Guidelines – NICE, not NICE and the *Daily Mail*

2018

Dr Andy Poullis
Consultant Gastroenterologist

- Coeliac
- IBS
- Gall bladder polyps
- PEI
- PPI

NICE National Institute for Health and Care Excellence

NICE guideline

Coeliac disease: recognition, assessment and management

NICE guideline

Published: 2 September 2015
nice.org.uk/guidance/ng20

Who to test for Coeliac

- persistent unexplained abdominal or gastrointestinal symptoms
- faltering growth
- **prolonged fatigue**
- unexpected weight loss
- **severe or persistent mouth ulcers**
- unexplained iron, vitamin B12 or folate deficiency
- **type 1 diabetes, at diagnosis**
- **autoimmune thyroid disease, at diagnosis**
- **irritable bowel syndrome (in adults)**
- **first-degree relatives of people with coeliac disease**

Consider testing

- Metabolic bone disorder (reduced bone mineral density or osteomalacia)
- Unexplained neurological symptoms (particularly peripheral neuropathy or ataxia)
- Unexplained subfertility or recurrent miscarriage

Genetic testing

"Only consider using HLA DQ2/DQ8 testing in the diagnosis of coeliac disease in specialist settings (for example, in children who are not having a biopsy, or in people who already have limited gluten ingestion and choose not to have a gluten challenge)."

HLA DQ2 / DQ8

- 90% of CD carry HLA DQ2
- Remainder carry DQ8

- DQ2 or DQ8 neg CD 0.4%

- But 20% of healthy population carry DQ2 or DQ8

In addition to GFD…

- Vaccinations

    NICE – no

    Coeliac UK – yes

-Pneumococcal at diagnosis and 5 yearly booster

-Flu annual vaccination should be considered

-Anyone born between 1995 and 2014 to consider having the Meningococcal A,C,W,Y vaccination

NICE National Institute for Health and Care Excellence

NICE advice

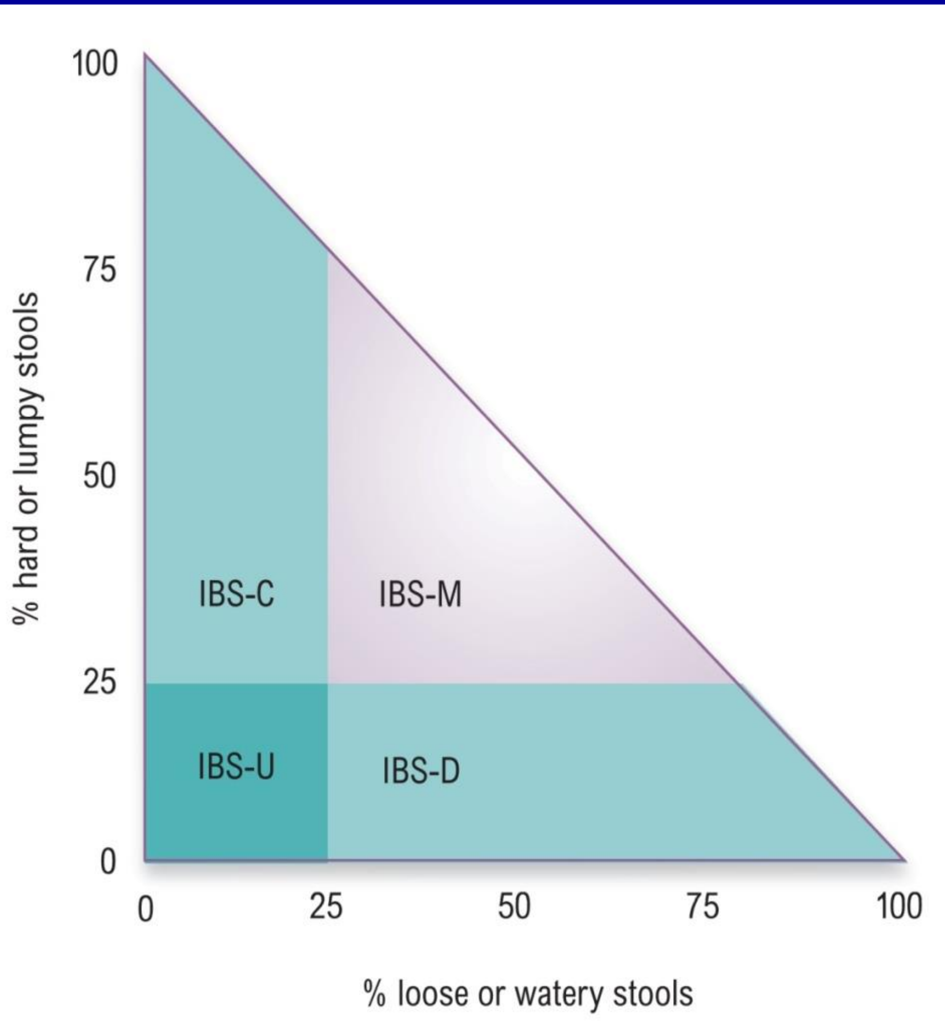
Irritable bowel syndrome with constipation in adults: linaclotide

Evidence summary

Published: 9 April 2013

nice.org.uk/guidance/esnm16

IBS subtypes



IBS with constipation: >25% hard stools, <25% loose stools

IBS-mixed: both hard and loose stools

IBS with diarrhoea: >25% loose stools, <25% hard stools

Linaclotide

- Linaclotide is a Guanylate Cyclase-C receptor agonist (GCCA) with visceral analgesic and secretory activities. Binds to the GC-C receptor, on the luminal surface of the intestinal epithelium to increase colonic transit.

- Linaclotide is licensed for the symptomatic treatment of moderate-to- severe irritable bowel syndrome with constipation (IBS-C) in adults.

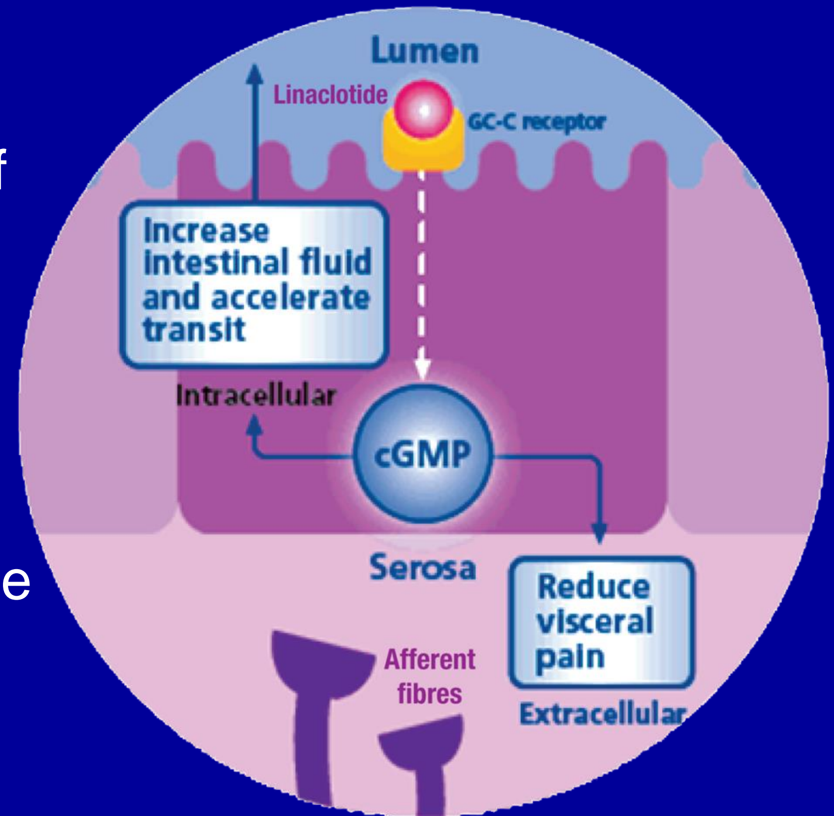
Linaclotide

1. **Reduces abdominal pain**

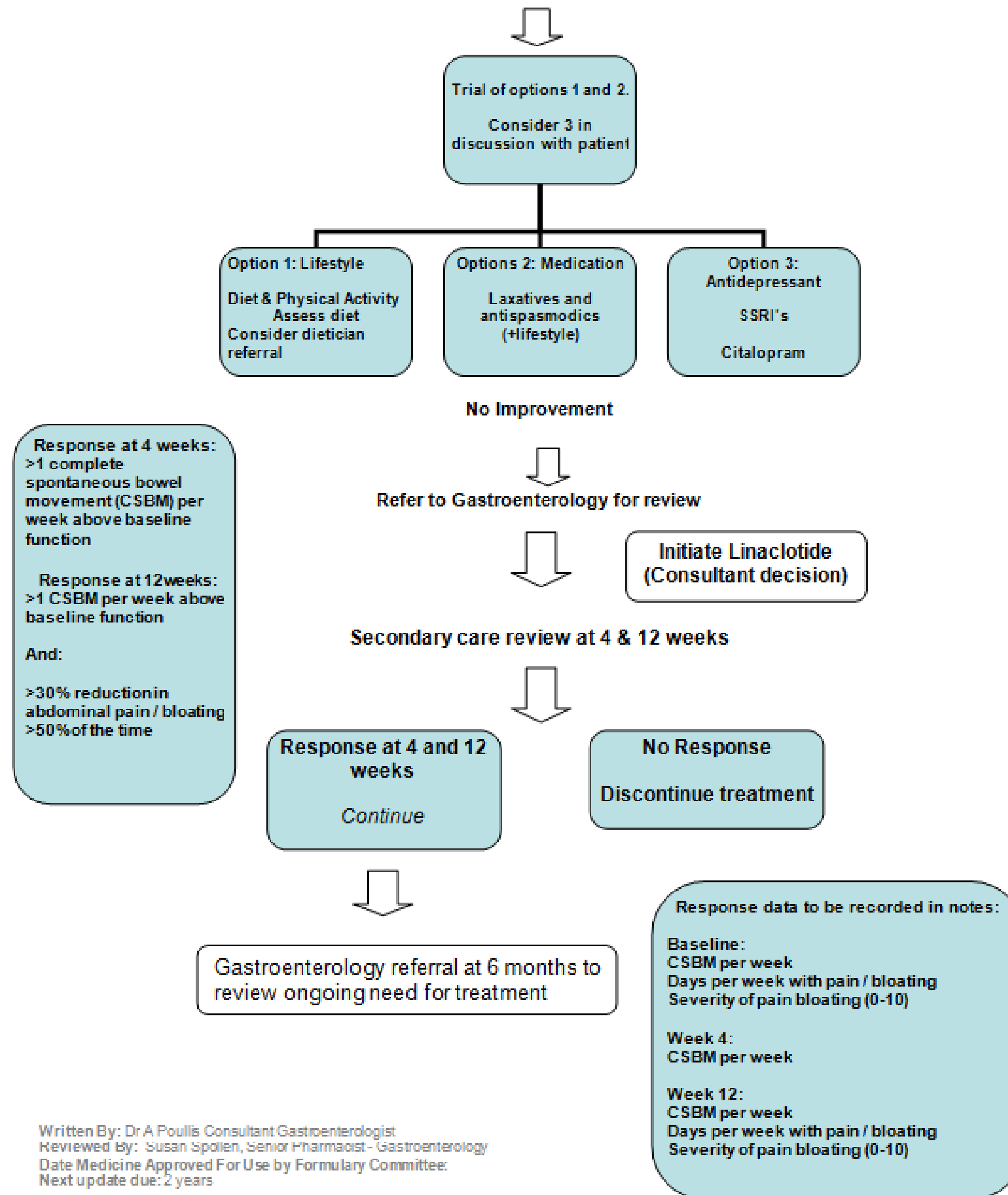
   Extracellular action to reduce firing of afferent pain fibres.[1,2]

2. **Relieves constipation**

   Intracellular action to increase chloride/bicarbonate secretion to raise fluid levels and improve intestinal transit.[1,2]



1.Chey WD, Gastroenterology 2012; 107: 1702-1712.
2.Eutamene H, Neurogastroenterology and Motility 2010; 22: 312-e84.


Referral and Management pathway for Linaclotide
Patient has been diagnosed with IBS-C.
Trial of options 1 and 2.
Consider 3 in discussion with patient
Option 1: Lifestyle
Diet & Physical Activity
Assess diet
Consider dietician referral
Options 2: Medication
Laxatives and antispasmodics (+lifestyle)
Option 3: Antidepressant
SSRI's
Citalopram
No Improvement
Response at 4 weeks:
>1 complete spontaneous bowel movement (CSBM) per week above baseline function
Response at 12weeks:
>1 CSBM per week above baseline function
And:
>30% reduction in abdominal pain / bloating >50% of the time
Refer to Gastroenterology for review
Initiate Linaclotide (Consultant decision)
Secondary care review at 4 & 12 weeks
Response at 4 and 12 weeks
Continue
No Response
Discontinue treatment
Gastroenterology referral at 6 months to review ongoing need for treatment
Response data to be recorded in notes:
Baseline:
CSBM per week
Days per week with pain / bloating
Severity of pain bloating (0-10)
Week 4:
CSBM per week
Week 12:
CSBM per week
Days per week with pain / bloating
Severity of pain bloating (0-10)
Written By: Dr A Poullis Consultant Gastroenterologist
Reviewed By: Susan Spollen, Senior Pharmacist - Gastroenterology
Date Medicine Approved For Use by Formulary Committee:
Next update due: 2 years

Eur Radiol (2017) 27:3856–3866
DOI 10.1007/s00330-017-4742-y

CrossMark

GASTROINTESTINAL

Management and follow-up of gallbladder polyps

Joint guidelines between the European Society of Gastrointestinal and Abdominal Radiology (ESGAR), European Association for Endoscopic Surgery and other Interventional Techniques (EAES), International Society of Digestive Surgery – European Federation (EFISDS) and European Society of Gastrointestinal Endoscopy (ESGE)

Gall bladder polyps

- Benign GB polyps most commonly adenomas
- Adenoma – carcinoma sequence less well described than for colonic polyps
- Size & number define management:

- Symptomatic - surgery

- Asymptomatic – follow up to ensure no change in size or number

Gallbladder polyp

- demonstrated on ultrasound
- excluding definite pseudopolyp

≥ 10mm →

Increased risk of malignancy. Cholecystectomy recommended if the patient is fit for and accepts surgery.

(If cholecystectomy is not deemed appropriate, follow up as below)

< 10mm ↓

Does the patient have symptoms that are attributable to the gallbladder?

Yes →

Polypoid lesions of the gallbladder can be indicative of underlying gallbladder pathology such as cholelithiasis or inflammation.

Cholecystectomy is suggested if there is no alternative cause for the symptoms and the patient is fit for and accepts surgery.

(If cholecystectomy is not deemed appropriate, follow up as below)

No ↓

Does the patient have risk factors for gallbladder malignancy?

- Age >50
- Primary sclerosing cholangitis
- Indian ethnicity
- Sessile polyp
(including focal wall thickening >4mm)

Yes →

Polyp less than 6mm:

Follow up ultrasound* at

6 months

1 year

2 years

3 years

4 years

5 years

Polyp 6-9mm:

Increased risk of malignancy. Cholecystectomy recommended if the patient is fit for and accepts surgery

(If surgery not appropriate, follow up as per guidelines for patients with no risk factors)

No ↓

Polyp less than 6mm:

Follow up ultrasound* at

1 year

3 years

5 years

Polyp 6-9mm:

Follow up ultrasound* at

6 months

1 year

2 years

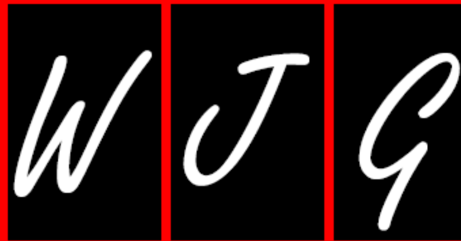
3 years

4 years

5 years

*If during follow up polyp:

- Increases by 2mm or more → cholecystectomy advised if patient is fit for and accepts surgery
- Reaches 10mm → cholecystectomy advised if patient is fit for and accepts surgery
- Disappears → discontinue follow up



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TOPIC HIGHLIGHT

Asbjørn Mohr Drewes, MD, PhD, DMSc, Professor, *Series Editor*

Diagnosis and treatment of pancreatic exocrine insufficiency

Björn Lindkvist

Causes of P.E.I.

- Chronic pancreatitis
- Cystic fibrosis
- Pancreatic atrophy
- Pancreatic cancer
- Idiopathic

Associated with

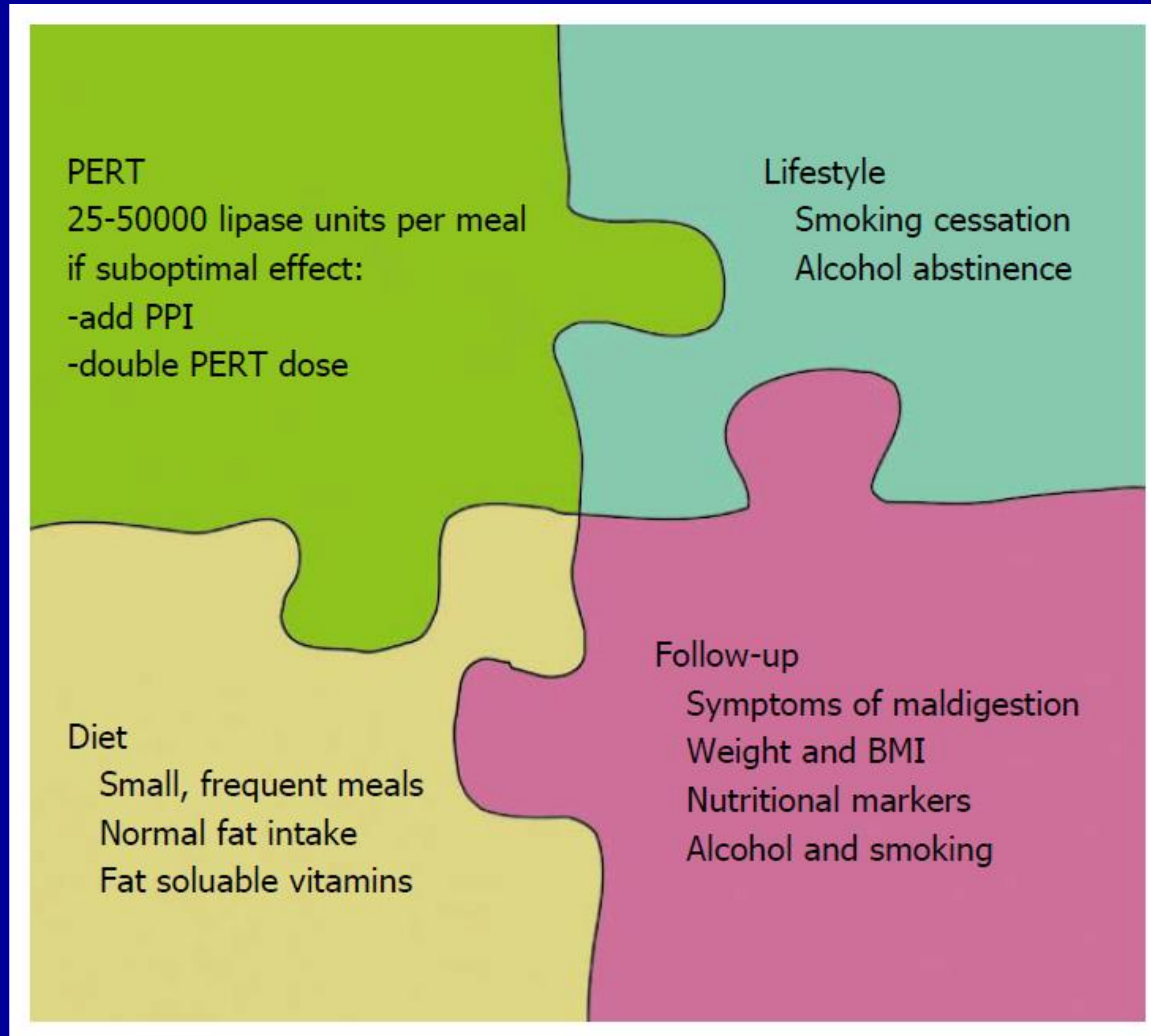
- DM
- Coeliac disease
- IBD

Faecal Elastase

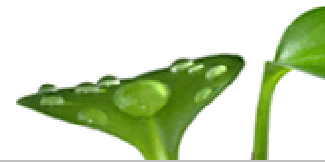
- One off stool sample
- P.E.R.T. does not affect result
- Low result suggest P.E.I.

- But, watery diarrhoea – dilatational false positive result

Treatment



Mail Online



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Over-the-counter and prescription acid reflux pills taken by millions 'raise the risk of stomach cancer by up to eight-fold' if they are used regularly

- Those who use proton pump inhibitors twice as likely to develop stomach cancer
- Risk of cancer increases the longer the drugs are used, scientists claim
- Suspected the pills create gastrin which triggers growth of cancerous cell

- Hong Kong based study looking at PPI use and rates of gastric cancer in subjects who had received *H pylori* eradication therapy.

- 63 000 subjects. Median follow up was 7.6 years.
-
- PPI use was associated with an increased gastric cancer risk (HR 2.44, 95% CI 1.42 to 4.20), while H2RA was not (HR 0.72, 95% CI 0.48 to 1.07).

- The risk increased with duration of PPI use:

HR 5.04, 95% CI 1.23 to 20.61 ≥1 year
6.65, 95% CI 1.62 to 27.26 ≥2 years
8.34, 95% CI 2.02 to 34.41 ≥3 years

The adjusted absolute risk difference for PPI versus non-PPI use was 4.29 excess gastric cancers (95% CI 1.25 to 9.54) per 10 000 person-years.

However…

- *H pylori* is a risk factor for gastric cancer and is more common in Hong Kong, *H pylori* eradication failure is more common in Hong Kong due to antibiotic resistance and these factors may well impact on the study result.
- Dietary and family history details were not known in study subjects.
- Smoking, alcohol and obesity information was poorly collected.
- PPI users were older than non-users (and age is a risk factor for gastric cancer).
- Gastric cancer rates are higher in Hong Kong than the UK suggesting other genetic and environmental factors are involved.
- There has been a 48% reduction in gastric cancer rates in the UK between the early 1990's and 2014, over the same timescale there has been a considerable increase in PPI use.

Long term PPI use

- Review the original indication for PPI use
- Consider stepping down treatment
- Consider a switch to H2 receptor antagonist
- Reassure

Take home messages

- Low threshold for testing for coeliac disease
- Subtype IBS, consider Linaclotide for C-IBS
- Gall bladder polys need follow up
- Read the *Daily Mail* (and *Gut*)

Daily Mail

An electrifying human drama and a seismic election creating shockwaves on both sides of the Atlantic . . .

TRUMPQUAKE

A REVOLT by America's 'forgotten' white working class swept Donald Trump to the presidency yesterday.