LOWER GI PRIMARY CARE DIAGNOSTIC PATHWAY (ADULT)

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COULD IT BE SELF LIMITING?

Consider duration of symptoms and history. For example, recent travel, changes in diet, alcohol, medications (e.g. NSAIDs/antibiotics), infection causing gastroenteritis, menstrual symptoms, possibility of haemorrhoids and fissures.

START HERE

COMMON SYMPTOMS OF LOWER GI CONDITIONS

- Change in bowel habit
- Abdominal pain, cramping, bloating, excessive wind and pain
- Mucus in stools/fatty stools
- Mouth ulcers
- Weight loss
- Fatigue
- Nausea and vomiting
- Symptoms made worse with eating
- Rectal bleeding

RED FLAG COLORECTAL CANCER SYMPTOMS

FIT testing in primary care to support asessment of colorectal cancer may be needed.

Follow country cancer pathway:
England, **Scotland**, **Wales**, **Northern Ireland**

RED FLAG OVARIAN CANCER SYMPTOMS

CA125 blood test in primary care will confirm need for an ovarian cancer referral.

Follow country cancer pathway:
England, **Scotland**, **Wales**, **Northern Ireland**

Woman aged 50 or over with IBS symptoms in the previous 12 months should be tested for ovarian cancer. IBS rarely presents for the first time in women of this age.

The main forms of IBD are Crohn's Disease and Ulcerative Colitis. More rarely, Microscopic Colitis.

COULD IT BE INFLAMMATORY BOWEL DISEASE (IBD)?

IBD often presents with diarrhoea, abdominal pain, rectal bleeding or weight loss but may also present with common symptoms in the box above. Presents at any age but mainly teens/twenties. Family history increases risk especially in Crohn's.

POTENTIAL DISTINGUISHING SYMPTOMS:

Nocturnal defecation, fevers, night sweats (not to be confused with menopause), enlarged lymph glands, extra intestinal manifestations. Microscopic colitis mainly in women 50+ presents as profuse watery diarrhoea.

COULD IT BE COELIAC DISEASE?

Coeliac Disease is undiagnosed in two thirds of cases. It can present in non-specific ways, e.g. persistent or unexplained nausea and vomiting. It may also present with common symptoms in the box above. More likely if family history (first degree relative 1 in 10 risk), history of autoimmune conditions, Down's/Turner's syndromes.

POTENTIAL DISTINGUISHING SYMPTOMS:

Iron deficiency anaemia or B12 or folate deficiency, dermatitis herpetiformis, tooth enamel problems, unexplained subfertility or repeated miscarriages, neurological problems such as ataxia and peripheral neuropathy.

COULD IT BE IRRITABLE BOWEL SYNDROME (IBS)?

IBS is a longstanding illness with frequent abdominal discomfort and bowel symptoms that cannot be explained by any other disease.

PRESENTATION:

- Usually presents 20-40 years age
- But can be any age
- Slightly more women than men
- Post gastroenteritis
- Can be made worse by emotional stress

Based on history and clinical examination, consider which of the core primary care lower GI investigations to request for your patient.

CORE PRIMARY CARE LOWER GI INVESTIGATIONS

BASELINE BLOOD TESTS:

- Full Blood Count: looking for signs of anaemia or infection or systemic inflammation
- C-reactive protein: tests for inflammation and autoimmune disease
- Coeliac screen (patient should not eliminate or reduce gluten from diet)
- Thyroid Function Tests: to exclude hyperthyroidism as a cause of diarrhoea and hypothyroidism as a cause of constipation

STOOL TESTS:

- Faecal Calprotectin (FC) and/or Faecal Immunochemical Test (FIT) to support diagnosis or exclusion of IBD depending on local pathway.
- Stool Microscopy Culture and Sensitivity (MCS). Consider also parasites and if specific tests need to be requested e.g. C. difficile.

Aim to do all necessary blood tests at the same time to avoid the patient making multiple trips.

- **Coeliac Screen positive**. REFER to secondary care for diagnosis. Second serology test required and possible biopsy. If **Coeliac diagnosis confirmed**, treat in primary care with dietitian support (as per **Country** national/local guidance).
- Coeliac Screen negative. See green box below and safety netting.

Exact thresholds for Coeliac serology and the requirement for biopsy may vary locally.

- FC for IBD testing high (>250) with high index of suspicion: REFER to gastroenterology urgently.
- FC for IBD testing high (>250) with lower index of suspicion or equivocal (100-250). Repeat FC test within 4 weeks and REFER if result high (>250) or equivocal (100-250).
- FC for IBD testing low (<100): See green box below and safety netting.

- FIT threshold ≥10µg Hb/g. REFER to Colorectal Cancer pathway.
- FIT threshold <10µg Hb/g. See green box below and safety netting.

Exact thresholds for FC and FIT tests may vary and should be based on local assays and audit data

- Make a positive **diagnosis of IBS** if Coeliac and IBD are excluded. **TREAT** in primary care and safety net/reassess if symptoms suggest.

CLINICAL JUDGEMENT SHOULD OVERRIDE TEST RESULTS. IF THE PATIENT'S CLINICAL CONDITION SUGGESTS REFER TO GASTROENTEROLOGY.

SAFETY NETTING

- No diagnosis of cancer on the cancer pathway – reassess against lower GI pathway
- If severe symptoms - urgent GI referral may still be needed
- If symptoms persist or symptoms change – reassess
- Consider the possibility of:
  - upper GI cancer (if not already excluded)
  - multiple lower GI conditions at the same time
  - false negative FIT tests if ongoing symptoms – could still be IBD
  - false negative Coeliac serology – too little gluten in diet, IgA deficiency
  - other lower GI conditions (for example, the need to exclude **microscopic colitis** by biopsy, **bile acid malabsorption**, **diverticulitis**, **pancreatic insufficiency**, small bowel bacterial overgrowth)