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Gastroenterology: An evening in two parts

Dr Gary Mackenzie
Consultant Gastroenterologist

The Lumen and The Liver

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The Lumen

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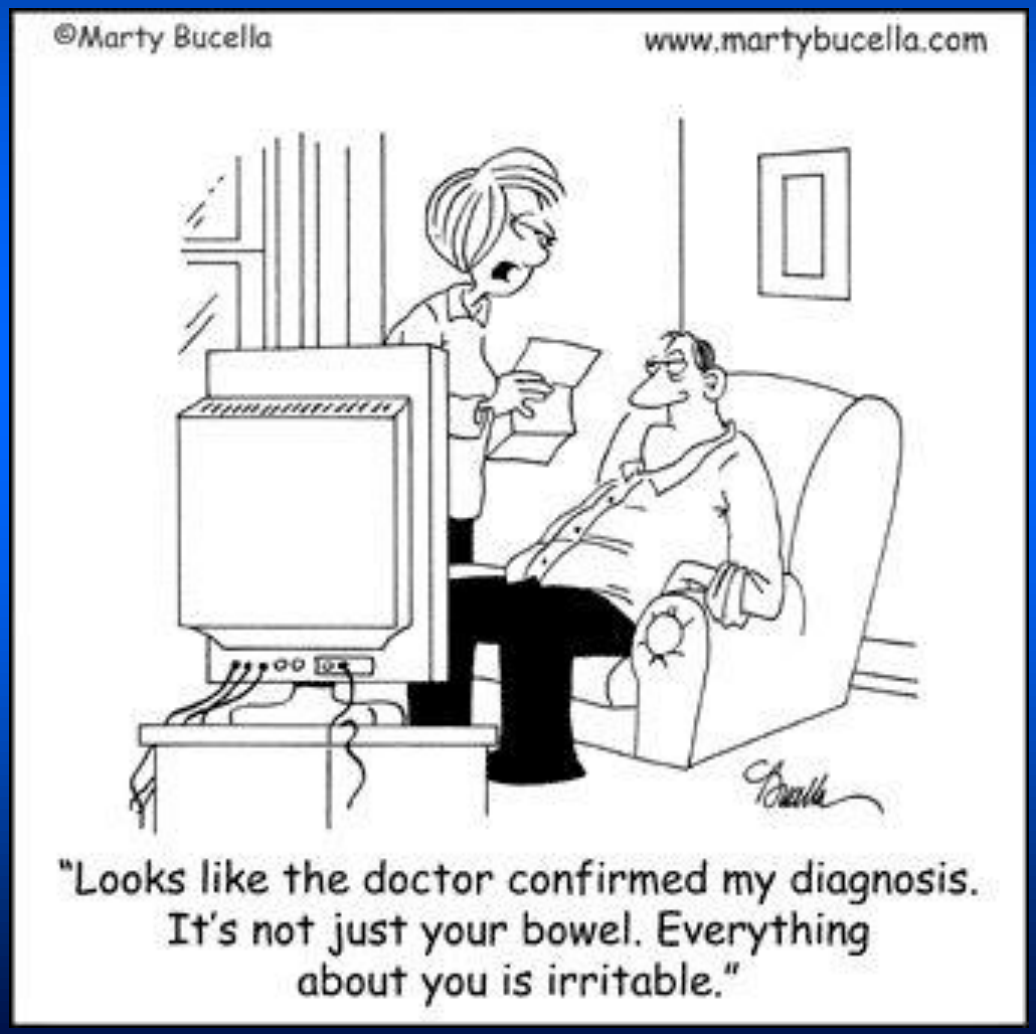

Introduction

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- Part 1: The Lumen
  - Latest on H Pylori
  - Calprotectin; IBS or IBD? NICE Guidance
  - Managing flares of IBD in the community
  - DOACs: A New Hope?
- Part 2: The Liver
  - Abnormal LFT’s

H. Pylori

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- 1 month PPI and test for H Pylori
  - UBT highly accurate.
- Endoscopy urease test highly accurate if off PPI
  - Can turn later occasional inconsistency in reports
- Eradicate, check if still symptomatic or improved then relapsed, consider repeat
- Consider culture but unreliable

H. Pylori

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- Standard Triple therapy 1 week
- Two week courses better than one.
- Clarithro & amoxyl > metronidazole.
- Four agents better than three and offer 94% eradicaiton in 1 weeks therapy
  - PPI, Amoxyl, Claritho, Tinidazole 500mg BD
- Quadruple therapy 2 weeks. (54% success)
- DDW: Rifabutin 150mg BD, amoxyl &PPI 10 days 50% success

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Faecal Calprotectin

IBS or IBD

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- Young people 16-45 with abdominal pain
  - Older investigate
  - Raised inflammatory markers
  - Weight loss
  - Diarrhoea possibly nocturnal or persistent symptoms
- Faecal calprotectin
  - NICE guidance up to 45 yo
  - False positives
  - Results 50-150? Repeat test

Abnormal findings by indication

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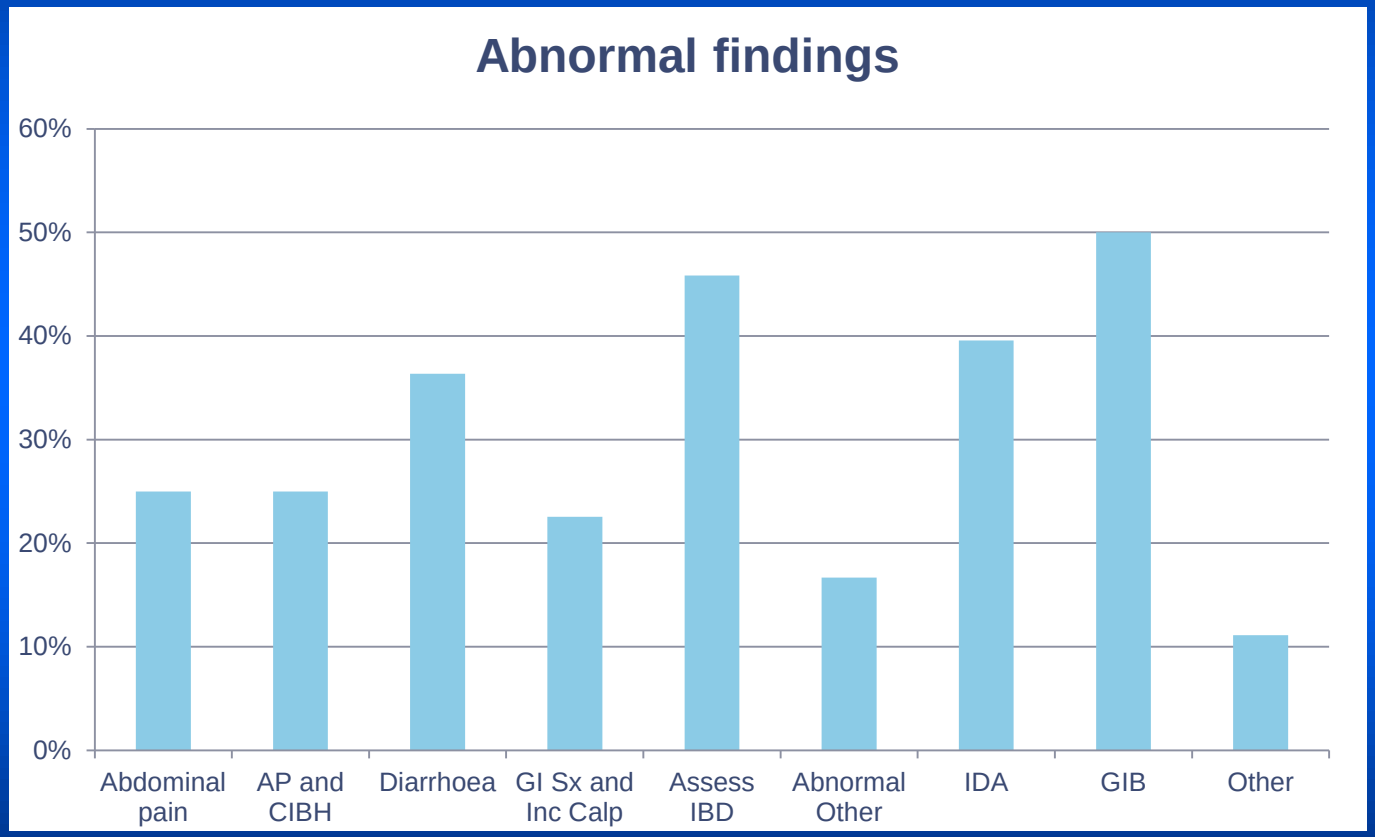

- Other includes polyposis syndromes, weight loss only, coeliac assessment.

Abnormal findings by indication

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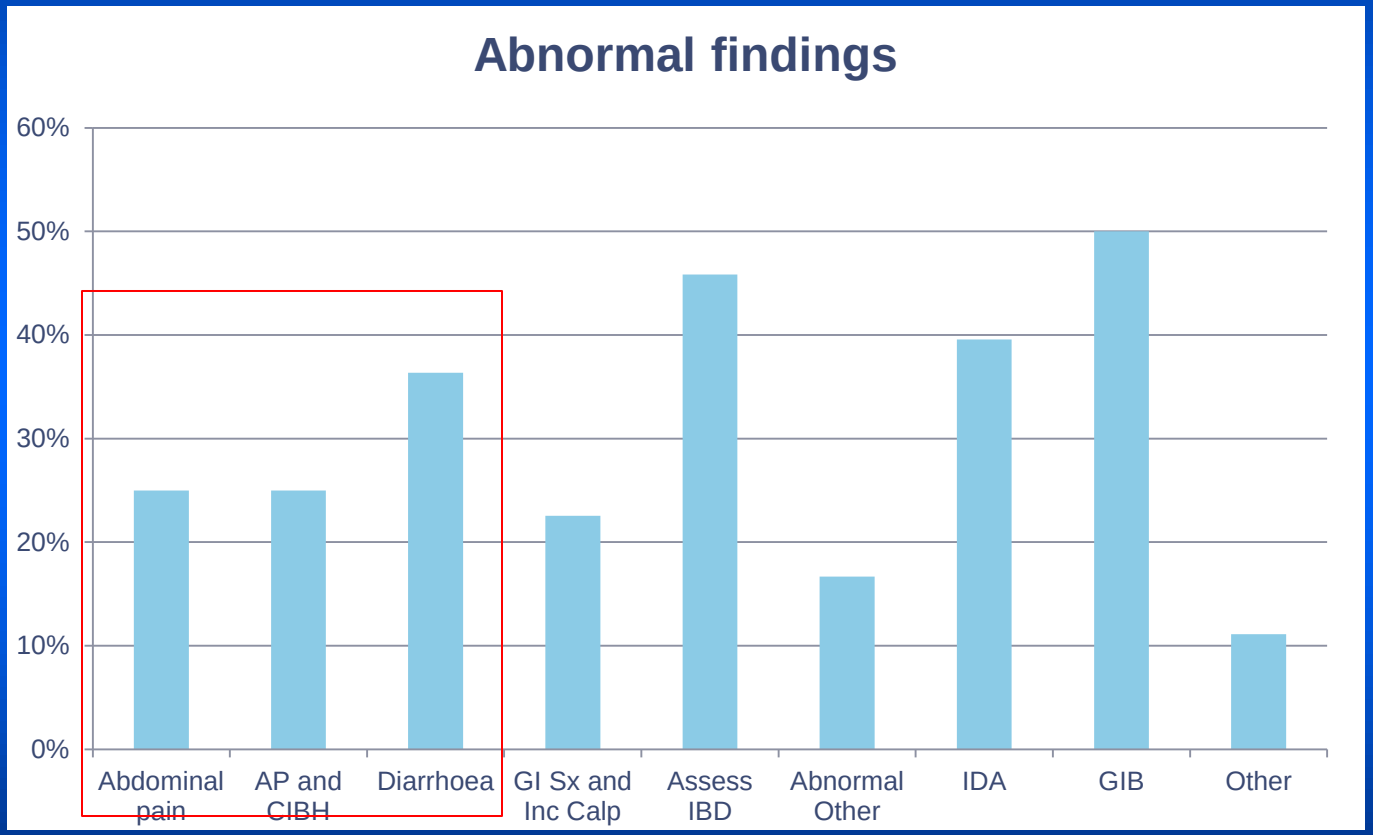

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Abnormalities depending on Calprotectin

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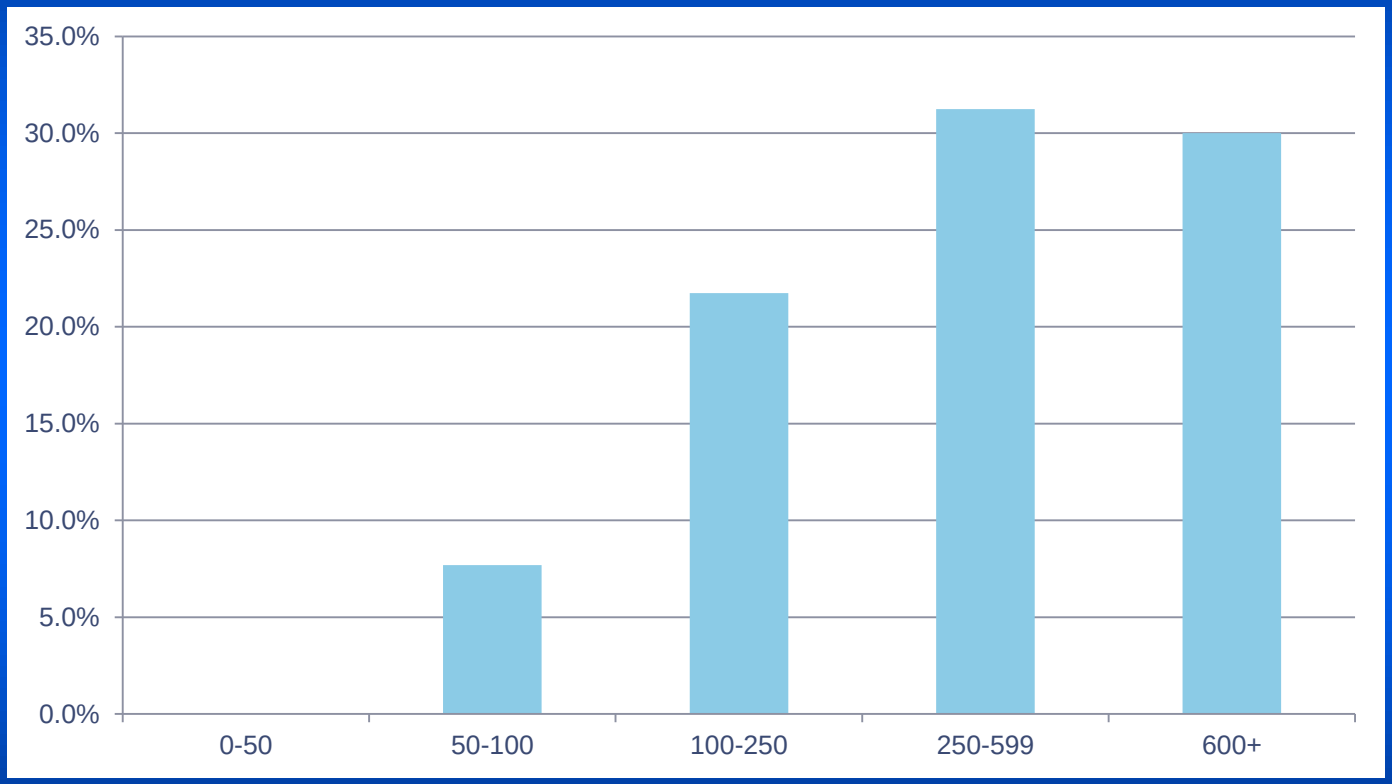

- Note: Only 2 normal calprotectin patients referred for capsule study. Both studies normal but used for clear clinical purpose.
- 10 calprotectin results available

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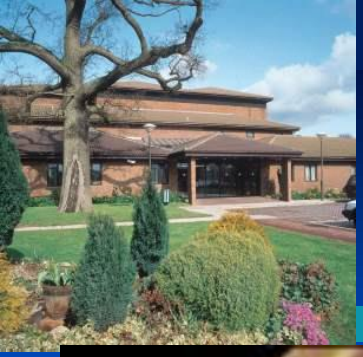
IBD Flares in the community



Crohn's Disease

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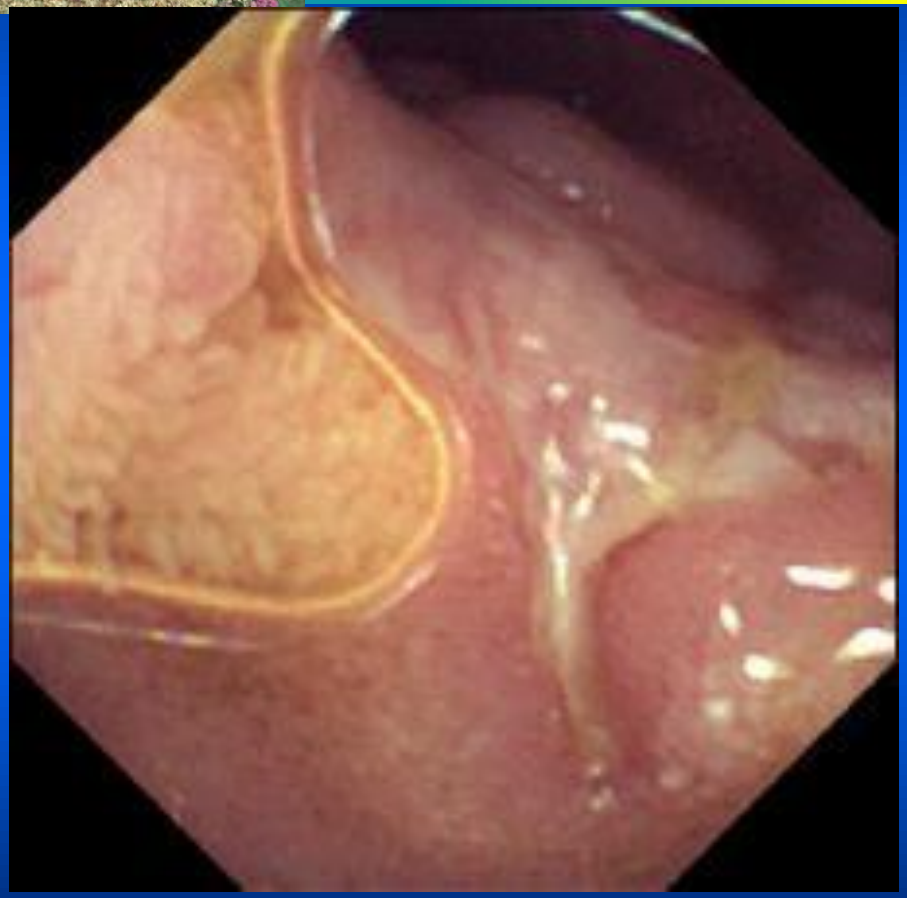

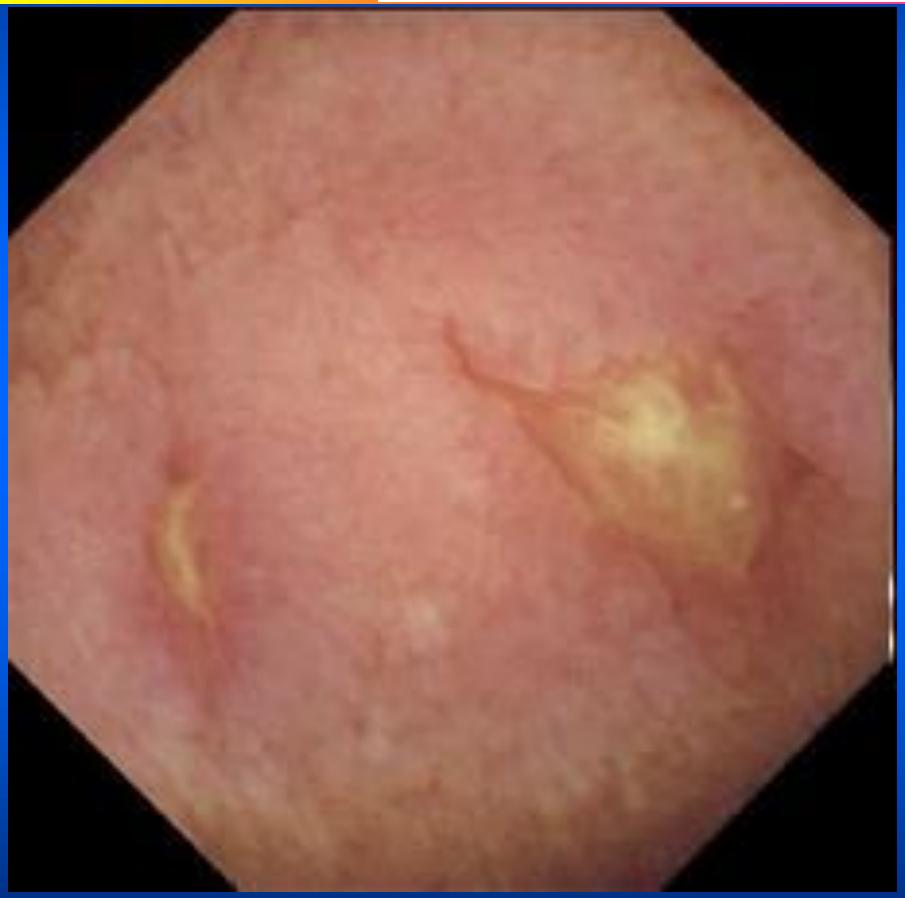

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IBD Flares

Markers of Severity

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- Many Complicated Activity Scores

Managing a FLARE

Assess severity using Truelove & Witts classification:

Mild <4 bloody stools per day and no other criteria. Severe >6 bloody stool per day and at least one of:

Temperature >37.8
Pulse >90
ESR >30

Simplest: Truelove and Witts

Concerns

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- If severe or concerned: Patients can call
  - **IBD Nurse Specialists**

- Set up e-referral advice section
- 01737 768511 ext 2815
- ibd.helpline@sash.nhs.uk
- gary.mackenzie@nhs.net

Concerns

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Mild distal flares

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Distal disease (ie rectosigmoid or proctitis)

Mild	Moderate	Severe
Mesalazine or Steroid Enemas/Supp. 1g BD (2 weeks)	Combine increase 5 ASA and suppositories	Call hospital for advice/ admission
Check 5 ASA preparation/increase dose	Oral Steroids starting at 40mg OD	
Oral Steriods: 20mg OD for 1 wk then Reduce 5mg/wk		

Adcal D3 with courses of steroids

Proximal flares

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- As for more distal except topical treatments

Mild	Moderate	Severe
Check 5 ASA preparation/increase dose	Check 5 ASA preparation/increase dose	Call hospital for advice/ admission
Oral Steriods: 20mg OD for 1 wk then Reduce 5mg/wk	Oral Steroids starting at 40mg OD	

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DOACs: The new hope?

DOACs

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- Locally use Ribaroxaban
- Excellent for young fit patients. Low GIB risk, better endpoints, no monitoring
- Job done,

except…..

DOACs

- Irreversible

- Significantly higher GIB risk in >75 yo
  - 3-5 x greater than warfarin
  - 10x with anti-platelet agents
- Looking to switch to Apixaban lower GI risk, similarly effective

DOACs

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- Stopping 3 days prior to endoscopy.
- Bleeding is extremely difficult to stop on these agents
- Reduced clearance in decreased renal function
- Restart later than other anticoagulants as rapid onset of action
- Topical activity as not as well absorbed.

NBCSP

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- Cancer detection rates from TWR referrals is 4.5%

- Local FOBt service
  - Starts at 60yo-75 yo. Two yearly FOBt test
  - Stools tests only 75% accurate for cancer
  - 10% cancer detection rate, 45% adenoma detection rates

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Questions

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The Liver

The Liver

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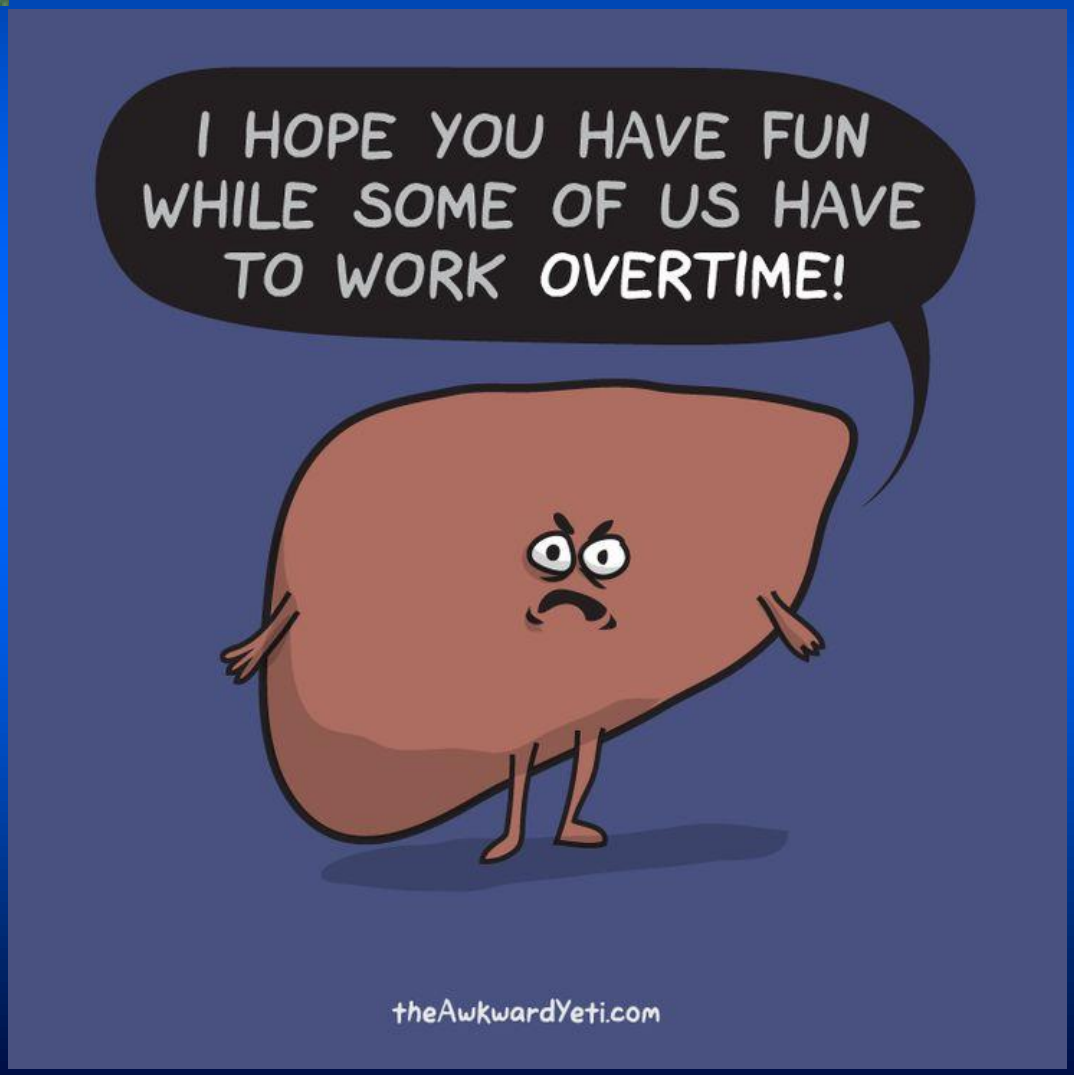

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Abnormal LFTs

When not to worry

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- Isolated raised Bilirubin
  - Raised unconjugated bilirubin, 5%
- Isolated rises in GGT
  - Drugs, NAFLD, Sometimes ETOH
- Low rises in ALT
  - Less than 3x ULN
  - Consider ferritin
  - Drug review
  - Fibroscan as often NAFLD

When not to worry

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- Rises in ALP (with GGT)
  - If <3x ULN post Cholecystecomy
  - Minor duct dilatation on USS post- op
- Haemangiomas on USS
- Gallbaldder polyps on USS
  - If less than three and <1cm
  - Repeat in 6 months

ALT >1000

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- Easy (diagnostically)
  - Drugs (commonest paracetamol)
  - Hepatitis A (or E rarely) or B
  - Ischaemia (hospitalised only really)
  - Autoimmune hepatitis

Autoimmune

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- The one not to miss!
- Autoantibodies (anti smooth-muscle)
- Most treatable
- Good prognosis although often need Azathioprine

Hepatitis B

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- If acute (and not fulminant) this is good news longterm
- Acute Hep B should not become persistent
- Monitor LFTs and Viral load if not sero-converting then Lamivudine

ALT <1000

- Very much more common

- Common causes:
  - Alcohol
  - NAFLD/NASH
  - Drug induced: statins
  - Hepatitis B and C (typically ALT 200-500)
  - Autoimmune

Alcohol

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Spotting the abuser

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NAFLD/ NASH

NAFLD

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- Associated with (metabolic syndrome):
  - Insulin resistance
  - Obesity,
  - Hyperlipidaemia, Hypertension
  - Diabetes mellitus (type II)
- Not due to excessive alcohol use.
- Not due to other causes of hepatitis

Treatment - Lifestyle

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- Nutrition: Diet changes have shown significant histological improvement.
- Weight loss: Gradual weight loss
- Controversially rapid loss may worsen NAFLD.
- Insulin resistance probably plays a strong role
  - Exercise
  - Diabetic control

"I always pass on good advice. It is the only thing you can do with it?

When advice fails?

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- Insulin sensitisers (eg metformin have shown some efficacy).
- Possible advantages with:
  - antioxidants
  - ursodeoxycholic acid,
  - lipid-lowering drugs,
- Mild alcohol consumption (one glass of wine a day) might reduce the risk of NAFLD by 50%

Therapeutic Options

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- Timing of liver biopsy (now fibroscan, locally very soon)
- Liver Transplantation
  - Shortage of organ
  - Avoidable
  - Recurrence up to 18%
- Anti-obesity measures
  - Improvement and/or resolution of NASH in around 80% of patients (AASLD).

Hepatitis B/C

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- Confirm with viral loads
- In HCV genotyping important
- Tertiary care
  - Excellent eradication with ledipasvir & sofosbuvir or sofosbuvir &velpatasvir. Even in cirrhosis and even Genotype 1 and 4
  - Genotype 2 & 3 PEG and ribavirin
- Hep B consider PEG, entecavir and tenofovir high risk
  - Lamivudine

When to worry, refer & seek advice

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- ALT >1000 or persistently >100 (or 3x ULN)
- Acute onset significant jaundice
- Encephalopathy
  - Sub-acutes do worst. Jaundice to encephalopathy 7-31 days
- Deteriorating Synthetic function
  - Albumen, Bilirubin and INR together
- Decompensation, infection, fluid retention

Summary of LFTs

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- Mostly liver disease is caused by exogenous toxins (drugs, overeating) or viruses
- Autoimmune is the one to watch for
- Rising tide of chronic liver disease mainly NASH/NAFLD and ETOH not Hep C!

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Questions