Change in bowel habit

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Chelsea & Westminster Hospital
Case history 1

- Sarah, 23 y medical student
- 6 y bowel frequency 6 x/d, urgency
- Stool consistency Bristol scale 6 or 7
- No weight loss, rectal bleeding
- Investigated @ Nottingham Uni 4 y ago
  - Diagnosed IBS, discharged
- Normal “bloods” now
- Refer urgently? Routinely? Rx IBS?
THE BRISTOL STOOL TART
CG27 (NICE 2005)

• URGENT REFERRAL IN THE FOLLOWING:
  – > 40 years: > 6 weeks rectal bleeding WITH looser stools &/or increased stool frequency
  – > 60 years: > 6 weeks rectal bleeding OR looser stools &/or increased stool frequency
  – Right lower abdominal mass
  – Palpable rectal mass
  – Men with unexplained iron deficiency anaemia and a haemoglobin < 110 g/L
  – Non-menstruating women with unexplained iron deficiency anaemia and a haemoglobin < 100 g/L

Adapted from NICE (June 2005). CG27. Referral Guidelines for Suspected Cancer
Case history 2

- Fred, 62 y oil worker
- Rectal bleed 12/12 ago – defaulted Ix
- 3/12 constipation and tenesmus
- No new “red flags”
  - No bleeding, weight loss, anaemia; normal PR
- Unexplained iron deficiency
- Refer urgently? Routinely? Rx IBS?
Iron deficiency in the elderly

- 151 consecutive elderly patients with iron deficiency
- Cancer most common colonic lesion
  - Of those, 11 of 18 asymptomatic
- Synchronous upper & lower GI lesions present

<table>
<thead>
<tr>
<th></th>
<th>Anaemic</th>
<th>Iron deficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper GI lesion (%)</td>
<td>49</td>
<td>56</td>
</tr>
<tr>
<td>Lower GI lesion (%)</td>
<td>32</td>
<td>16</td>
</tr>
</tbody>
</table>

Case history 3

- Tyler, 67 y retired plumber
- Fatigue over 3/12
- Vague abdominal pains
- Looser motions
- Hb 80 g/L, MCV 77 fL
- Family history sickle cell disease
- Refer urgently? Routinely? Rx IBS?
All patients with symptoms that could be due to colorectal cancer, particularly rectal bleeding or a recently-established change to looser and/or more frequent motions, should have rapid access to colonoscopy or flexible sigmoidoscopy and any further procedures that may be necessary to reach a diagnosis.
CG27 (NICE 2005)

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Adapted from NICE (June 2005). CG27. Referral Guidelines for Suspected Cancer
Colorectal Cancer Incidence
According to Race in the US

- Currently highest incidence in African Americans
- Incidence ↓: Caucasian > Asian Pacific Islander > Hispanic > American Indian

Colorectal Cancer Death According to Race in US

- Death rate correlates with incidence rate
- Rate ↓ less in black patients
- Asian Pacific Islander, Hispanic and American Indians = similar death rate

Case history 4

- Patience, 62 y executive
- “Loose” motions for past 7 weeks
- No other symptoms
- Normal blood tests
- No relevant family history
- Stress at work

• Refer urgently? Routinely? Rx IBS?
## Risk Factors for CRC

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>9 out of 10 cases are over 50 years old</td>
</tr>
<tr>
<td>History of polyps</td>
<td>↑ risk if large size, high frequency, or specific types</td>
</tr>
<tr>
<td>History of bowel disease</td>
<td>Ulcerative colitis and Crohn’s disease (IBDs) ↑ risk</td>
</tr>
<tr>
<td>Certain hereditary family syndromes</td>
<td>Having a family history of familial adenomatous polyposis or hereditary nonpolyposis colon cancer (Lynch Syndrome) ↑ risk</td>
</tr>
<tr>
<td>Family history (excluding syndromes)</td>
<td>Close relatives with colon cancer ↑ risk esp. if before 60 years (degree of relatedness and # of affected relatives is important)</td>
</tr>
<tr>
<td>Other cancers and their treatments</td>
<td>Testicular cancer survivors ↑ risk</td>
</tr>
<tr>
<td>Race</td>
<td>African Americans are at ↑ risk</td>
</tr>
<tr>
<td>Ethnic background</td>
<td>Ashkenazi Jew descent ↑ risk due to specific genetic factors</td>
</tr>
</tbody>
</table>
## Risk Factors (cont’d)

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diet</td>
<td>High in fat, especially animal fat, red meats and processed meats ↑ risk</td>
</tr>
<tr>
<td>Lack of exercise</td>
<td>↑ risk</td>
</tr>
<tr>
<td>Overweight</td>
<td>↑ risk of incidence and death</td>
</tr>
<tr>
<td>Smoking</td>
<td>-↑ risk of incidence and death</td>
</tr>
<tr>
<td></td>
<td>-30-40% more likely to die of colorectal cancer</td>
</tr>
<tr>
<td>Alcohol</td>
<td>Heavy use of alcohol ↑ risk</td>
</tr>
<tr>
<td>Diabetes</td>
<td>30% ↑ risk of incidence and ↑ death rate</td>
</tr>
<tr>
<td>Night shift work</td>
<td>More research is needed but over time may ↑ risk</td>
</tr>
</tbody>
</table>
Case history 5

- Samuel, 23 y clerk
- Bloating and tenesmus
- Occasional rectal bleeding
- Stress at work
- Recent travel to Magaluf
- Normal blood tests; + FHx IBD
- Stool calprotectin 188 ug/g
- Refer urgently? Routinely? Rx IBS?
Risk for Developing CD

Empirc Risk for Developing Crohn's Disease (%)

- Offspr Both Parents
- MZ Twin
- Sib Ashk Jew
- Parent
- Offspr Ashk Jew
- DZ Twin
- Sib Non-Jew
- Homozygote NOD2
- Heterozygote NOD2
- General Population

Risk values:
- Offspr Both Parents: 50.0%
- MZ Twin: 37.0%
- Sib Ashk Jew: 16.8%
- Parent: 7.5%
- Offspr Ashk Jew: 7.4%
- DZ Twin: 7.0%
- Sib Non-Jew: 4.6%
- Homozygote NOD2: <4.0%
- Heterozygote NOD2: <0.2%
- General Population: 0.1%
National IBD Twin Registry

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The man from Calpro....and me!
Faecal calprotectin testing is recommended by NICE as an option to help doctors distinguish between inflammatory bowel diseases, such as Crohn’s disease and ulcerative colitis, and non-inflammatory bowel diseases, such as irritable bowel syndrome.

Many people with irritable bowel syndrome have unnecessary invasive hospital investigations before their condition is diagnosed. Using faecal calprotectin testing will mean most people with irritable bowel syndrome will be diagnosed without the need for these investigations.
So what have we learnt?

1. Learnt to investigate extreme bowel habits; reminded urgent referral guidelines
2. Discussed implications Fe^{++} deficiency
3. Afro-Caribbeans develop CRC earlier
4. Reviewed risk factors for CRC
5. Role calprotectin IBS vs IBD; risks for IBD
Algorithms in IBD
The ECCO vision
Active terminal ileal CD
Fibrotic disease
SPECIAL ARTICLE

The second European evidence-based Consensus on the diagnosis and management of Crohn's disease: Special situations


Received 19 August 2009; received in revised form 22 September 2009; accepted 22 September 2009

KEYWORDS:
Crohn's disease
post-operative recurrence
Pediatrics
Pregnancy
Psychosomatic
Extraintestinal manifestations

Guideline production
Guidelines

• Useful for patients
• Useful for training
• Useful for doctors
• Useful for authors
  • Highly cited
Guidelines

• Useful for patients
• Useful for training
• Useful for doctors
• Useful for authors
  • Highly cited
• Often not read
Inflammatory bowel disease patient of reproductive age

Preconception counseling
- nutrition – TPN if malnourished
- supplements – folate, calcium, Vitamin D
- smoking and alcohol cessation
- achieve and maintain remission
- avoid pregnancy until 3 months in remission

In remission

Pregnancy

Active disease

Continue on current therapy
Medications safe in pregnancy:
- 5-ASA products (caution with Asacol, suggest switching)
- Immunomodulators (AZA, MP)
- Biologics (hold after 30 weeks gestation), restart post delivery
Medications contraindicated in pregnancy:
- Methotrexate
- Thalidomide

Induction of remission:
Medications safe in pregnancy:
- 5-ASA products (caution with Asacol, suggest switching)
- Biologics (hold after 30 weeks gestation), restart post delivery
- Corticosteroids (avoid dexamethasone)
- Ciclosporin
Medications contraindicated in pregnancy:
- Methotrexate
- Thalidomide

Delivery
- recommend c section if active perianal disease or ileoanal pouch

Breast feeding
Medications safe in breast feeding:
- 5-ASA (Mesalamine) products (monitor for kernicterus)
- Immunomodulators (AZA, MP)
- Corticosteroids (wait 4 h after oral dose)
- Biologics
Medications contraindicated in breast feeding:
- Ciclosporin

UC require surgery
- recommend ileostomy and rectal sparing initially then IPPA later
Information flow - technology connecting patients and care providers

Paper report for patients & other stakeholders

E-reports for external stakeholders e.g. GP, pharmacy, dietetics, PCT, CNS, patient

Electronic Document Management

Multi-disciplinary team

Webform

Database

audit, research

Patient