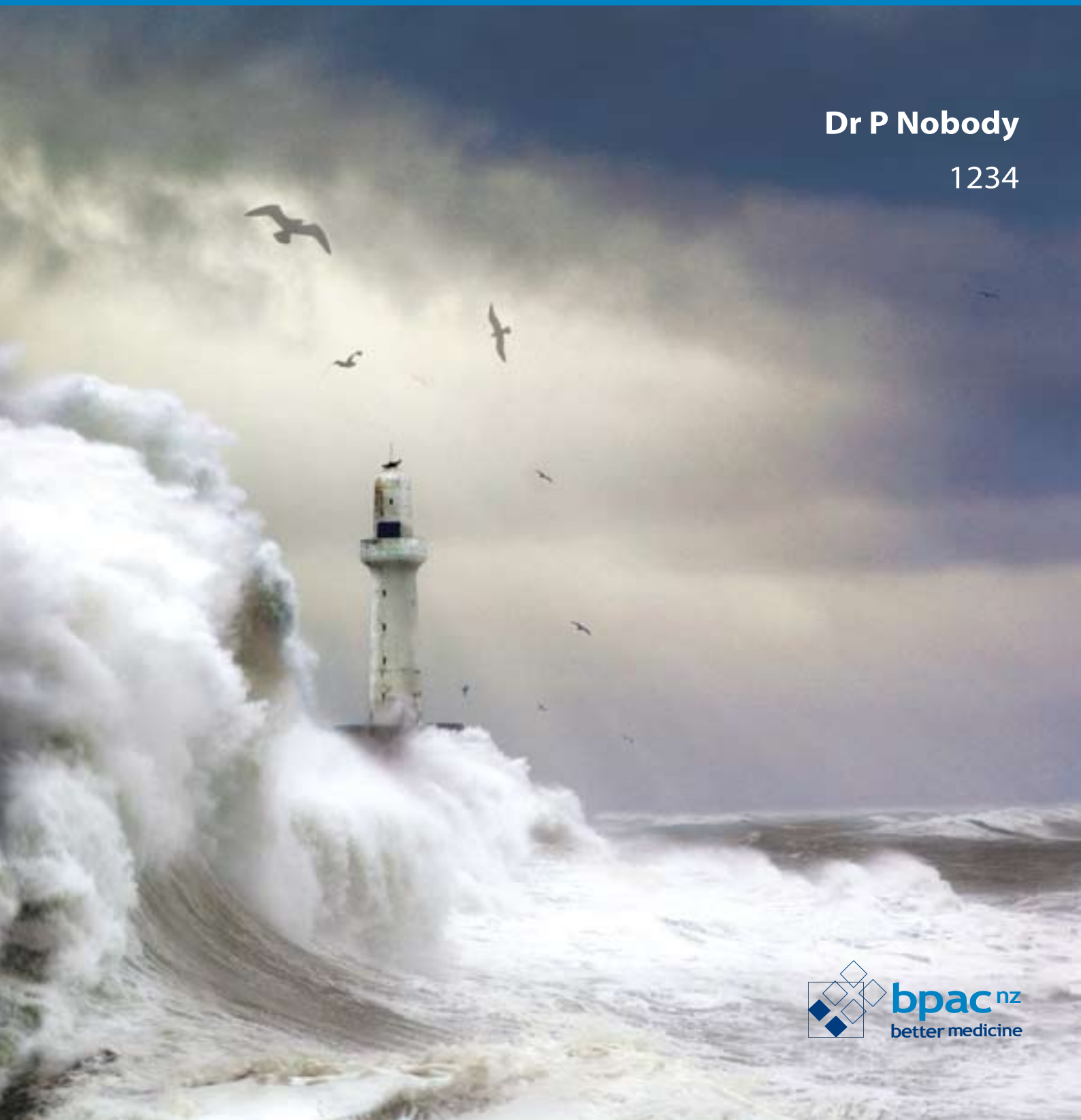
Quiz feedback:

Gastrointestinal conditions



Dr P Nobody

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Dear Dr Nobody

Thank you for responding to our Gastrointestinal conditions quiz. It covered four conditions that can be problematic in primary care and the results showed GPs understand the issues well.

We hope Best Practice Journal (9) was helpful to you. As always we would be pleased to have your comments, criticisms and correspondence.

Yours truly,

bpac team

Quiz feedback: Gastrointestinal conditions

1. Which of the following statement(s) are true about the clinical features of Irritable Bowel Syndrome (IBS)

	You	Your Peers	GP Panel
The abdominal pain or discomfort of IBS is frequently reported following meals		24%	
The abdominal pain or discomfort of IBS is usually improved with defaecation		94%	●
The prevalence of IBS is equal across genders		1%	
Tenderness in the left iliac fossa is a frequent finding in IBS		6%	
IBS cannot be diagnosed with confidence until a colonoscopy or barium study has ruled out colon cancer		6%	

GP panel

The panel and most respondents agree that the abdominal pain or discomfort of IBS is usually improved with defaecation. Pain that is not associated with bowel habit raises the possibility of other causes.

Panel members have noticed LIF tenderness in people with IBS, especially when constipation is the predominant symptom. Similarly, they are not surprised when a patient with IBS mentions pain or discomfort following meals but first think of upper GI causes.

A colonoscopy is not usually needed to make a diagnosis of IBS. Specialists may use this investigation often but they are seeing a selected sub-set of patients. GPs do not need to feel they need to organise a colonoscopy because that is what happens in specialist practice.

Screening colonoscopy for bowel cancer is best considered separately and should be recommended for those who fulfill the criteria as per the current NZGG recommendations.

Specialist comment

Diagnostic Criteria (Rome III) clearly state one of the key features of IBS is improvement in abdominal pain with defaecation. Studies have shown that sufferers of IBS do also report other symptoms and in particular upper gut symptoms but these are not diagnostic criteria.

The diagnostic criteria have been developed to allow confident diagnosis without resorting to invasive diagnostic procedures.

2. **Which of the following statement(s) about dietary interventions in IBS are true?**

	You	Your Peers	GP Panel
Alteration of fat intake is often useful		91%	●
Carbohydrate intolerance is common in people with IBS		9%	
Most patients with IBS will improve with increased dietary fibre		16%	
Food exclusion diets are often effective in IBS		13%	

GP panel

People with IBS have often tried dietary manipulations before visiting a doctor. Increasing fibre has often already been unsuccessful resulting in further increases in fibre intake. The panel find it useful to be able to reassure patients that although fibre works for some people, it does not work for the majority and there is no benefit in increasing further.

The panel feel that it is probably not widely known that reducing fat intake often helps and think this is a useful dietary intervention to offer patients

Specialist comment

Transient improvements in symptoms are often reported by IBS sufferers with a variety of dietary interventions. The role of diet in the causation and management of IBS is still not clear and is an ongoing area of research

Dietary interventions depend on the major symptom the patient presents. Fibre will help constipation but at least 30% of sufferers will not tolerate it

3. Which of the following statements are true about therapeutic intervention in IBS?

	You	Your Peers	GP Panel
NSAIDs are effective in IBS		<1%	
SSRIs reduce abdominal pain and bowel symptoms in people with IBS		7%	
Regular stimulant laxatives are useful for people with IBS and constipation		3%	
Regular soluble fibre laxatives decrease abdominal pain for people with IBS		23%	
Psychological therapies have good evidence of effectiveness in IBS		87%	●

GP panel

Although the panel are in no doubt about the importance of psychological support for people with IBS they are not entirely convinced about the quality of the evidence supporting more formal psychological interventions.

Soluble fibre laxatives are the medication of choice in primary care for IBS when constipation is the predominant symptom. However, although they help the constipation, they do not usually improve the abdominal pain.

Specialist comment

Preferred therapeutic intervention depends on the major symptom the patient presents with. Clinical trials have all demonstrated a large placebo response which translates to only a small therapeutic benefit from agents being tested. There is evidence supporting low dose tricyclic antidepressants for improvement in abdominal pain, but SSRI's do not have this effect.

The quality of studies of formal psychological interventions is variable. The studies are often small or in specialised patient groups e.g. tertiary referral centres.

4. **Which preparation(s) would be preferred for the treatment of constipation caused by opioid analgesics ?**

	You	Your Peers	GP Panel
Lactulose		8%	
Psyllium (e.g. Metamucil, Konsyl-D)		3%	
High fibre diet		4%	
Macrogols (Movicol)		6%	
Docusate sodum with sennosides (Coloxyl with Senna)		93%	●

GP panel

Most respondents and the panel chose the only stimulant laxative from the list of possible responses. Panel members note that hospices seemed to favour using both a stimulant and lactulose for people on opiates and asked our specialist reviewer to comment on the rationale behind this.

The panel are often surprised by how some people can put up with constipation before they see it as a problem. A daily struggle with a 'hard pellets' outcome may not be considered constipation. Not asking for a description of the bowel habit and the bowel motion can allow constipation to remain undiagnosed.

Specialist comment

Constipation secondary to opioid analgesia is very difficult to manage and will not usually respond to fibre supplementation alone. Peristaltic stimulants are usually required, possibly in combination with an osmotic laxative such as lactulose, and in practice this is what is commonly done. Movicol has recently been subsidised for chronic, resistant constipation so practice may change in view of this.

5. Which of the following drugs can cause constipation?

	You	Your Peers	GP Panel
Ondansetron (Zofran)		86%	●
Omeprazole		83%	●
Metoprolol		6%	
Oxybutinin (Dithropan)		94%	●
Ferrous sulphate (iron supplementation)		96%	●

GP panel

The panel agreed with respondents that metoprolol was the only medication on this list unlikely to cause constipation but commented: “Even placebos can cause constipation”.

Specialist comment

As a general rule, consider any therapeutic agent as a possible cause of constipation or change in bowel habit.

6. Which of the following statement(s) are true in regards to laxative use?

	You	Your Peers	GP Panel
Lactulose is unsuitable for use in diabetics		4%	
Docusate (coloxyl) has some stimulant activity		84%	●
Lactulose usually works within 24 hours		7%	
Phosphate enemas are suitable for hard impacted stools in the lower bowel		92%	●
Prolonged use of stimulant laxatives can lead to hypokalaemia		87%	●

GP panel

There appears to be good knowledge of the use of laxatives. Whenever the panel prescribes lactulose, they advise patients there may be a few days before effect. They do this so patients do not take additional doses when the initial dose has not worked within a few hours.

Specialist comment

Lactulose is not absorbed in the small intestine, so in theory is safe to use in a patient with diabetes as it will have a negligible effect on blood glucose levels. Lactulose has several possible mechanisms of action, apart from the simple osmotic effect in the colon. It will be fermented by colonic bacteria leading to production of short chain fatty acids which may have an effect on gut motility. This effect will occur with prolonged use.

Docusate does display some stimulant activity and prolonged use of stimulant drugs has been associated with hypokalemia. Hard impacted stools can be managed by phosphate enema.

7. Which of the following statement(s) are true about coeliac disease?

	You	Your Peers	GP Panel
There is a 10% risk of a first degree relative developing or having coeliac disease		96%	●
Once the diagnosis is made and the gluten free diet initiated, no further follow-up is required		2%	
Medication may be required to correct nutritional deficiencies		61%	●
There is an increased risk of other autoimmune conditions, osteoporosis and some malignancies		90%	●

GP panel

There is some uncertainty in the panel's minds about the persistence of nutritional deficiencies when a person with coeliac disease is on a gluten free diet. They are interested in John Wyeth's comment on this.

Specialist comment

Coeliac disease has been associated with diabetes and there is an increased risk of gastro-intestinal malignancy, especially small intestinal lymphoma. Once patients are established on a gluten free diet, regrowth of villi will occur to at least some degree with correction of any malabsorption. Initially vitamin and/or mineral supplements may be of benefit but long term use is not usually required.

Regular follow up is recommended to encourage adherence to diet.

Refractory coeliac disease, which is by definition villous atrophy persisting with clinical symptoms of malabsorption after six months of strict gluten withdrawal, is rare. Exception is diagnosis in an older female patient where there is an increased risk of osteoporosis.

Family members are at increased risk of developing coeliac disease and testing may reveal siblings with positive serology but normal duodenal biopsy, suggesting latent disease.

8. **Which of the following statement(s) about making a diagnosis of coeliac disease are true?**

	You	Your Peers	GP Panel
A diagnosis can be made by taking a comprehensive history of the presenting symptoms		6%	
A diagnosis can be made using serological testing		38%	
A diagnosis can be made by an endoscopic duodenal biopsy		98%	●
Negative serological results exclude a diagnosis of coeliac disease		2%	
Coeliac disease is uncommon and most GPs won't find people with undetected coeliac disease in their practice		1%	

GP panel

The panel welcome the flow chart summarising the pathway to the diagnosis of coeliac disease in general practice but note that often the patient calls the tune. Coeliac disease has received a lot of publicity recently and people thinking they may have coeliac disease often arrive armed with a list of tests they have downloaded from the internet or read about in a magazine. The panel is looking forward to John Wyeth's comments on this question.

Specialist comment

Coeliac disease is common and is under diagnosed. Diagnosis of coeliac disease can only be made by biopsy of the small intestine. A patient may have positive serology but not have the associated villous atrophy. These patients are almost certainly at greater risk of developing coeliac disease in the future. Conversely, negative serology could indicate adherence to a gluten free diet. In rare situations, use of tissue type markers is required to **exclude** coeliac disease.

Even though coeliac disease is common, most patients presenting with symptoms will not have coeliac disease. Many of these patients will have obtained information from a variety of sources and may have fixed ideas on diet and health. Symptoms they may describe will be from normal physiological reactions such as colonic fermentation with gas production. It is important to remember that a gluten free diet is a perfectly acceptable and balanced diet and it is reasonable for a patient to choose to exclude gluten from their diet even if objective tests for coeliac disease are negative. The critical issue is maintaining a balanced diet.

9. **Which of the following statement(s) about lactose intolerance are true?**

	You	Your Peers	GP Panel
People with lactose intolerance are allergic to milk		1%	
Lactase deficiency always results in lactose intolerance		13%	
Vomiting is a strong feature of lactose intolerance		1%	
In lactose intolerance, all lactose-containing products should be eliminated from the diet		7%	
People with lactose intolerance should be encouraged to gradually and regularly increase their intake of milk		92%	●

GP panel

People with lactose intolerance can tolerate some lactose in their diet, especially in yoghurt and cheese.

Advising patients that gradual reintroduction of milk usually improves tolerance and symptoms is a useful intervention.

Specialist comment

Lactose deficiency is an inability to digest lactose, not an allergy. It is relative and many people with lactose deficiency can ingest lactose without symptoms developing. Symptoms from lactose intolerance are from events in the colon, including bacterial fermentation and an osmotic laxative effect.

10. **Which statements about secondary (acquired) lactose intolerance are true?**

	You	Your Peers	GP Panel
Gastrointestinal illness may result in lactose intolerance		97%	●
Milk should never be given to children with infectious diarrhoea		3%	
Lactose intolerance needs to be resolved before the primary illness is treated		3%	
Once secondary lactose intolerance occurs, it is a lifetime condition		1%	
Some antibiotics may cause secondary lactose intolerance		73%	●

GP panel

Secondary lactose intolerance associated with antibiotic use is a possibility worth considering when people present with post-antibiotic diarrhoea. This resolves spontaneously within days/weeks.

Specialist comment

Secondary lactose intolerance is related to a number of GI diseases, infections and drugs. It is usually transient. In children with infectious diarrhoea, giving milk may worsen their symptoms but otherwise is not contraindicated.

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