

# Abstracts: Gastroenterology symposium 2007

## SESSION I EVERY-DAY PRACTICAL DILEMMAS

Chair: Dr Deepak Dwarakanath, Consultant Gastroenterologist, University Hospital of North Tees, Stockton, England, UK

### *Iron deficiency anaemia – who and how to investigate?*

Dr John Morris, Consultant Gastroenterologist, Royal Infirmary, Glasgow, Scotland, UK  
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**Background** Iron deficiency anaemia (IDA) is a common presentation in primary care with an estimated prevalence of 5–15% in the adult population in the UK.<sup>1</sup> Referral guidelines have identified IDA as a potential marker for gastrointestinal malignancy and therefore this is identified as a reason for urgent referral for diagnostic evaluation.<sup>2</sup> The British Society of Gastroenterology has recommended the importance of establishing iron deficiency as the cause of anaemia and excluding coeliac disease. Despite the link between iron deficiency anaemia and possible cancer, considerable and multifactorial referral selection still occurs in primary care.<sup>3</sup> Endoscopic evaluation of the upper and lower GI tract are the methods of choice in investigating IDA, but despite this the overall diagnostic yield is still only approximately 50% with these modalities.<sup>4</sup> The optimum management strategy in patients with unexplained IDA after bidirectional endoscopy remains to be fully defined. Small bowel enteroscopy and wireless capsule endoscopy offer considerable additional diagnostic potential and should be considered in patients who have recurrent anaemia or remain transfusion dependent.

### *Conclusions*

1. IDA is common in the general population and referral for investigation to exclude GI malignancy is recommended.
2. Bidirectional endoscopic evaluation of the GI tract should follow confirmation of iron deficiency indices and exclusion of coeliac disease.
3. A significant proportion of patients will have no explanation for IDA after initial evaluation and small bowel sources of blood loss should be excluded if anaemia persists.

### *References*

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- 2 National Institute for Clinical Excellence. *NICE Guideline 2005 Referral for Suspected Cancer*
- 3 Yates JM *et al.* Iron deficiency anaemia in general practice: clinical outcomes over three years and factors influencing diagnostic investigations. *Postgrad Med J* 2004; **80**:405–10

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**Keywords:** Iron deficiency anaemia, referral guidelines, gastrointestinal cancer, endoscopy, colonoscopy, capsule endoscopy

**Sponsorship:** none.

**Declaration:** The author provides consultancy services to Ferring and Schering Plough and has research interest in Given Imaging and Olympus (Keymed).

### *To PEG or not to PEG*

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**Background** When patients lack capacity and are unable or unwilling to take sufficient quantity of food by mouth, the decision as to whether PEG feeding should be initiated poses difficult clinical and ethical questions.

**Method or theme** The NCEPOD report (2004)<sup>1</sup> suggested that many PEG insertions are futile, that many patients do not have the benefit of assessment by a multidisciplinary team, and that deaths occur because PEG insertion is performed when they have an active chest infection. Two audits of PEG insertion performed in northern England show a 45% decrease in the number of PEG insertions following publication of the NCEPOD report, along with a decrease in the 28-day mortality from 15.8% to 6.9%.<sup>2</sup>

Three cases are presented that explore the decision-making process and its ethical implications.

PEG tube feeding in patients lacking capacity involves a judgment as to whether its benefits are likely to outweigh the risk of complications and the burden that PEG feeding would place upon them.

**Conclusions** There is a strong presumption that the prolongation of a patient's life is in their best interests, although for some patients, the quality of life may be so intolerably poor that the additional burden of PEG feeding would not be in their best interests, even though it might prolong their life.

### *References*

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- 2 Maitra S, White S, Torrance A *et al.* Fall in PEG insertion rate in northern England following NCEPOD. *Gut* 2007; **56** (suppl 2):A138; Abs 425

**Keywords:** PEG feeding, mental capacity, best interests

**Sponsorship:** none.

**Declaration:** No conflict of interests.

### Irritable Bowel Syndrome – how can we help?

Professor Mike Ford, Consultant Gastroenterologist, Western General Hospital, Edinburgh, Scotland, UK

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**Definition** The irritable bowel syndrome (IBS) is a constellation of bowel symptoms, including abdominal pain or discomfort and altered bowel habit for which no underlying structural or biochemical cause can be found. Explicit criteria for the diagnosis of IBS were agreed by an international working team in Rome in 1988 (hence the 'Rome Criteria') and subsequently refined (Rome III 2006) – see [www.romecriteria.org](http://www.romecriteria.org).

#### 'Rome III criteria' for IBS

Recurrent abdominal pain or discomfort on at least three days per week in the last three months associated with at least two of the following three criteria:

- Pain relieved by defecation
- Onset associated with altered stool frequency (<3/week or >3/day)
- Onset associated with altered stool form (lumpy, hard, loose, watery)

Clinical manifestations

Psychosocial aspects

Diagnosis and investigation

How can we help?

Drug treatment

Antidiarrhoeal agents

Pain modifying agents

Non-pharmacological approaches

Cognitive behaviour therapy (CBT)

Relaxation therapy – hypnotherapy

Prognosis

#### References

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**Sponsorship:** none.

**Declaration:** No conflict of interests.

## SESSION 2 ACUTE BLEEDING

Chair: Professor Roger Barton, Professor of Clinical Medicine, University of Newcastle Faculty of Medicine, England, UK

#### Variceal bleeding

Dr David Westaby, Consultant Gastroenterologist and Director of Endoscopic Services, Hammersmith Hospital, London, England, UK

No abstract provided.

#### Alcoholic hepatitis

Professor Ian Gilmore, President, Royal College of Physicians of London, England, UK

No abstract provided.

## SESSION 3 ENDOSCOPIC SAFETY AND DEVELOPMENT

Chair: Dr Kelvin Palmer, Consultant Gastroenterologist, Western General Hospital, Edinburgh, Scotland, UK

#### What can and does go wrong in Endoscopy Units – NCEPOD

Dr Jonathan Green, Consultant Gastroenterologist, City General Hospital, Stoke on Trent, England, UK

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**Background** Approximately one million GI endoscopies are performed in the UK each year, and year by year an increasing proportion of these examinations is therapeutic. In 2004, NCEPOD published a study on therapeutic endoscopy entitled *Scoping our practice (2004)*.<sup>1</sup> This report contains serious criticisms of the then current state of UK therapeutic endoscopy.

**Methods or theme** The NCEPOD report, its methods and findings will be examined in detail to assess their validity. This will be by cross-referencing with other studies of endoscopy.

It will be found that many of the more serious conclusions of the NCEPOD report had some basis in reality but, because of methodology, over-stated the size of the problem. Notwithstanding this, many valid messages remain.

**Conclusions** Adverse events during and after GI endoscopic procedures are intrinsic to the process, but much more can be done to minimise these. Those requesting and performing endoscopy need continuous awareness that these invasive procedures can cause harm. A great deal has been done to reduce the potential for harm, but there is no basis for complacency. The single most important way of reducing harm is to ensure that every procedure that is performed is indicated and needed.

1 NCEPOD *Scoping our practice (2004)*. BSG audit of ERCP: Williams EJ *et al.* Are we meeting the standards set for endoscopy? Results of a large-scale prospective survey of endoscopic retrograde cholangio-pancreatograph practice. *Gut* 2007; **56**: 821–9

**Keywords:** NCEPOD, endoscopy complications, ERCP audit  
**Sponsorship:** none.  
**Declaration:** No conflict of interests.

### **Bowel cancer screening – why and how?**

Dr Edwin Swarbrick, Consultant Gastroenterologist, New Cross Hospital, Wolverhampton, England, UK

#### **Why?**

- 36,000 people are diagnosed as having bowel cancer annually and 16,000 die from the disease. This compares with an annual incidence from breast cancer of 44,600 and a mortality of 12,000.
- Most bowel cancers start as adenomatous polyps that grow, become dysplastic, then frankly malignant, invade the bowel wall and finally metastasise.
- Most symptomatic cancers are incurable, but if they can be removed before invasion of the bowel wall, a 95% cure can be achieved. Removing benign, adenomatous polyps significantly reduces the risk of cancer.
- There is clear evidence from clinical trials that such a strategy will reduce mortality.

#### **How?**

- Colonoscopy is the gold standard for visualisation of the whole colon and enables histological diagnosis and the removal of polyps. Sensitivity is operator-dependant and it is an uncomfortable, labour-intensive, technical and potentially hazardous procedure. Complications arise from missing lesions, causing bleeding, perforation and, rarely, death. Currently there is not the capacity within the NHS to offer colonoscopy screening for all asymptomatic individuals within the target population aged 50–75.
- The detection of occult blood in the stool sample is a marker of malignancy and controlled trials have shown that occult blood testing in combination with flexible sigmoidoscopy, colonoscopy or barium enema can detect asymptomatic cancer and lead to the reduction of mortality in about 16%.
- In a pilot study of occult blood detection in stool, followed by colonoscopy, if positive, in 478,250 participants, the overall uptake, number of positive test results, the positive predictive value of FOB and the distribution of stage of screen-detected cancers were comparable with the results from the Nottingham Trial. These results suggest that a national programme is not only feasible but should lead to a reduction in mortality from bowel cancer.
- As a result, the National Bowel Cancer Screening Programme in England was started in 2006. Over three years, five regional hubs for occult blood testing will link to 60 Bowel Cancer Screening Centres serving populations of between 0.5 and 2 million people.
- To achieve quality and safety, an intensive programme of training in colonoscopy, the achievement of high standard of endoscopy practice, the inspection of units and the accreditation of colonoscopists has been developed over five years.

**Keywords:** Epidemiology of colorectal cancer, the Bowel Cancer Screening Project  
**Sponsorship:** none.  
**Declaration:** No conflict of interests.

## **SESSION 4 FUTURE PROBLEMS?**

Chair: Dr Steven Masson, Specialist Registrar in Gastroenterology, Freeman Hospital, Newcastle-upon-Tyne, England, UK

### **Adolescents with Crohn's disease – are we failing them?**

DC Wilson, PM Gillett, RK Russell, J VanLimbergen, J Satsangi, Child Life and Health, University of Edinburgh, and Department of Paediatric Gastroenterology and Nutrition, Royal Hospital for Sick Children, Edinburgh; Gastrointestinal Unit and Molecular Medicine Centre, University of Edinburgh, Edinburgh, Scotland, UK  
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**Background** Crohn's disease most usually evolves during adolescence, a time of great challenge due to the need for growth, pubertal development and educational attainment, together with the ability to establish self-esteem and peer relationships.

**Methods** Themes for this presentation have been developed from my previous training in paediatric IBD in the largest North American centre (Toronto), together with day-to-day work with the now 240 children and adolescents we have looked after with IBD in southeast Scotland over the past 10 years. This has been supplemented by experience as a member and ex-chair of the IBD working group of the British Society of Paediatric Gastroenterology, Hepatology and Nutrition.

#### Themes

Assessment of IBD – for the adolescent, the disease should be thoroughly assessed by upper GI endoscopy and ileo-colonoscopy with relevant radiological examination, preferably performed under general anaesthetic or conscious sedation. This will enable determination of diagnosis of IBD, sub-type of IBD and extent of IBD. We have shown the sigmoidoscopy examination in this population leads to delay in diagnosis, as well as traumatising vulnerable adolescents. Growth, pubertal staging (Tanner staging), and the effect of disease on academic and social functioning must also be explored.

Treatment – We use exclusive enteral nutrition rather than corticosteroids for the induction of remission, and have early recourse to immunomodulation with Azathioprine (and Methotrexate for Azathioprine intolerance or non-response) unless remission is rapidly attained and maintained. Close collaboration with paediatric and colorectal surgeons is needed. Adolescents need higher relative drug doses than the literature suggests for adult patients.

Transition – transition clinics are vital for the adolescent.

**Conclusions** Adolescents with Crohn's disease must be looked after either completely or in shared care with a paediatric gastroenterology multidisciplinary team. This allows appropriate addressing of issues such as growth, puberty, social function, education and use of steroid-sparing nutritional therapies.

**Keywords** IBD, paediatrics, assessment, growth, puberty, treatment

**Declaration** The first author has a current specific research interest in INFORM – infant feeding consultancy and a lapsed non-personal/non-specific research interest in Elan Pharmaceuticals – Natalizumab trial.

#### Fatty liver – a large problem – who, when and why investigate?

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Incidence of cirrhosis due to both alcoholic liver disease and those unrelated to alcohol has increased during the last decade in the UK. With an estimated prevalence of 20–25%, non-alcoholic fatty liver disease (NAFLD) is the most common chronic liver disease in the western countries. Even if a small proportion of these developed cirrhosis, it will account for a substantial burden on health service. While it has been well established that metabolic syndrome is a risk factor for the development of NAFLD and its progression to non-alcoholic steatohepatitis (NASH), mounting evidence suggests that hepatic insulin resistance perpetuates and may even precede peripheral insulin resistance. Hence, simple measurement of liver enzymes may be useful to predict future development of diabetes. Clinical and epidemiological studies also indicate that NAFLD is a risk factor for cardiovascular disease independent of other confounders.

In the long term, NAFLD appears to be associated increased liver related morbidity and mortality as well as cardiovascular events. Therefore, clinical management of metabolic syndrome should include detection of NAFLD, assessment of its severity and specific interventions that reduce the severity of liver disease. Algorithms using simple clinical parameters and measurements of serum markers that accurately estimate the severity of NAFLD will soon be available for clinical use. Insulin sensitising, anti-inflammatory and anti-fibrotic properties of thiazolidinediones make them effective in the treatment of NASH.

#### References

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**Keywords:** Non-alcoholic fatty liver disease, cirrhosis, metabolic syndrome, insulin sensitizers, thiazolidinediones  
**Declaration** Takida, UK supplied pioglitazone and placebo for the investigator initiated randomised controlled trial.