

Digestive Problems

One in a series of curriculum statements produced by
the Royal College of General Practitioners:

- 1 Being a General Practitioner
- 2 The General Practice Consultation
- 3 Personal and Professional Responsibilities
 - 3.1 Clinical Governance
 - 3.2 Patient Safety
 - 3.3 Clinical Ethics and Values-Based Practice
 - 3.4 Promoting Equality and Valuing Diversity
 - 3.5 Evidence-Based Practice
 - 3.6 Research and Academic Activity
 - 3.7 Teaching, Mentoring and Clinical Supervision
- 4 Management
 - 4.1 Management in Primary Care
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- 5 Healthy People: promoting health and preventing disease
- 6 Genetics in Primary Care
- 7 Care of Acutely Ill People
- 8 Care of Children and Young People
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- 10 Gender-Specific Health Issues
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Key messages

- Digestive problems are common in general practice.
- The general practitioner has a central role in the diagnosis and management of digestive problems in primary care.
- Dyspepsia and gastro-oesophageal reflux disease (GORD) are common conditions, affecting around 28% of the population.
- Prevention and early treatment of colorectal cancer are priorities of the Departments of Health.

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[INTRODUCTION]

Rationale for this curriculum statement

Digestive problems are common in general practice. The general practitioner (GP) has a central role in the diagnosis and management of digestive problems in primary care. This RCGP curriculum statement on *Digestive Problems* covers conditions of the entire gastrointestinal tract, including the liver, pancreas, gall bladder and perianal area. The full range of generic competences is described in the *core* RCGP curriculum statement 1, *Being a General Practitioner*.

UK health priorities

Dyspepsia and gastro-oesophageal reflux disease (GORD) are common conditions, affecting around 28% of the population.^{1,2} They cause significant impairment of quality of life.³ Only 20% of those with dyspepsia or GORD consult a doctor, but this accounts for 2% to 8% of all primary care consultations.^{1,4,5} Almost all of those who consult receive a prescribed medication and 49% of all patients with dyspepsia take over the counter medications, with disease-modifying drugs now available without prescription.⁶ In the UK, dyspepsia costs the National Health Service over £500 million every year, and the cost to society has been estimated at a further £1 billion per year.⁷

Scotland has one of the highest incidences of colorectal cancer in the world (41 per 100,000 in men, 29 per 100,000 in women)⁸ and is the second most common cause of cancer death.⁹ The first SIGN colorectal cancer guideline was published in 1996, and was prompted by the poor survival from colorectal cancer in Scotland relative to the United States of America (USA) and parts of Europe. The guideline was updated in 2003.¹⁰

The Departments of Health in Wales and England have also called for action to improve recognition of potential symptoms of colorectal cancer in primary care. The National Institute for Health and Clinical Excellence (NICE) together with the National Collaborating Centre for Cancer have published cancer service guidance for the NHS in England and Wales on colorectal cancer.¹¹ GPs have an important role in the early diagnosis of colorectal cancers by ensuring that patients who may have colorectal cancer are rapidly referred for endoscopy.

[LEARNING OUTCOMES]

The following learning objectives describe the knowledge, skills and attitudes that a GP requires when managing patients with digestive problems. This curriculum statement should be read in conjunction with the other RCGP curriculum statements in the series. The full range of generic competences is described in the *core* RCGP curriculum statement 1, *Being a General Practitioner*.

Primary care management

- Manage primary contact with patients who have a digestive problem.
- Demonstrate a consistent, evidence-based approach to prescribing for dyspepsia.
- Explain the indications for urgent referral to specialist services, especially for patients with suspected gastrointestinal (GI) cancer.

The knowledge base

Symptoms:

- Dyspeptic symptoms (epigastric pain, heartburn, regurgitation, nausea, bloating)
- Abdominal pain
- Nausea, vomiting, anorexia, weight loss
- Haematemesis and melaena
- Rectal bleeding, tenesmus
- Jaundice
- Diarrhoea and constipation
- Dysphagia.

Common and/or important conditions:

- GORD
- Non-ulcer dyspepsia, gastritis, peptic ulceration
- Gallstones
- Irritable bowel syndrome
- Gastroenteritis
- Constipation
- Coeliac disease
- GI cancers (oesophageal, gastric, hepatic, pancreatic, colonic)
- Inflammatory bowel disease
- Diverticulosis
- Acute abdominal conditions, e.g. appendicitis, cholecystitis, pancreatitis
- Perianal disease (e.g. haemorrhoids, perianal haematoma, pilonidal sinus).

Investigations:

- Liver function tests
- Amylase
- *H. pylori* testing – serology, breath test, stool antigen testing
- Coeliac antibody screening
- Stool testing

- Faecal occult bloods
- Abdominal ultrasound
- Knowledge of secondary care investigations including endoscopy (oesophago-gastro-duodenoscopy, sigmoidoscopy, colonoscopy), abdominal imaging techniques (barium swallow, barium enema, computed tomography), liver biopsy, endoscopic retrograde cholangio-pancreatography and jejunal biopsy.

Treatment:

- Understand principles of treatment for common conditions managed largely in primary care
- Be aware of secondary care management of digestive problems, including surgical options.

Emergency care:

- Recognition of the acute abdomen
- Acute management of haematemesis and melaena.

Prevention:

- Dietary advice to include five portions of fruit or vegetables daily
- Smoking cessation and alcohol reduction to prevent GI cancers.

Person-centred care

- Recognise that some patients may find digestive problems, particularly lower GI, difficult to discuss openly.
- Demonstrate a non-judgemental, caring and professional consulting style to minimise embarrassment of patients with digestive problems.
- Demonstrate the ability to support people to self-care.

Specific problem-solving skills

- Intervene urgently when patients present with an acute abdomen.
- Recognise and respond urgently to red-flag symptoms, which may indicate GI cancer.
- Demonstrate a structured, logical approach to the diagnosis of abdominal pain, e.g. to enable a positive diagnosis of irritable bowel syndrome to be made, rather than making the diagnosis by exclusion.

A comprehensive approach

- Advise patients appropriately regarding lifestyle interventions that have an impact on gastrointestinal health, such as advice on diet and on stress reduction.
- Describe the gastrointestinal side effects of common medicines.
- Modify the form or modalities of treatment to cater for the patient's GI function and preferences.

Community orientation

- Evaluate the arguments for and against a national screening programme for colorectal cancer.
- Describe the rationale for restricting referrals for upper gastrointestinal endoscopy in the management of dyspepsia.

- Recognise the need for increased availability of lower gastrointestinal endoscopy for the diagnosis of colorectal cancer.
- Recognise the place of simple therapy and expectant measures in cost-effective management, whilst ensuring that the patient's condition is adequately monitored.

A holistic approach

- Recognise the effects psychological stress can have upon the gastrointestinal tract, especially with functional disorders, e.g. non-ulcer dyspepsia, irritable bowel syndrome, abdominal pain in children.
- Recognise the impact of social and cultural diversity, and the important role of health beliefs relating to diet, nutrition and gastrointestinal function.

Contextual aspects

- Recognise how common digestive problems are in the general population.
- Summarise the debate about the role of upper gastrointestinal endoscopy in the management of dyspepsia.
- Summarise the debate about the role of rapid-access GI investigation, including imaging and endoscopy.

Attitudinal aspects

- Recognise the embarrassment and reluctance of some patients to undergo rectal examination and respect the patient's autonomy.

Scientific aspects

- Demonstrate an understanding of the key national guidelines that influence healthcare provision for digestive problems.

Psychomotor skills

- Demonstrate complete abdominal examination, including rectal examination.
- Proctoscopy.

[FURTHER READING]

Examples of relevant texts and resources

- Beckinham I (ed.). *ABC of Liver, Pancreas and Gall Bladder* London: BMJ Books, 2001
- British Medical Association and Royal Pharmaceutical Society of Great Britain. *The British National Formulary 50* London: BMJ Books, 2005
- Delaney BC. 10-minute consultation: dyspepsia *BMJ* 2001; 322: 776
- Jankowski J, Jones R, Delaney B, Dent J. 10-minute consultation: gastro-oesophageal reflux disease *BMJ* 2002; 325: 945
- Jones DJ (ed.). *ABC of Colorectal Disease (2nd edn)* London: BMJ Books, 1998
- Jones R, Galloway J, de Wit NJ, et al. (eds). Digestive problems (Section 4). In: Jones R, Britten N, Culpepper L, Gass DA, Grol R, Mant D, et al. *Oxford Textbook of Primary Medical Care, Vol. 2: clinical management* Oxford: Oxford University Press, 2004, pp. 729–73
- Kerr D, Young A, Hobbs FDR. *ABC of Colorectal Cancer* London: BMJ Books, 2001
- Logan R, Harris A, Misiewicz JJ, Baron JH (eds). *ABC of Upper Gastrointestinal Tract* London: BMJ Books, 2002
- Truswell AS. *ABC of Nutrition (4th edn)* London: BMJ Books, 2003
- Warrell D, Cox TM, Firth JD, Benz EJ (eds). *Oxford Textbook of Medicine (4th edn)* Oxford: Oxford University Press, 2004

Web resources

British Society of Gastroenterology

The British Society of Gastroenterology (BSG) is an organisation focused on the promotion of gastroenterology within the United Kingdom. It has over 2000 members drawn from the ranks of physicians, surgeons, pathologists, radiologists, scientists, nurses, dieticians and others interested in the field. Founded in 1937 it has grown from a club to be a major force in British medicine, with representation within the British Royal Colleges and thus to the Department of Health and government. Internationally it is represented at world and European level. The BSG is a registered charity. The BSG runs an annual scientific meeting at which many hundred original papers are presented to audiences approaching 2600 professionals. It is also intimately involved in all aspects of training of British gastroenterology and to original research in the field. Research is supported indirectly through promotion of high standards and offering platforms for scientific presentation and publication, and directly through substantial financial contributions to the Digestive Disorders Foundation. *GUT*, the Society's scientific journal is Europe's highest ranked, by citation-related impact factor. The Society regularly produces guidelines on aspects of contemporary practice.

www.bsg.org.uk/

National ~~Electronic~~ Library for Health and National ~~Electronic~~ Library for Public Health

The aim of the National ~~Electronic~~ Library for Health (NeLH) is to provide clinicians with access to the best current know-how and knowledge to support health care related decisions. Patients, carers and the public are also welcome to use the site, because the NeLH is open to all. The ultimate aim is for the Library to be a resource for the widest range of people both directly and indirectly.

The main priority for the NeLH is to help the NHS achieve its objectives. However, it is also aimed at those healthcare professionals who are working in the private sector where common standards should apply. For example, the National Screening Committee is not only an NHS advisory committee, but its mission is also to promote the health of the whole population and its

recommendations are relevant to the private sector. Part of the content of the NeLH such as Clinical Evidence and Cochrane Library is licensed from commercial providers.
www.nelh.nhs.uk/new_users.aspwww.library.nhs.uk

National Institute for Health and Clinical Excellence

National Institute for Health and Clinical Excellence (NICE) is the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health. It produces three kinds of guidance:

- Technology appraisals – guidance on the use of new and existing medicines and treatments within the NHS in England and Wales
- Clinical guidelines – guidance on the appropriate treatment and care of people with specific diseases and conditions within the NHS in England and Wales
- Interventional procedures – guidance on whether interventional procedures used for diagnosis or treatment are safe enough and work well enough for routine use in England, Wales and Scotland.

NICE – Cancer service guidance for the NHS in England and Wales: *Improving Outcomes for Colorectal Cancer* (update), 2004

www.nice.org.uk/page.aspx?o=204541

www.nice.org.uk/guidance/index.jsp?action=byID&r=true&o=10895

NICE – CG17. *Dyspepsia: managing dyspepsia in adults in primary care*, 2004

www.nice.org.uk/page.aspx?o=218377

www.nice.org.uk/guidance/index.jsp?action=byID&r=true&o=10950

NICE – CG27. *Referral Guidelines for Suspected Cancer in Adults and Children*, 2005

www.nice.org.uk/pdf/CG027fullguideline.pdf

www.nice.org.uk/guidance/index.jsp?action=download&o=29816

NHSScotland – online health information including up-to-date SIGN guidelines

The Scottish Intercollegiate Guidelines Network (SIGN) was formed in 1993. Its objective is to improve the quality of health care for patients in Scotland by reducing variation in practice and outcome, through the development and dissemination of national clinical guidelines containing recommendations for effective practice based on current evidence.

www.sign.ac.uk/guidelines

Primary Care Society for Gastroenterology

The Primary Care Society for Gastroenterology (PCSG) was founded in 1985 to provide a network for GPs and others interested in all clinical, research and educational aspects of gastroenterological disorders, and in particular their management in primary care. The Society has established links with the British Society of Gastroenterology and a number of other bodies. They aim to provide a general practice voice and perspective to policy-makers and expert bodies.

The Society holds an annual scientific meeting and also a session at the annual British Society of Gastroenterology meeting where original papers are presented and issues concerning gastroenterology in primary care are discussed and debated. Since the bulk of patients with gastroenterological disorders are managed in primary care the Society is keen to promote research in a general practice setting. A small number of research grants are awarded for suitable projects. The PCSG has issued evidence-based decision points in the management of *Helicobacter pylori*, the early detection of colorectal cancer and most recently the management of coeliac disease in primary care. Its aim is to produce guidelines backed by research evidence that are relevant and accessible to working GPs. Further guidelines are planned and all are available from its website.

Its web pages aim to provide an information resource, which includes its guideline documents, NICE Guidance and a selection of recent articles as a good starting point for busy

primary care workers seeking information on the diagnosis and management of common gastrointestinal problems. Subjects covered include: gastro-oesophageal reflux disease, peptic ulceration, *Helicobacter pylori*, colorectal cancer, Crohn's disease, ulcerative colitis, irritable bowel syndrome and coeliac disease. It also covers liver and biliary tract problems, including hepatitis C.

www.pcsq.org.uk/

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[PROMOTING LEARNING ABOUT DIGESTIVE PROBLEMS]

Work-based learning – in primary care

This is probably the best place for a GP to learn how to manage digestive problems because of the wealth of clinical material that presents. There is no substitute for clinical experience supported by a GP trainer and experienced members of the primary healthcare team.

Many local health communities also have GPs who have a special interest in digestive problems, many of whom are highly skilled in endoscopy and other colorectal procedures. Specialty registrars (GP) will find their clinics valuable learning environments to learn more about the pathology of the problems but also about the possibilities of extending their role as a General Practitioner with Special Interests (GPwSI).

Work-based learning – in secondary care

Specialty registrars (GP) will usually have gained some experience of digestive problems during their foundation programme or equivalent in a surgical or gastroenterology hospital placement. Some GP training programmes will also contain placements of varying length with surgeons or gastroenterologists who give exposure to patients with serious digestive problems in the acute setting. Most specialist care is, however, provided in outpatient or clinic settings. These are ideal places for seeing concentrated groups of patients with digestive problems whether upper or lower GI tract or hepatobiliary in cause. They also provide opportunities to observe rarer digestive conditions, investigations and specialist treatments.

Specialty registrars should also take the opportunity to attend gastroenterology and other relevant clinics when working in other hospital posts, and should also consider attending specialist clinics during their general practice placements.

Non-work-based learning

Many postgraduate deaneries provide courses on digestive problems. Other providers include universities and the RCGP.

Learning with other healthcare professionals

The RCGP is keen to encourage the provision of multiprofessional training opportunities in primary care. A multiprofessional approach, combining the training of pharmacists, nurses and GPs, would greatly benefit patients and help to promote greater integration in local services. Care of patients in the postoperative period and for those with stomas are ideal learning opportunities with other members of the primary healthcare team.

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- ² Stanghellini V. Three-month prevalence rates of gastrointestinal symptoms and the influence of demographic factors: results from the Domestic/International Gastroenterology Surveillance Study (DIGEST) *Scand J Gastroenterol Suppl* 1999; 231: 20-8
- ³ Enck P, Dubois D, Marquis P. Quality of life in patients with upper gastrointestinal symptoms: results from the Domestic/International Gastroenterology Surveillance Study (DIGEST) *Scand J Gastroenterol Suppl* 1999; 231: 48-54
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- ⁶ Haycox A, Einarson T, Eggleston A. The health economic impact of upper gastrointestinal symptoms in the general population: results from the Domestic/International Gastroenterology Surveillance Study (DIGEST) *Scand J Gastroenterol Suppl* 1999; 231: 38-47
- ⁷ Moayyedi P and Mason J. Clinical and economic consequences of dyspepsia in the community *Gut* 2002; 50: 10iv-12
- ⁸ Clinical Outcomes Working Group. *Clinical Outcome Indicators* Edinburgh: Clinical Resource and Audit Group, 2000
- ⁹ ISD Scotland. *Cancer Incidence and Mortality by Site/Type of Cancer, Sex and Year of Diagnosis/Registration of Death: 1989-1998* Edinburgh: ISD Scotland, 2000
- ¹⁰ Scottish Intercollegiate Guidelines Network (SIGN). *Guideline No 67 Management of Colorectal Cancer* Edinburgh: SIGN, 2003, www.sign.ac.uk/guidelines/fulltext/67/index.html [accessed January 2007]
- ¹¹ NICE. *Cancer Service Guidance for the NHS in England and Wales: improving outcomes in colorectal cancer (update)* London: NICE, 2004, www.nice.org.uk/page.aspx?o=204541 [accessed January 2007]