Why are women special?

• All common GI conditions are more common in women than men – except bowel cancer

• Partially related to hormone fluctuations,
• pregnancy and childbirth
<table>
<thead>
<tr>
<th>Condition</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaemia</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>IBD</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>Diverticular disease</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Colorectal cancer</td>
<td>13</td>
<td>10</td>
</tr>
<tr>
<td>Microscopic colitis</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Coeliac disease</td>
<td>1</td>
<td>3.3</td>
</tr>
<tr>
<td>Constipation</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>IBS</td>
<td>1</td>
<td>2.5</td>
</tr>
</tbody>
</table>
Whats new in IBD?
Most Important News:

• BRI IBD helpline has reopened!

• 0117 342 1100

• Two extra new IBD nurses:

• Heather and Molly
Immunosuppression in IBD

• Azathioprine and 6-mercaptopurine can work well but...

• Used to use weight based estimate of dose

• With TPMT enzyme measurement as guide of patients ability to metabolise the drug
Problems

• 1) Didn’t work!
• 2) Liver toxicity
• 3) leucopaenia
• 4) side effects
Solutions

• Co prescription of allopurinol

• Preferentially increases the 6 TGN levels (active metabolite, shown to improve disease control)

• Allows reduction on dose of azathioprine and hence reduction in side effects
Second solution

• Measure of metabolites:
  – 6- thioguanine nucleotide and 6 methyl mercaptopurine
    – Allows careful titration of dose to suit the patient
    – Done in secondary care
Biosimilars

Biological agents, now being manufactured and marketed under different names
Remicade (infliximab) is now off patent
Humira (adlimimumab) will lose its patent next year
At BRI

• Undertaken a switchover

• Infliximab now given as Inflectra
Lots of new NICE guidance

• Biologics range has increased recently

• Biosimilars replacing remicade (infliximab) with ‘Inflectra’ or ‘Remsima’

• Anti TNFs now licensed for UC longterm use
New Biologics

- Entyvio Type (vedolizumab)
  - monoclonal antibody against α4β7 integrins
- Used for both Crohn's and UC
- Given by regular IV infusion
- Slowish onset of action
- Tending to use it in UC (?better evidence of efficacy)
- Gut selective – probably safer?
Another new biologic

• Golimumab
• - for UC
• SC injections every 2 weeks

• More coming, including oral preparations!
Studies into IBD

• The GEM project
• - study following the healthy siblings of those with Crohns or UC to see if they develop the disease

• BRI GI research nurses
• Edel and Shinney  0117 342 2154
Example 1

• 27 year old lady
  – Exhausted all the time
  – About to be thrown off her post graduate course
  – Initially told that she had IBS
  – GP had done some blood tests and noticed low iron levels
  – Had requested blood test for coeliac disease
  – Borderline result
Seen in clinic

- Main issue was fatigue
- But had unintentionally lost weight 4 months previously
- Frustrated by her variable bowel habit – scared to go out or eat in public

- Working diagnosis of coeliac disease
IBS symptoms and coeliac disease

• Two meta analyses looking at patients with Rome III criteria for IBS
• 38% of coeliacs will have these symptoms
• Prevalence of coeliac disease in IBS population 4.1%
• 1-2% prevalence of coeliac in the general population anyway
• Secondary care testing of all patients with GI symptoms suggested 2-13% will have coeliac
How helpful are the blood tests?

- Endomysial antibodies
  - Sensitivity/specificity of 95%
  - Subjective
  - Expensive
More blood tests

• tTG – varies between manufacturers but could be as high as 95% sensitivity/specificity

• DGP (deaminated gliadin peptide) antibody – not thought so accurate

• Point of care tests not validated

• Current recommendations are to use tTG
What happened to the patient?

• Biopsies reported quickly
• No villous atrophy reported!
Histology isn’t perfect

• This case didn’t have any villous atrophy, despite increased intra epithelial lymphocytes

• Could be caused by some drugs
• Has been reported in other autoimmune conditions
Non coeliac gluten sensitivity

- Well described phenomenon
- No abnormal blood tests
- No risk of anaemia or malabsorption
- No increased risk of osteoporosis

- Sanders et al 2011

- NB NOT eligible for gluten free foods on prescription
This patient

• Didn’t want to be rebiopsied or have any more blood tests

Happy to purchase her own gluten free foods

Working diagnosis of non coeliac gluten sensitivity
Introduction

• Commonest deficiency worldwide
• 2-5% of adult men and post menopausal women
• 4-13% of referrals to gastroenterology
• Often sub optimally investigated
• Dual pathology in 1-10%
Definitions

- **WHO:**
  - Hb <13g/dl in men (over 15 years old)
  - Hb< 12g/dl in women

- UK re anaemia in pregnancy suggests:
  - <11g/dl in first trimester
  - <10.5g/dl in second and third trimester
Mrs GG

- 52 year old woman
- Presented to GP with fatigue
- Non specific symptoms
- Some palpitations
- No weight loss,
- No breathlessness

- PMH – unremarkable, post menopausal
On examination

- Possibly a little pale
- No palpable lymph nodes
- Chest clear, no murmurs
- In sinus rhythm (confirmed on ECG)
- Abdomen soft

- Routine bloods sent, including TFTs
Blood results

- FBC – Hb 11.3  MCV 62
- U and Es – normal
- LFTs – normal
- TFTs normal
Causes of iron deficiency

• **Blood loss**
  - GI
  - Uterine
  - Urinary tract

  – **Increased demands:**
    - Pregnancy, prematurity, growth

  – **Others:**
    - Malabsorption eg gastrectomy, coeliac disease, ?
## Lower GI cancer (NICE)

### Urgent referral

Refer urgently patients:

- aged 40 years and older, reporting rectal bleeding with a change of bowel habit towards looser stools and/or increased stool frequency persisting 6 weeks or more
- aged 60 years and older, with rectal bleeding persisting for 6 weeks or more without a change in bowel habit and without anal symptoms
- aged 60 years and older, with a change in bowel habit to looser stools and/or more frequent stools persisting for 6 weeks or more without rectal bleeding

- of any age with a right lower abdominal mass consistent with involvement of the large bowel
- of any age with a palpable rectal mass (intraluminal and not pelvic; a pelvic mass outside the bowel would warrant an urgent referral to a urologist or gynaecologist)
- who are men of any age with unexplained iron deficiency anaemia and a haemoglobin of 11 g/100 ml or below
- who are non-menstruating women with unexplained iron deficiency anaemia and a haemoglobin of 10 g/100 ml or below
Newish guidelines (2011)

BRITISH SOCIETY
OF GASTROENTEROLOGY

Guidelines for the
management of
iron deficiency anaemia
Main points

• Any level of anaemia should be investigated in the presence of iron deficiency (ferritin) – base on local reference ranges

• Gold standard lower GI investigation is colonoscopy; CT colonography is second choice (+90% sensitivity for lesions>10mm)

• Both are preferred to Ba enema

• FOB is not helpful (poor sensitivity and non specific)
Watch Out!

- Even if coeliac diagnosed, investigate for lower GI cancer if ‘marked ‘ anaemia or family history
- Fe def diets are common but should not deter further investigation if anaemic
- Post gastrectomy patients also need full investigation (2-3X increased risk gastric cancer after 20 years and ? increased risk of CRC
- Dual pathology thought to occur in 1-10% of
• Pre menopausal women - only need to check for coeliac (unless other concerns) – pre test probability 5%
• Must dipstick urine (1% will have renal cell tumour)

• Don’t investigate lone iron deficiency unless over 50 and risks of investigation discussed. Pick up rate of malignancy is extremely low in this group (0.9% men and post menopausal...
Guidelines perspective on persistent Fe def anaemia

• If normal scopes, eradicate H pylori, if present (colonisation may impair uptake and promote iron loss)

• Don’t investigate small bowel unless:
  – Symptoms of small bowel disease
  – Hb can’t be restored/maintained with oral iron
  – Capsule or enteroscopy suggested, if investigation required
Back to our patient

• Referred in to QDU and scopes booked
  – OGD normal (including duodenal biopsies)
  – Colonoscopy – normal

– Started on oral iron
– Hb improved

– Discharged back to GP (3 monthly checks as per guidelines)
Gastro department received another letter about her:

- Anaemia had only partially resolved on administration of oral iron
- GP was concerned
Repeat scopes were arranged
OGD – normal
Colonoscopy – normal

NB Miss rate in colonoscopy – Possibly 10% for polyps, particularly flattened polyps
Better since bowel prep improvements and scope guide
Capsule endoscopy
• Capsule endoscopy was essentially normal
• Comment made of a possible ‘blush’ of red seen on one picture
• Thought to be related to NSAID consumption

• Patient reassured and discharged
Undisclosed NSAID use is common in patients undergoing capsule endoscopy

- Aspirin
  - Trinder’s reaction spot test
- Non-aspirin NSAIDs
  - GC-MS
- Positive urinalysis in 10/76
  - 3 salicylates
  - 6 ibuprofen
  - 1 ibuprofen and diclofenac
    - Indications: suspected Crohn’s (n=7), anaemia (n=2) and suspected coeliac complication (n=1)
  - Only one patient disclosed NSAID in routine admission drug history (aspirin)

Sidhu et al., BSG 2010
How does BCSP fit into all of this?

- FOBs from age 60 to 69
- Age extension currently underway
- Only about 50% return rate
  
- Recently started but not in all areas yet:
  - Bowel scope
  - Flexi sig offered to everyone at age of 55
Update on Diverticulosis

Dr Amanda Beale
Consultant Gastroenterologist
BRI/Nuffield Hospital
Colonoscopic view
Background facts and figures

• Subdivided into:

• 1) diverticulosis – no symptoms (incidental finding) – 75% of those with the condition
• 2) diverticular disease – lower abdominal pain with no inflammation or infection (25%)
• 3) diverticulitis – infection present
Diverticulitis may be....

- Uncomplicated
- Complicated – perforation
  - Local
  - Free
Who gets it?

• 50% of the population by 50 years old
• 70% of the population by 80 years old

• Men:women 1:1
• BUT men tend to develop it younger

• Usually affects the sigmoid colon, right side in those of Asian descent
Alarm features from NICE and BSG guidelines.¹,²

- Age >50 years
- Short symptom history
- Unintentional weight loss
- Nocturnal symptoms
- Male sex
- Family history of bowel/ovarian cancer
- Anaemia
- Rectal bleeding
- Recent antibiotic use
- Abdominal mass
Treatment

• Evidence is very limited

• Diverticulosis needs no treatment

• Suggestion of high fibre diet to prevent development of more diverticulae
Treatment of diverticular disease

• Authorities suggest treatment with paracetamol NOT NSAIDs (possibly linked to perforation risk)
• Role of diet is debated
• Aetiology of uncomplicated diverticulitis speculative
  Luminal obstruction, raised intradiverticular pressure
  Microperforation?
  Primary inflammatory process?
• Complicated diverticulitis
  Perforation – focal necrosis?
Treatment of diverticulitis

• At home:
  • Clear fluids
  • Paracetamol
  • Antibiotics – co amoxiclav or cipro and metronidazole

• If concern/frail patient – admission should be considered
When it all goes wrong!
• Incidence increases with age
• Mortality increases with age
• Increases more pronounced in women

• Incidence increasing with time
• Definitions & diagnostic techniques not standardised

Morris et al BJS 2008
Humes et al Gastroenterol 2009
• Finally, some research on best management strategies for these high risk patients.
That’s all folks

• Any questions?