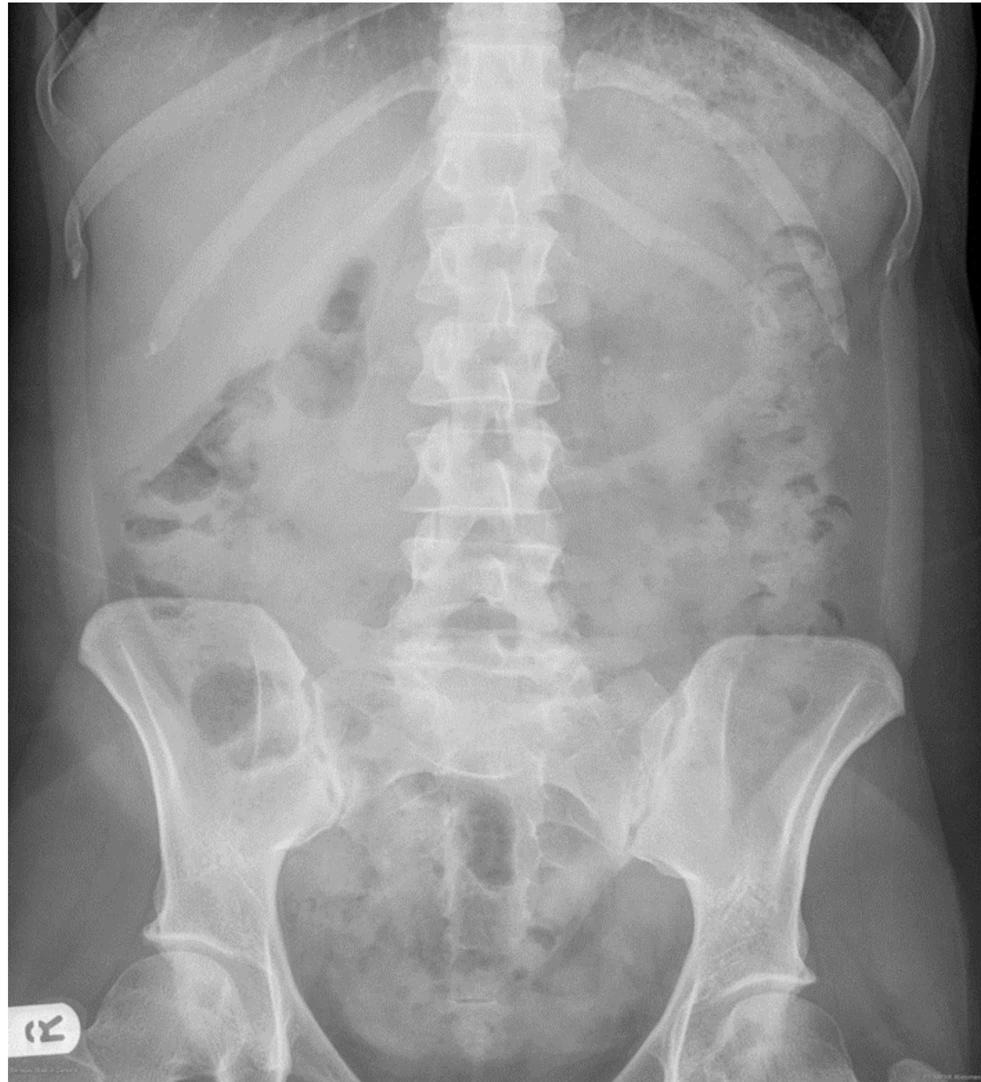


08/2015

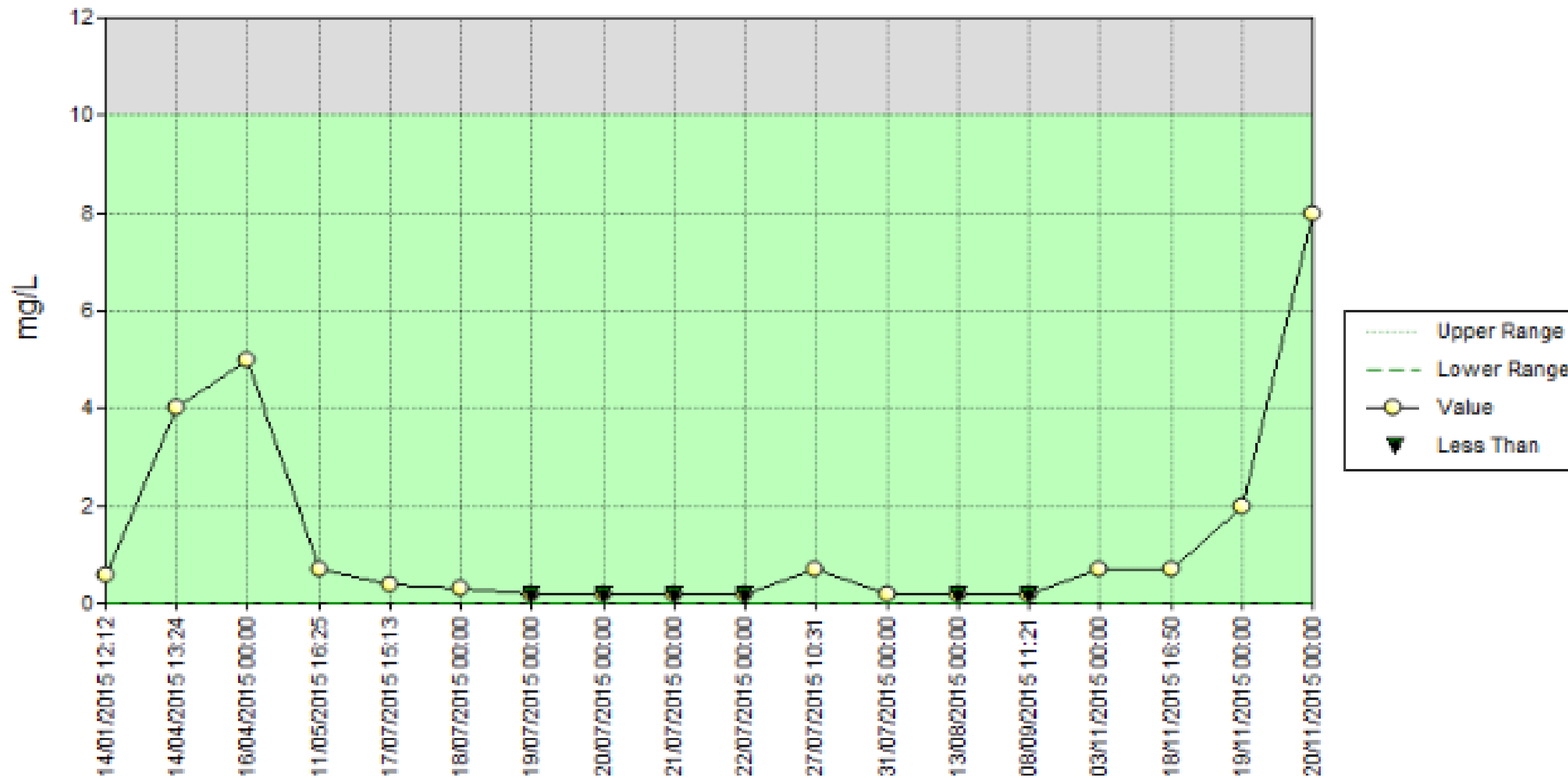
- BO x1, Bristol 4
- no PR bleeding

11/2015

- Abdominal pain
- Bloating
- Diarrhoea



CRP



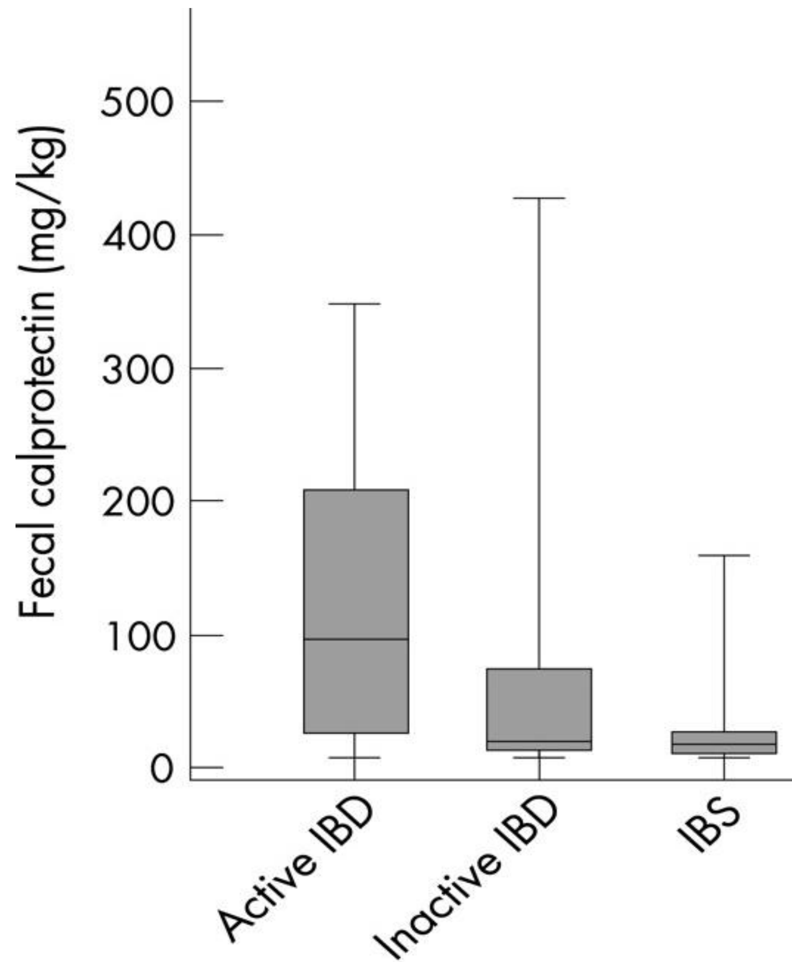
15% of patients fail to mount a CRP response

C-Reactive Protein, Fecal Calprotectin, and Stool Lactoferrin for Detection of Endoscopic Activity in Symptomatic Inflammatory Bowel Disease Patients: A Systematic Review and Meta-Analysis
Mosli et al, Am J Gastroenterol. 2015 Jun;110(6):802-19.

Faecal calprotectin diagnostic tests for inflammatory diseases of the bowel

Diagnostics guidance
Published: 2 October 2013
nice.org.uk/guidance/dg11

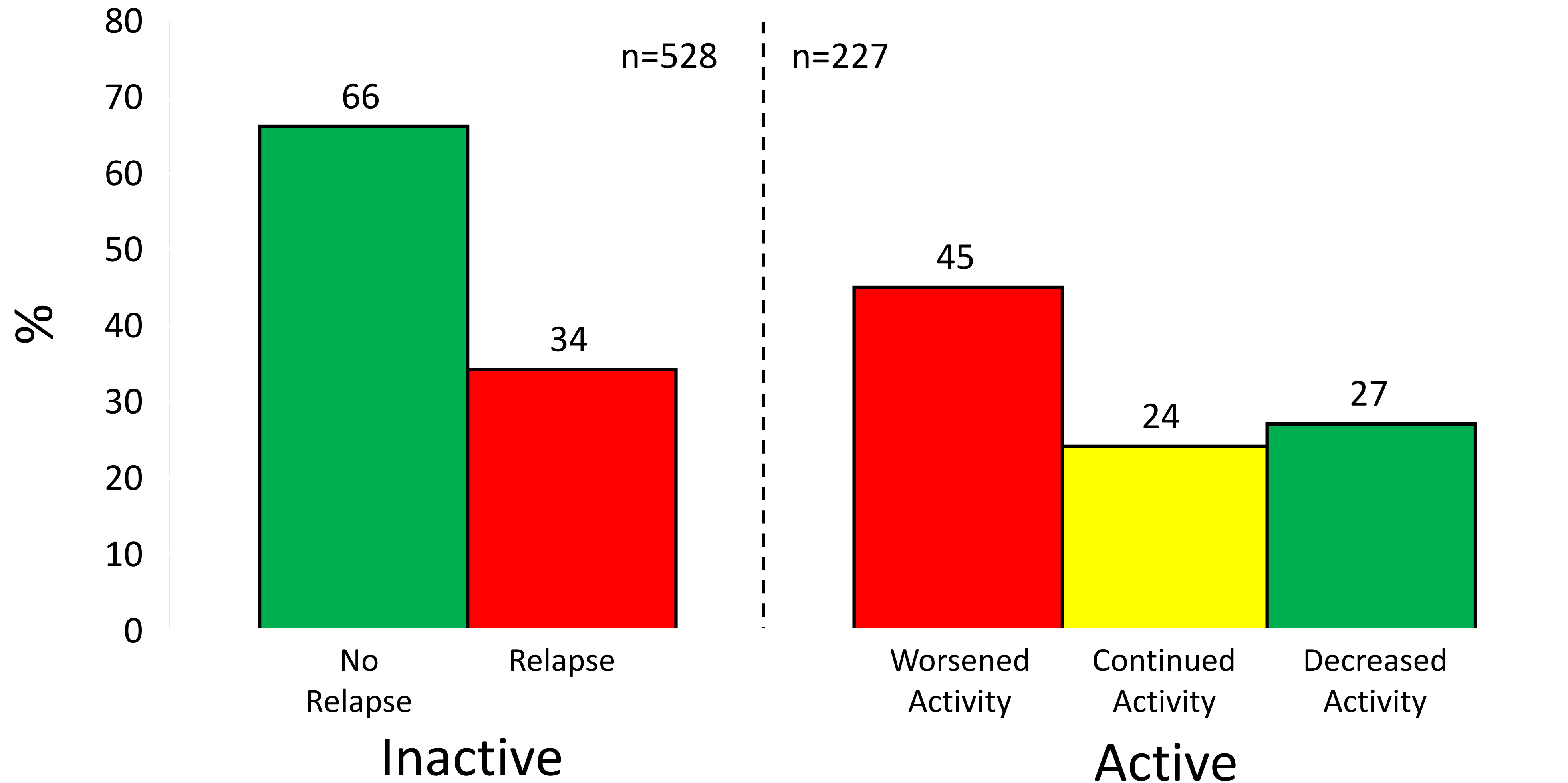
Faecal Calprotectin



I want a baby.

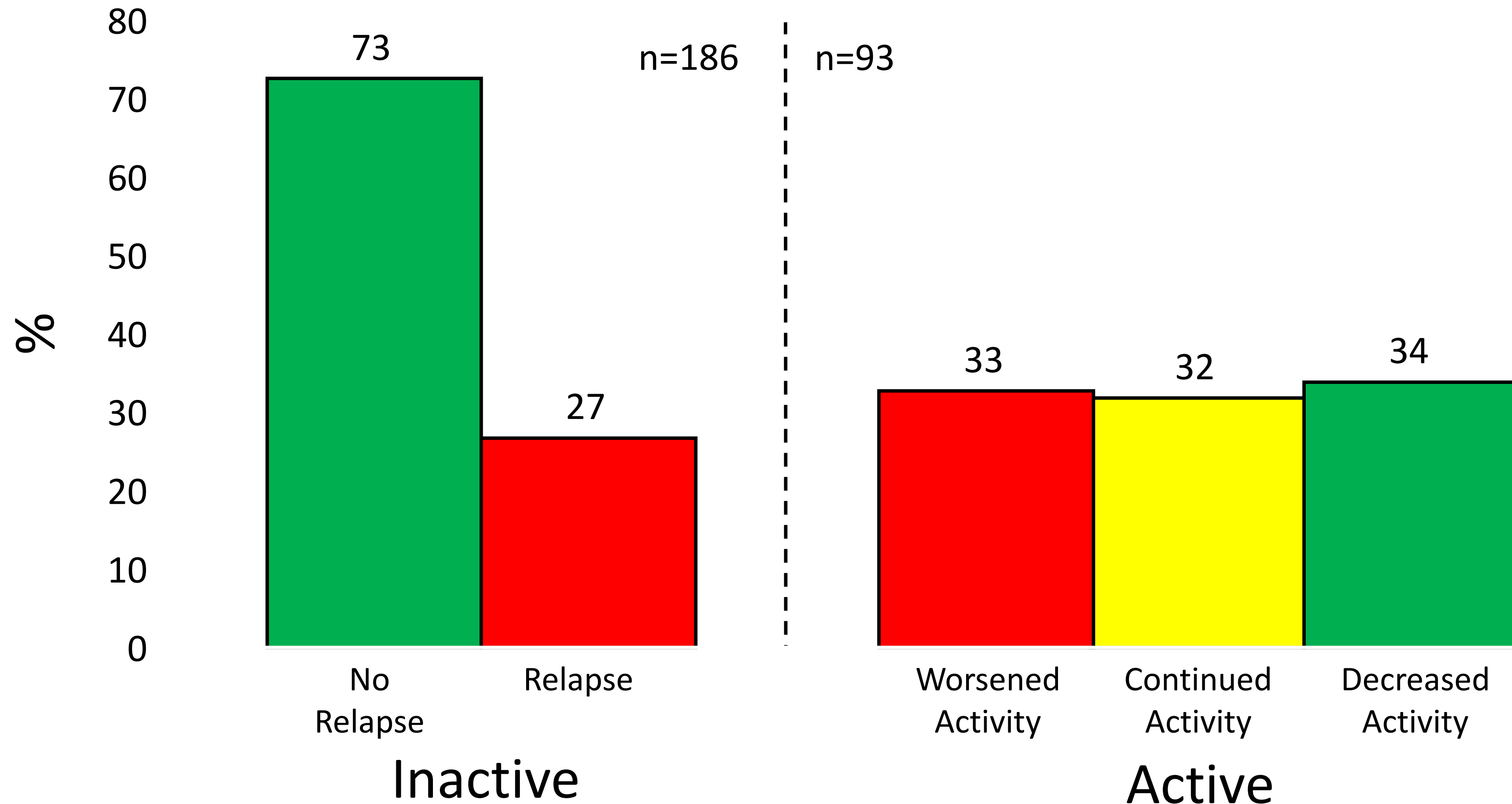
Is my colitis going to get worse?

Effect of Pregnancy on Ulcerative Colitis: Disease Activity at Conception



Miller JP. *J R Soc Med.* 1986;79:221-225.

Effect of Pregnancy on Crohns Disease: Disease Activity at Conception



Miller JP. *J R Soc Med.* 1986;79:221-225.

Assessment of Pregnant IBD Patients

- Laboratory studies (ESR, Hb, Albumin, CRP)
- Ultrasound
- X-rays (low dose Xrays pose minimal foetal risk[1])
- Endoscopy – low risk if used for appropriate indications[2]
- Flexible sigmoidoscopy – low risk[2]
- Colonoscopy – should only be used for life-threatening colonic disease or when only alternative is laparotomy[2]

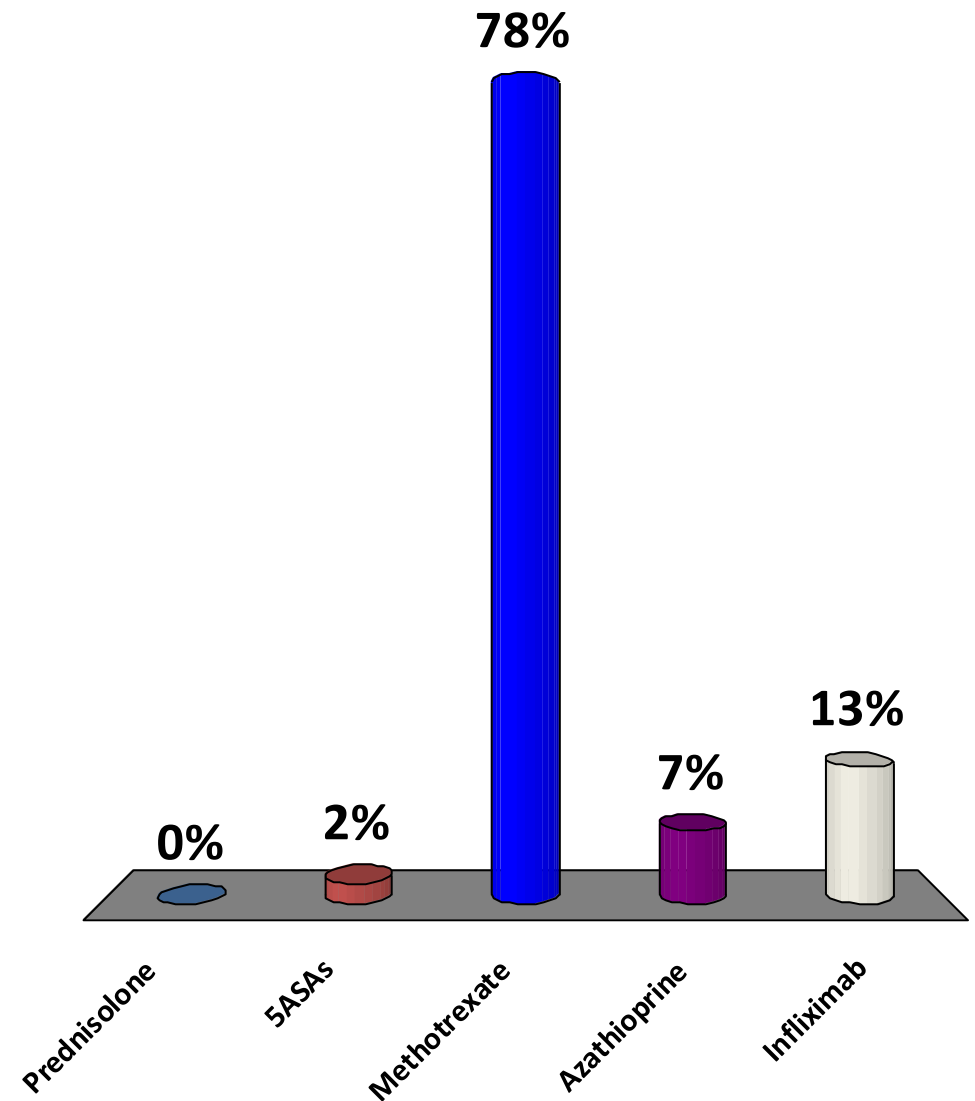
[1]Hufton AP. Br J Radiol. 1979;52:735-740.

[2]Cappell MS, et al. Dig Dis Sci. 1996;41:2353-2361.

Is the IBD medication going to hurt my unborn baby?

Which drug is contraindicated in pregnancy?

A. Prednisolone
B. 5ASAs
C. Methotrexate
D. Azathioprine
E. Infliximab



Which drug is contraindicated in pregnancy?

- Prednisolone
- 5ASAs
- Methotrexate
- Azathioprine
- Infliximab

Safety of IBD Medications in Pregnancy

Category B	Category C	Category D	Category X
Loperamide	Ciprofloxacin	Azathioprine†	Methotrexate
Mesalamine	Cyclosporine	6-Mercaptopurine†	Thalidomide
Balsalazide	Diphenoxylate		
Corticosteroids	Olsalazine		
Sulfasalazine	Tacrolimus		
Anti-TNF agents	Natalizumab		
Metronidazole*			

Briggs GG, et al. *Drugs in Pregnancy and Lactation.* 5th ed. Philadelphia, Pa: Lippincott Williams & Wilkins; 1998. *Physician's Desk Reference*®. 57th ed. Montvale, NJ: Thompson PDR; 2003.

Case 2

PC

- 20F
- Crohns Disease, aged 14
- Azathioprine and Infliximab for 6 years
- Opportunistic infections
- Now symptomatic despite Infliximab
- Referred by RHH for a second opinion

" I'd say it's your gallbladder, but if you insist on a second opinion, I'll say kidneys."

PC June 2014

- "In agony"
- "Will not consider alternative treatments"

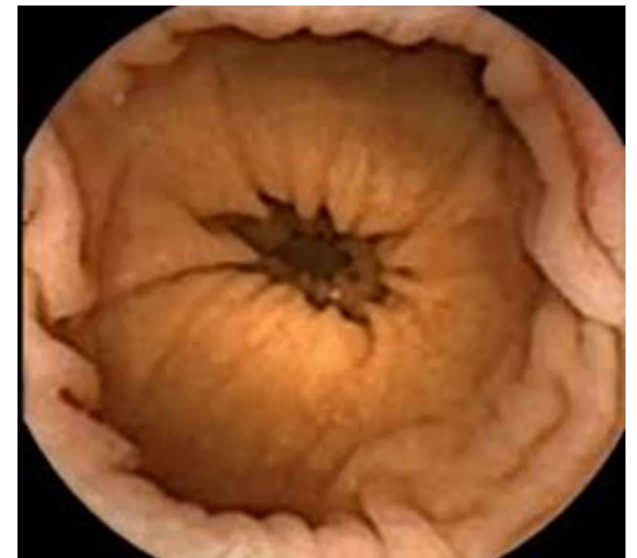
- Refusing reassessment
- Non-attendance at clinic

- "She just wanted Infliximab. She wondered why I could not believe her"

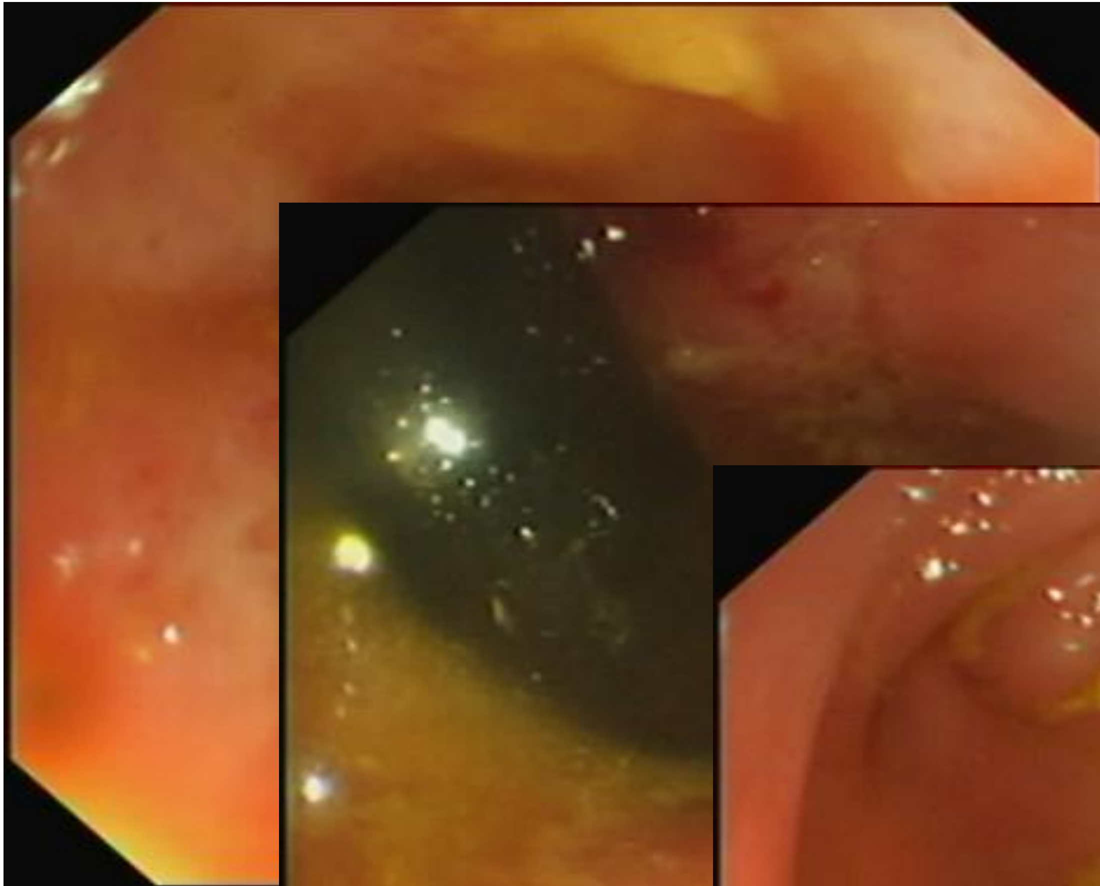
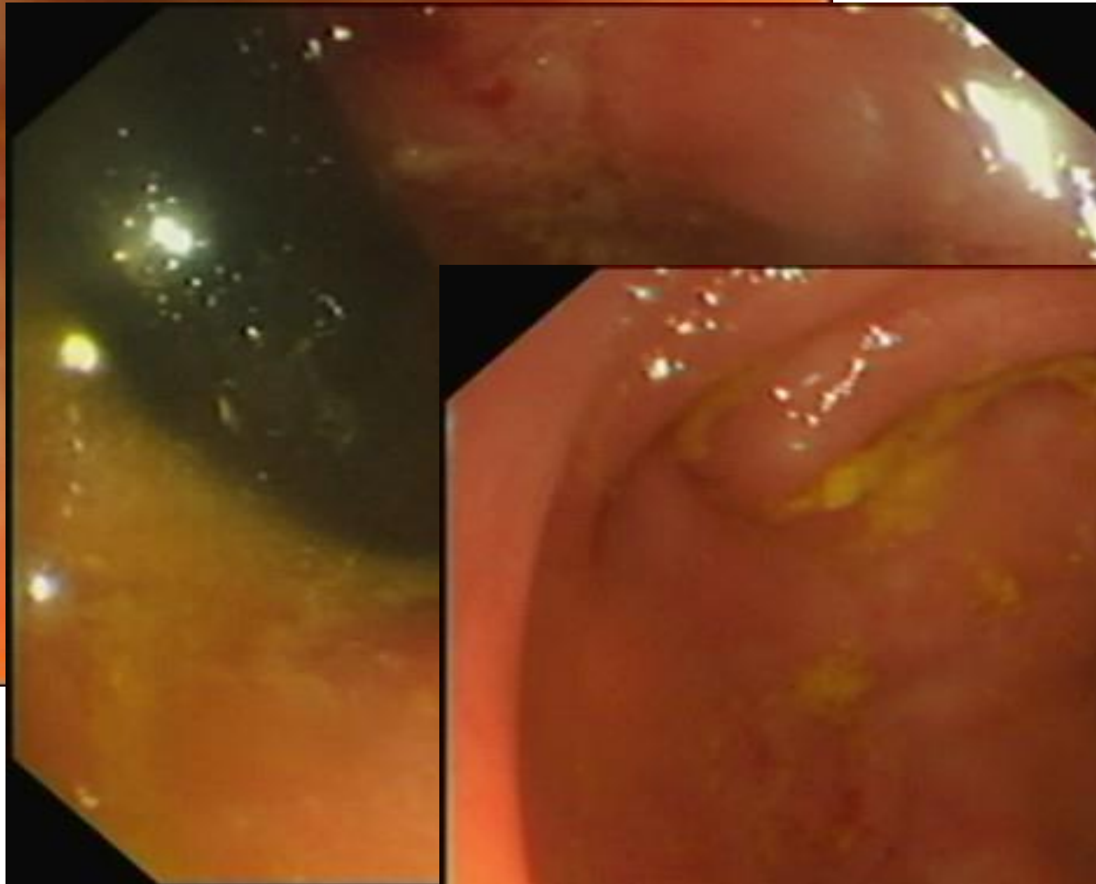
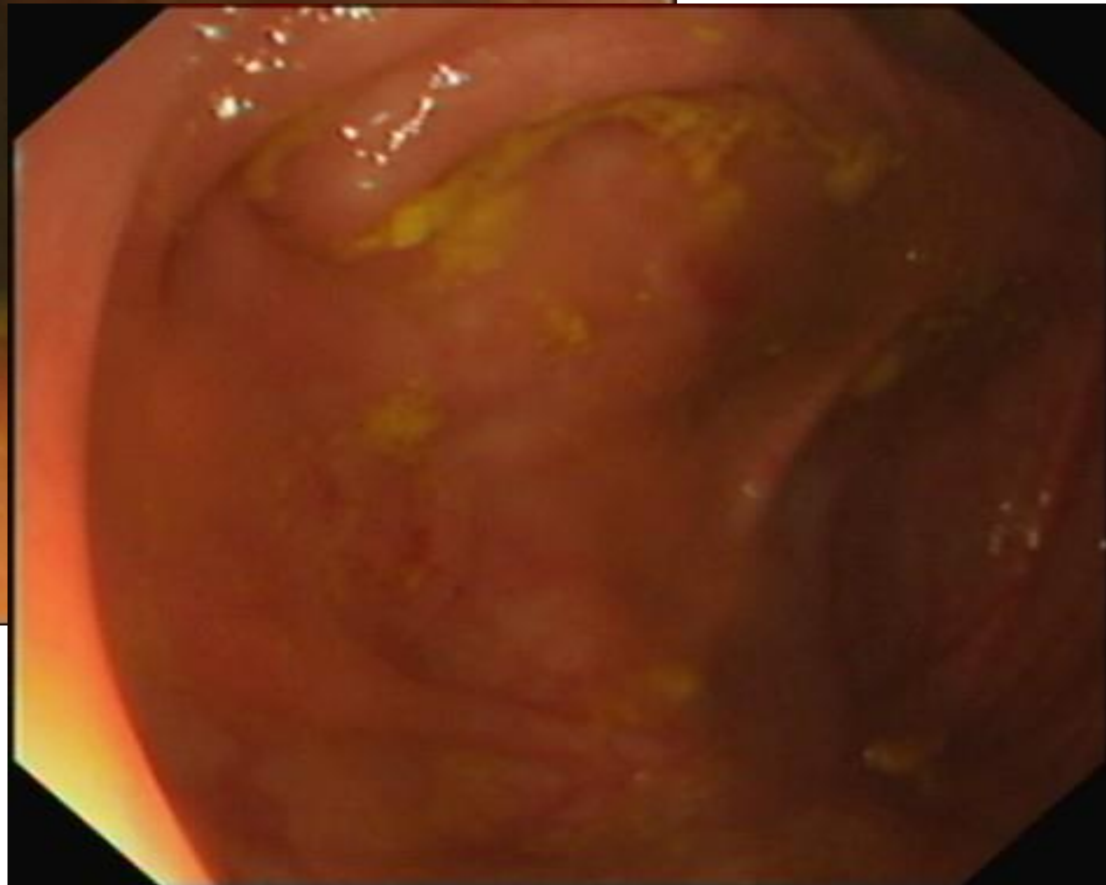
PC July 2014

- BO x 8, Bristol 7
- No blood, nil nocturnal
- Abdominal discomfort
- 48.5kg
- Off Infliximab
- (Azathioprine 100mg)
- Refusing colonoscopy
- Refusing dietetic support

- ESR 15, CRP 3
- Hb 135, Plt 554
- Faecal Calprotectin 269
- Normal capsule



Colonoscopy March 2015

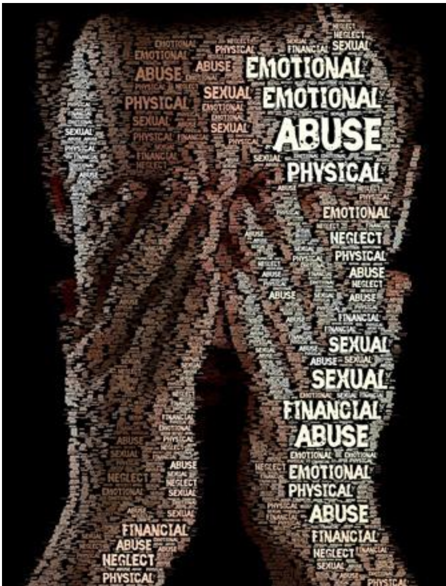




PC August 2015

- BO “hourly” despite restarting Infliximab 4/12 ago
- “A little depressed”
- Weight 35.6 kg

- Refusing Azathioprine
- Refusing admission
- Refusing endoscopy

- Dietician Review
  - “very upset that she was asked to see her”
  - “evasive about food intake”
  - “food goes straight through her, so why bother?



EMOTIONAL
EMOTIONAL
ABUSE
PHYSICAL
EMOTIONAL
NEGLECT
PHYSICAL
SEXUAL
SEXUAL
FINANCIAL
ABUSE
EMOTIONAL
PHYSICAL
ABUSE
FINANCIAL
NEGLECT

PC September 2015

- 39kg
- “Appears much brighter”
- “Working hard to increase weight”
- “Symptoms much improved”

Summary

- Make use of non-invasive tests
- Ignore negative inflammatory profiles if there is a high clinical index of suspicion
- Don't be afraid to add topical therapy if distal disease
- Look out for ↑symptoms with ↓ Prednisolone
- Be attuned to psychological distress in patients not responding to therapy

Iron Deficiency Anaemia

Stacey Ward

Capsule Endoscopy CNS

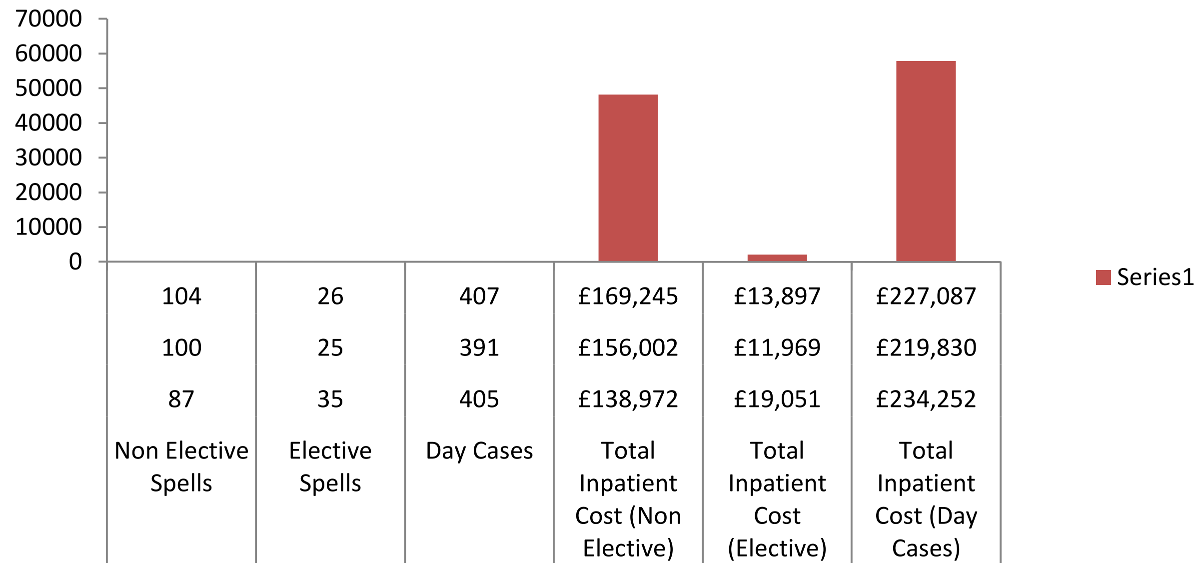
Disease Background

Iron Deficiency Anaemia (IDA) has a prevalence in 2-5% among adult men and post menopausal women in the developed world and is a common cause of referral to gastroenterologists (4-13% of referrals)

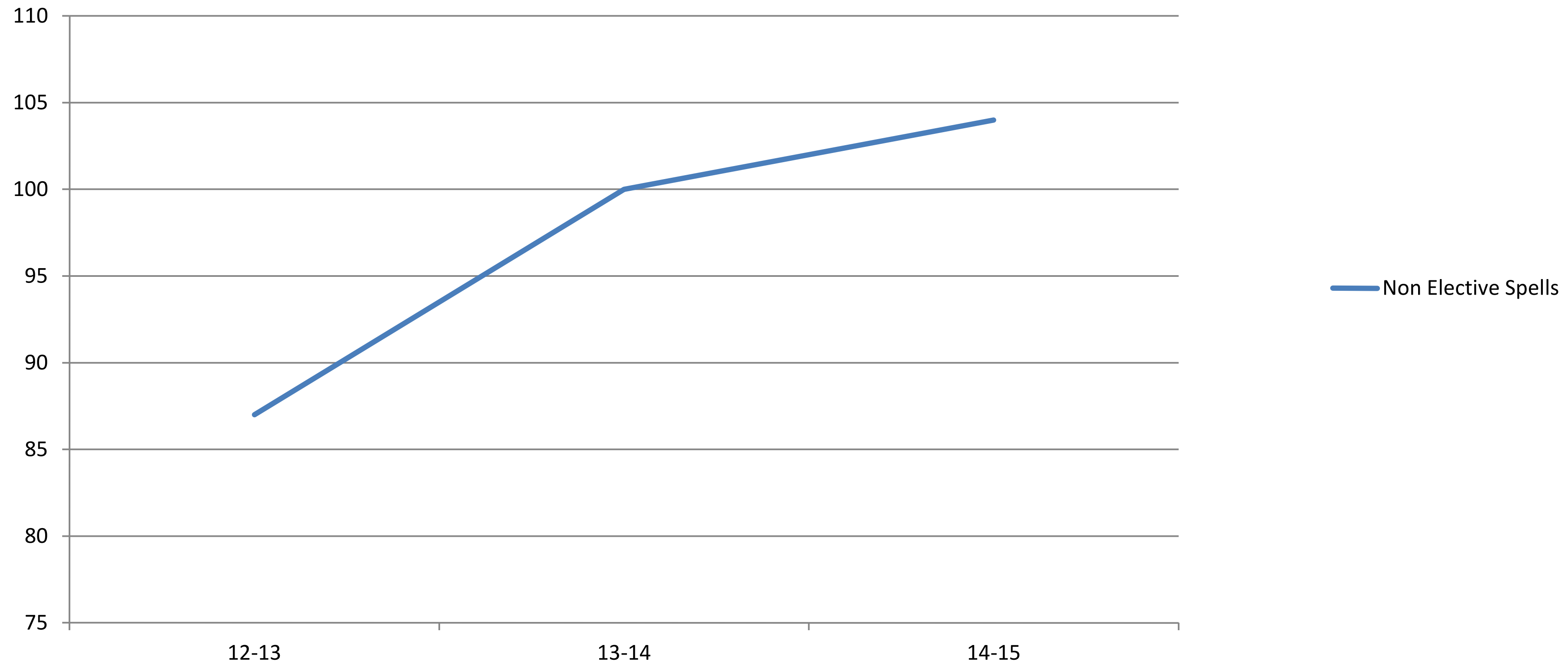
Identifying Iron Deficiency Anaemia

- Low Haemoglobin
- Low Ferritin
- Microcytosis
- Hypochromia

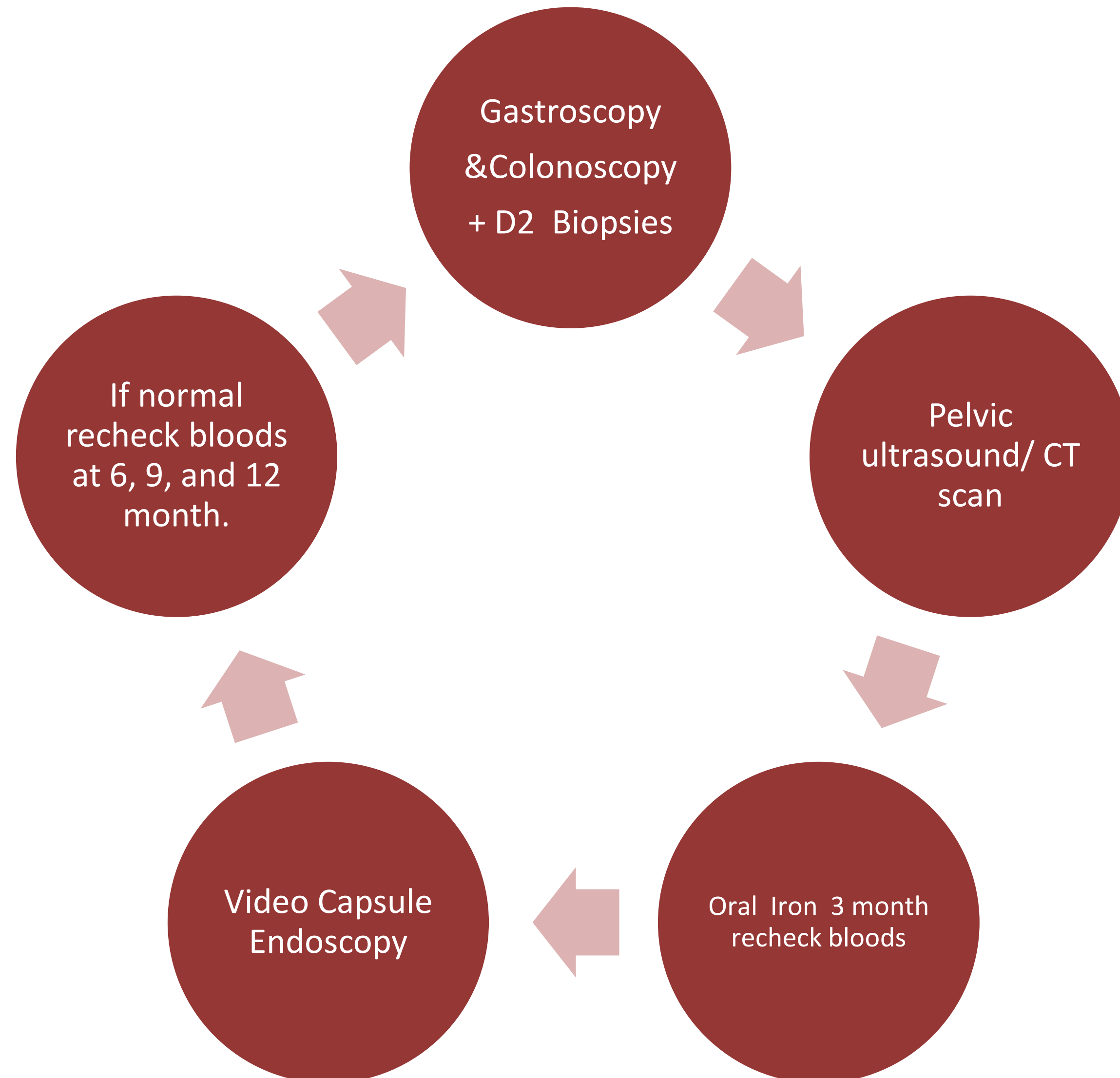
Cost to BDGH and the CCG



Non Elective Spells At BDGH



Pathway For Iron Deficiency Anaemia Patients



Benefits of a IDA Service

- A saving to the local Trust and the CCG.
- Partnership working with the CCG to proactively treat patients and prevent hospital admissions.
- A dedicated specialist nurse. For new and follow up patients.
- Centralised referrals with co-ordinated management pathway

Small Bowel Capsule Endoscopy

Stacey Ward

Capsule Endoscopy CNS

What is Capsule Endoscopy?

Definition:-

- Capsule endoscopy(CE) is a procedure that uses a tiny wireless camera to take pictures of the digestive tract

The Equipment

The Capsule

Real Time

Why do small bowel capsule endoscopy?

- Find the cause of obscure gastrointestinal bleeding. After normal gastroscopy/colonoscopy.
- Diagnose /assess inflammatory bowel disease
- Unexplained Iron Deficiency Anaemia.
- Coeliac disease.
- Screen for polyps.

Benefits to the patient

- The Capsule is easy to swallow.
- The procedure is non-invasive
- It is painless
- There is no potential harm from radiation
- Additional investigations can often be avoided.
- Gold standard for visualising the small bowel

Potential Risks

- Capsule endoscopy is a safe procedure that carries a few risks.
- Retention:-
- Routine Patient <1%
- Suspected IBD 1-4%
- Known Crohn’s 10%

Risks contd.

- Other factors – caution with NSAID's and previous bowel surgery

- Prevention:-
- Patency Capsule – We provide this service at BDGH.

What is a patency capsule?

- Same shape and dimensions as the real video capsule.
- Dissolvable after 30 hours.
- Detected by radiography
- If still detected further investigation such as CT or MRI is required.

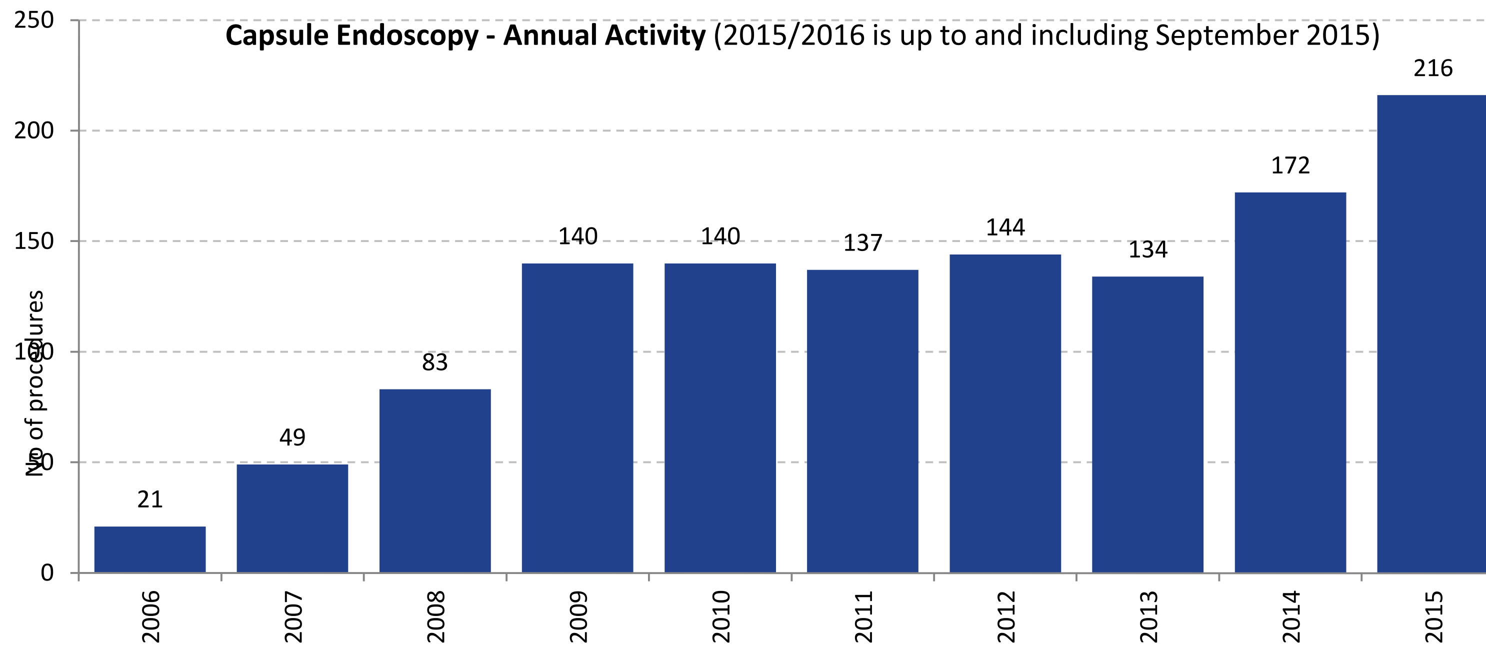
Why choose Barnsley?

- Dedicated Capsule team with over 10 years experience in capsule endoscopy.
- Short waiting times
- Short reporting times

The journey so far

- Capsule endoscopy service started 2005
- Service reviewed in 2014
- Improved patient satisfaction survey
- Quality of reports improved
- CNS appointed 2015
- Shortened turnaround time of capsule reports since CNS appointed
- Increased capacity

No. of procedures performed

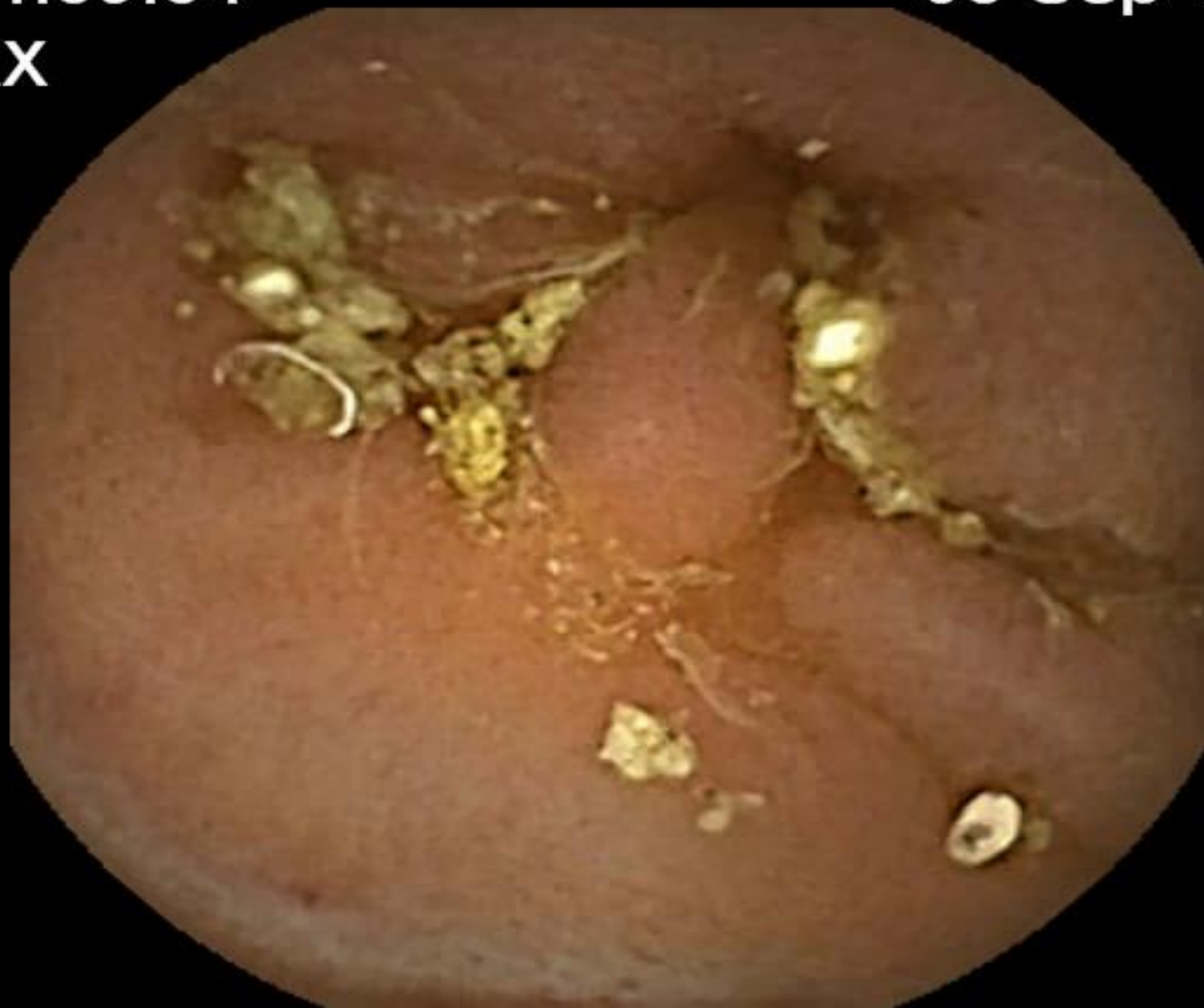


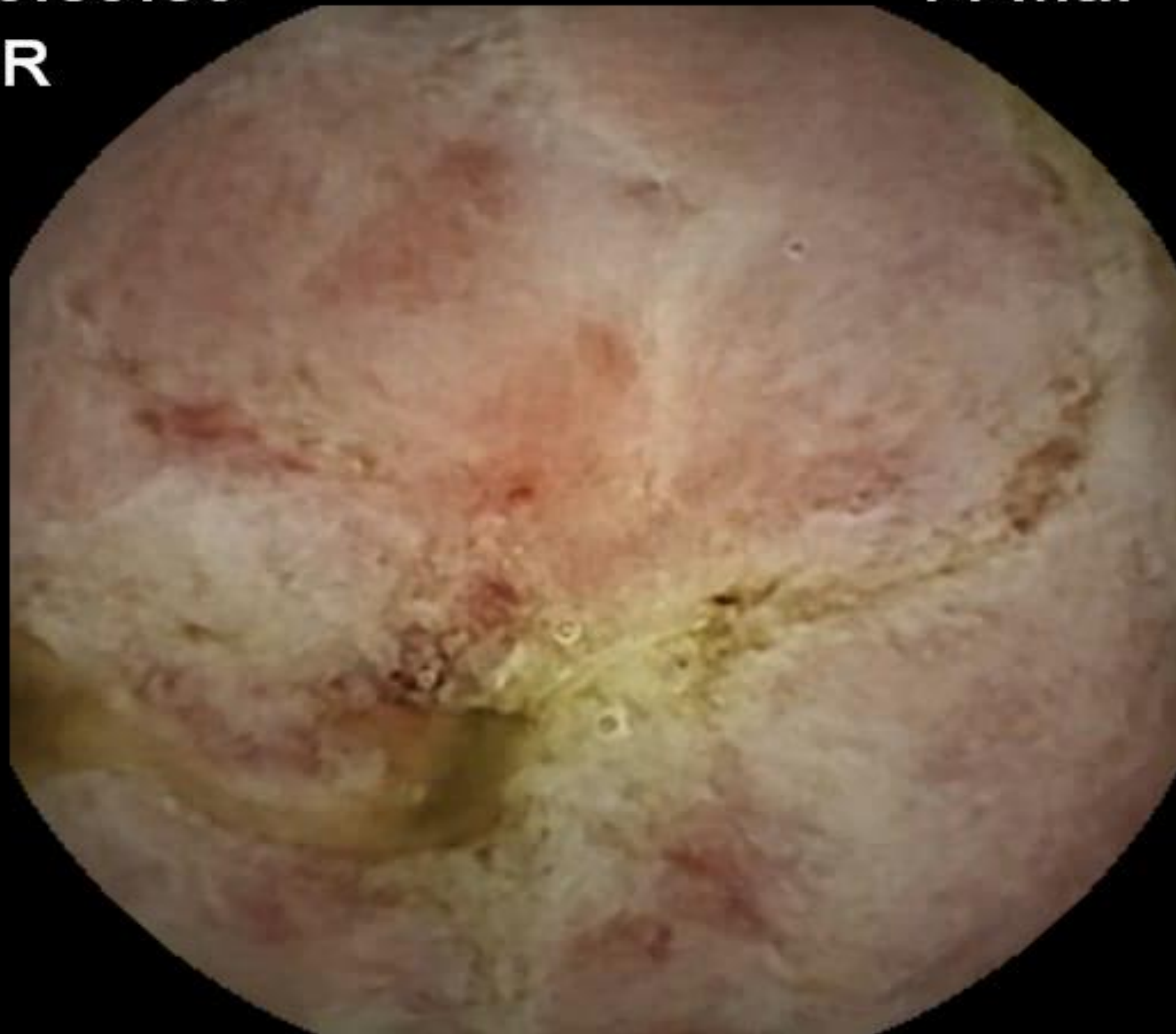
How to access the service?

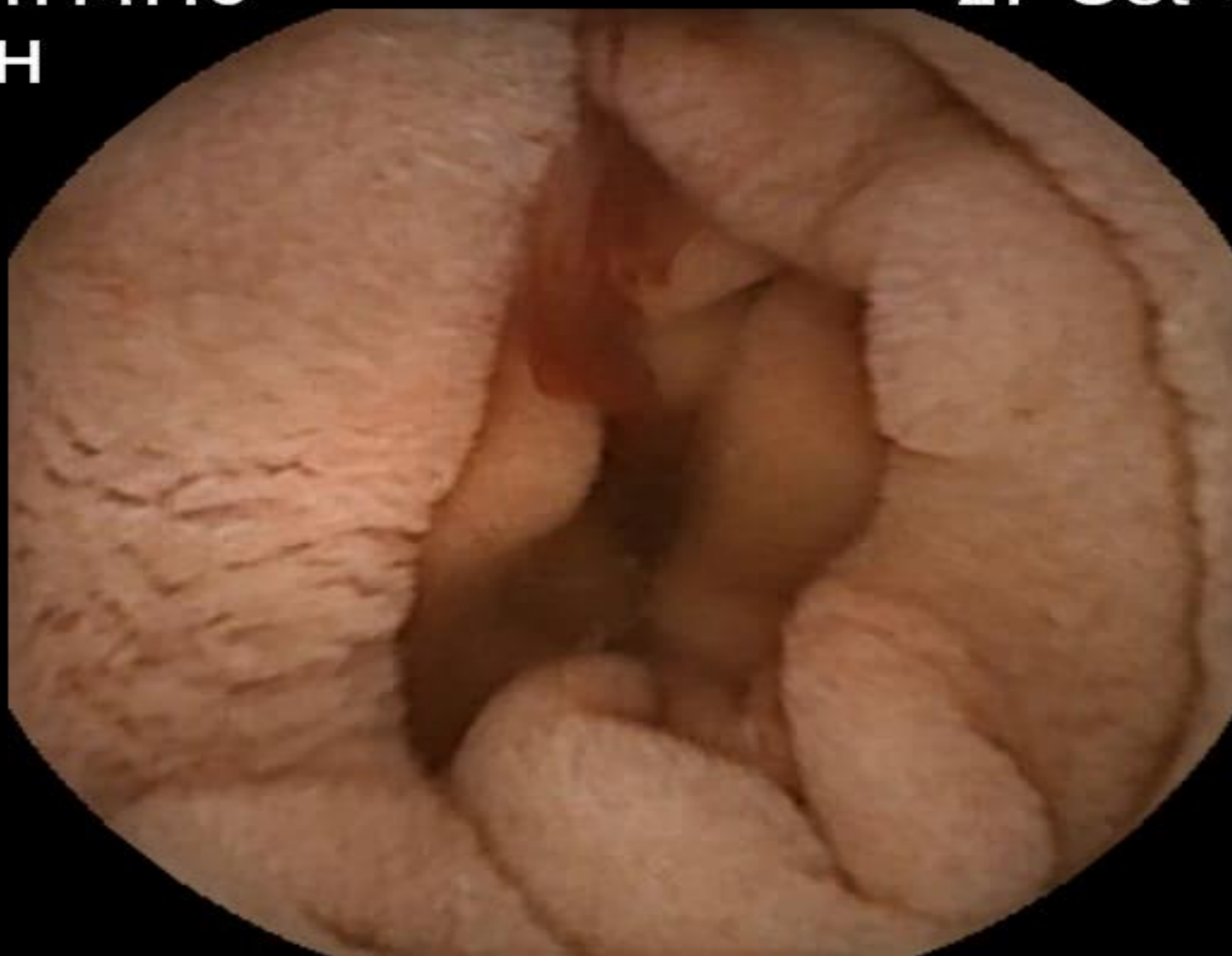
- Clinics (Iron Deficiency Anaemia Clinic)
- Endoscopy Coordinator
- Dr Kapur Or Stacey Ward Capsule Endoscopy Team.

The future……..

- To develop and expand the existing service.
- To introduce the colon capsule. This should be offered to patients that refuse colonoscopy, and patients that have inflammatory bowel disease for surveillance.

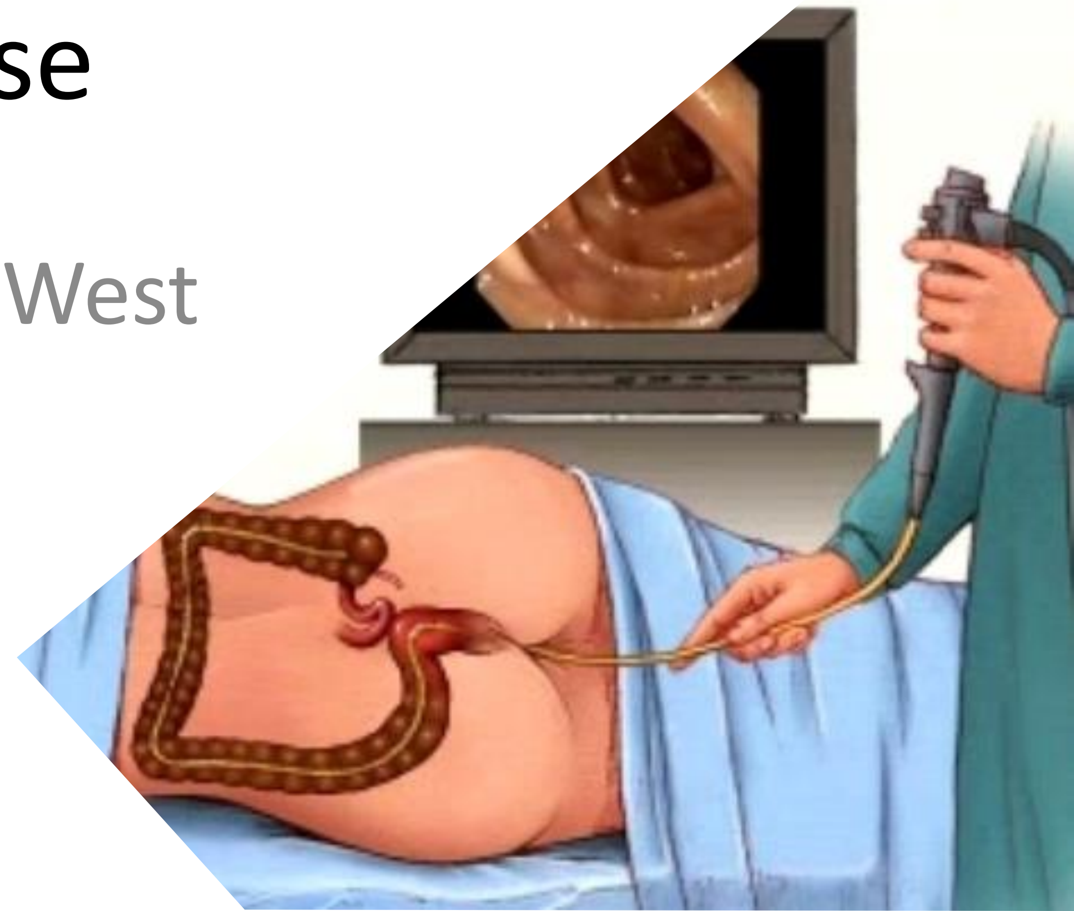

04:39:34
05 Sep 14
AX
PillCam® SB 3


06:59:50
14 Mar 14
DR
PillCam® SB 3


01:14:13
27 Oct 14
TH
PillCam® SB 3

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

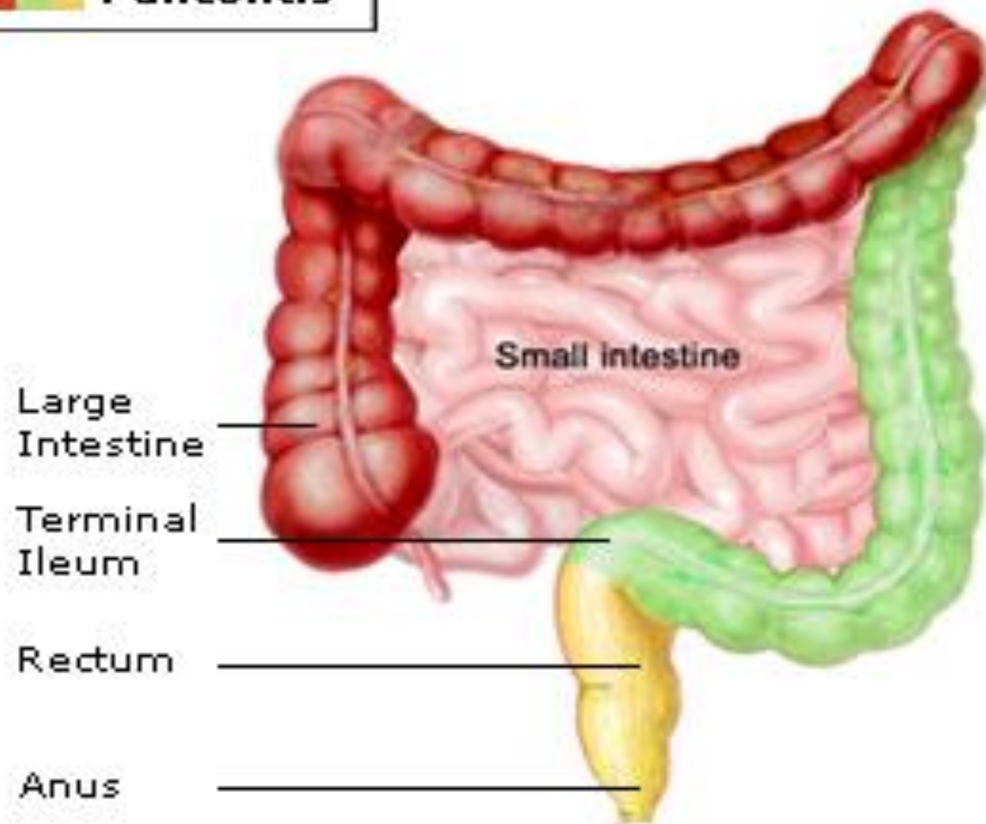
The Management of Left sided colitis

- 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
-

What is left sided colitis ?



Left sided 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 at10yrs

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 – Mesalasine suppositories 1gm for inducing remission and maintaining

Distal colitis – Mesalasine 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 , hepatoxicity and nephritis

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

Treatment options continued

•

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 mesalasine 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

Queisant 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

Shared Care

Dr. Kapil Kapur
Consultant Gastroenterologist
Barnsley Hospital NHS FT

Definition

- The joint participation of primary and secondary / specialist care physicians in the planned delivery of care supported by an adequate education programme and information exchange

Importance

- Main role is in the management of patients with a long term condition
- Currently more than 15 million people in the UK have a long term condition
- People with long-term conditions account for
  - 50-80% GP appointments
  - 64% hospital appointments
- Cost of providing care for this group of patients accounts for up to 70% of the total health care budget

Some long term conditions in gastroenterology

- Coeliac disease
- Barrett’s oesophagus
- NAFLD
- Autoimmune liver disease
- Alcoholic liver disease
- Inflammatory bowel disease
  - Ulcerative colitis
  - Crohn’s disease

Purpose of shared care

- Shared care is commonly used to improve the co-ordination of care and communication between primary and specialist care services for people with long term conditions

- Often involves a shift away from hospital care and the hospital based specialist

- A way to reduce the overall cost of care without any loss in quality and safety

Advantages of shared care

- Delivery of care closer to home
- QUIPP
- Personalisation
  - Health and care services tailored to needs of individual patients
- Reduced fragmentation of care with increased integration and improved continuity of care
- Stronger links between primary, secondary and tertiary care
- Improved patient and provider satisfaction
- More efficient use of scarce resources and improved cost effectiveness

Current shared care of gastroenterological conditions

- Patients who need treatment with Amber light drugs
  - Azathioprine, 6 Mercaptopurine, Methotrexate
- Inflammatory bowel disease
  - Ulcerative colitis
  - Crohn's disease
- Autoimmune liver disease
- Treatment is initiated in secondary care with follow - up prescribing in primary care

Options for managing long term conditions

- Long term hospital clinic follow-up
- Discharge into primary care
  - Clear guidelines about management
  - Monitoring and frequency of investigations
  - Surveillance e.g. for neoplasia
  - Criteria for re-referral to secondary care
- Annual hospital follow up
  - Outpatient
  - Virtual clinic
  - Clinician /CNS
- Shared care

(Active patient / carer involvement)

Uncomplicated Coeliac disease

- 35 year old with confirmed Coeliac disease I year ago
- Stable on Gluten free diet
- Normal TTG, Improved histology, normal bone density

- Annual follow-up (in surgery)
- Clinical parameters and weight
- TTG
- Dietary history
- Periodic bone density and suppliments as needed

Referral criteria for coeliac

- Weight loss
- New symptoms which do not resolve
  - Lymphoma, ulcerative jejunitis, PEI
- Issues with dietary compliance
- Lab abnormalities – TTG, Hb, etc

Uncomplicated IBD

- 45 year old patient who has left sided colitis 3 years ago
- Relapse free for more than a year
- Stable on medical treatment –5ASA
- Normal lab parameters and Calprotectin

- Regular review (in surgery)
- Monitor renal function-6-12 monthly
- Referral for surveillance colonoscopy after 10 years

Referral criteria for IBD

- Relapse which does not respond to treatment
- Recurrent relapses
- Steroid dependence
- Significant lab abnormalities
  - Hb, inflammatory markers, calprotectin
- New or red flag symptoms
- Symptoms to suggest acute complications

Uncomplicated Barrett's Oesophagus

- 68 year old patient with a 15 yr h/o reflux symptoms
- Endoscopy –hiatus hernia and 5 cm segment of Barrett's mucosa.
- Biopsies- confirm Barrett's, no dysplasia
- Asymptomatic on PPI, patient informed and educated

- Clinic discharge
- Maintain on PPI
- Surveillance endoscopy

Referral criteria for Barrett’s

- Worsening reflux symptoms or dyspepsia
- Dysphagia
- Red flag symptoms
- Endoscopic reassessment
- Concerns about possible neoplastic change

Examples of what is not suitable

- Coeliac
  - Refractory, Pancreatic insufficiency
- IBD
  - Immunomodulators, biologics
  - Strictures, fistulae, unstable disease, short bowel
- Barrett's oesophagus
  - Stricture
  - Significant oesophagitis

Advantages

- Care closer to home
- Avoids the need for hospital appointments
- Cost savings
- Reduced hospital waiting lists
- Shorter times to see new referrals
- Meets requirements for new to follow-up ratios

Disadvantages

- Lost to follow-up
- Increased work load for GP colleagues
- ? Potential for poor management
- ? Potential for missed complications
- Roles and responsibility

Concerns in secondary care

- Out of sight is out of mind
- Regular monitoring for side effects
- Regular monitoring for complications
- Early referral in case of problems
- Referral for surveillance procedures or investigations
- Regular CME for GP colleagues about concerned conditions

Concerns in primary care

- Increased burden of work
- Increased responsibility
- Be up to date with current treatment guidelines /CME
- Guidelines for surveillance
- Guidelines for re-referral
- Easy access to secondary care

For this to work

- Mandate from primary care
- Shared care agreements
- Identify suitable patients
- Clearly defined criteria for monitoring, review and re-referral
- Clear pathways for communication
- Understanding of roles and responsibilities
- Easy access
- Patient and carer involvement

Summary – shared care

- Good for overall patient care
- Not suitable for all conditions
- Requires active patient consent and involvement
- Requires good communication between primary and secondary care
- Requires quick and reliable fall back arrangements
- Should be subject to audit, governance and patient satisfaction surveys
- Can reduce the overall cost of health care

Mandatory requirements

- GPs need to be able to and willing to take on care
- The clinical responsibility of drug prescribing and it’s consequences rest with the person prescribing the medication
- GPs therefore need to be fully aware of the drugs and dosage prescribed, the monitoring necessary and dealing with side effects
- Excellent communication channels between primary and secondary care
- Explained and accepted by patient / carer

Responsibilities of secondary care

- Initiation and stabilisation of therapy (3-6 months)
- Notification to the GP that treatment has been commenced
- Baseline monitoring until the patient has been stabilised
- Patient / carer information and education
- Shared care arrangements in place
  - Request to GP to take over prescribing
  - Receipt of shared care documents
- Information about any dose changes
- Maintain good communication

Responsibilities of primary care

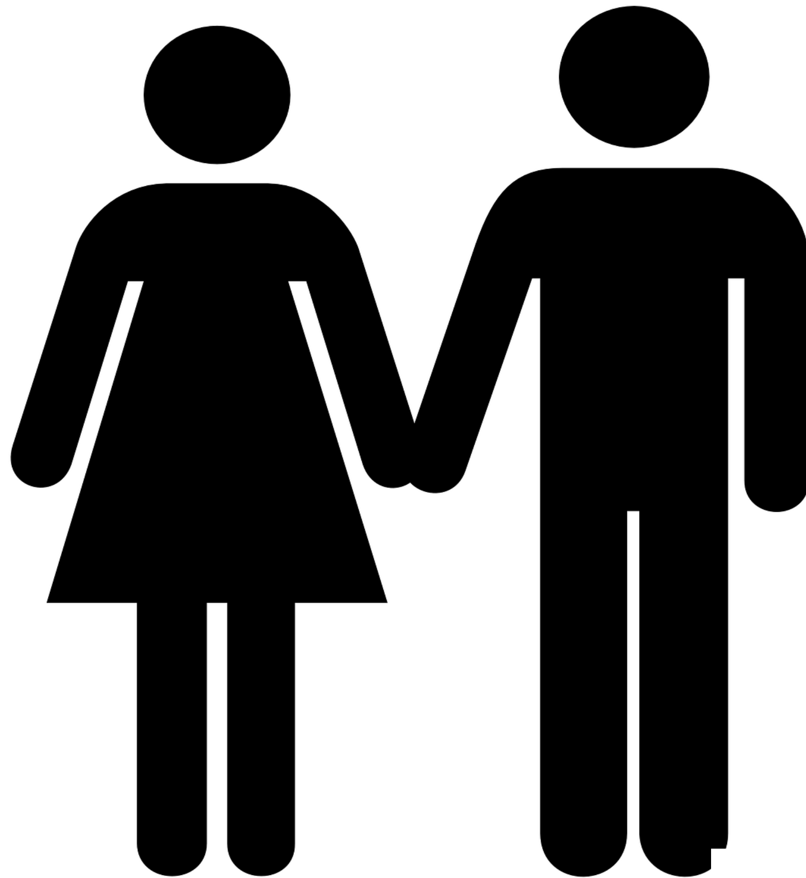
- Reply to the request for shared care
- Ensure shared care arrangements are in place
- Ensure and confirm in adequate information sheets and monitoring information along with timing of the needful is available
- Monitor treatment as stated in shared care protocol
- Confirm with specialists what changes should trigger urgent referral back
- Maintain good communication

Other requirements

- Contact details for immediate advice and support
  - Consultants
    - Telephone and email contacts
- Contact details for medicines information
  - Hospital pharmacy
- Out of hours contact information
- Information sheet with adequate guidance about the drug

B.E.S.T Event

Wednesday 20th January 2016



- **Sexually Transmitted Infections/HIV**
- **Domestic Abuse**
- **Cervical Screening**