# 1. Liver disease

**Date: October 2009**
**Revision date: October 2011**

## Gastroenterology

| Clinical problem | Management in primary care | Referral criteria |
|---|---|---|
| Hepatitis B | HepBsAg pos, ALT<60, normal aFP and no evidence of cirrhosis#<br>• 6mthly aFP and ALT<br><br>USS if<br>• family history of primary liver cancer<br>• clinical suspicion of cirrhosis | Refer gastroenterology clinic if;<br>• HepBsAg pos, ALT>60 for >6mths<br>• aFP raised<br>• Liver mass on imaging<br>• Suspected cirrhosis#<br>• Acute HBV with low albumin or high INR |
| Hepatitis C | Repeat RNA at 3 mths to ensure negative if anti-HCV pos$ | Refer gastroenterology clinic if<br>• HCV RNA pos |
| Other | (i) Alcohol:<br>• Exclude other liver diseases*<br>• No evidence cirrhosis#<br>• Abstinence and CADS/AA<br>• 6mthly LFTs, INR, FBC, alb<br><br>(ii) Fatty liver:<br>• Exclude other liver disease*<br>• No evidence cirrhosis#<br>• USS if diagnosis uncertain<br>• Treat obesity, DM, lipids, HT<br>• 6mthly LFTs, INR, FBC, alb<br><br>(iii) Medication related:<br>• Withdraw suspected medication<br>• Refer if no improvement in 2mths<br><br>(iv) Rt heart failure:<br>• Treat the Rt heart failure | Refer acutely to gastroenterology registrar if:<br>• Liver failure e.g. acute severe hepatitis (Jaundiced +/- ALT>500) with high INR require admission.<br><br>Discussed with gastroenterology registrar if:<br>• acute severe hepatitis (normal INR) or severe cholestasis to organise urgent out patient appointment or planned admission<br><br>Refer acutely to general surgical registrar if:<br>• Jaundice and biliary colic<br><br>Refer to gastroenterology clinic if:<br>• Unexplained abnormal LFTs for 6mths*<br>• Autoimmune hepatitis (ANA pos)<br>• Hereditary haemochromatosis if abnormal LFTs, Ferritin>1000 or hepatomegaly. Otherwise refer to Haemochromatosis Primary Care Management Guidelines on www.waikatodhb.govt.nz/gp<br>• Anyone with suspected cirrhosis# |

*=Screen for liver diseases (HepBsAg, antiHCV, ANA, AntiLKM/Sm/SLA, AMA, immunogloblins, Iron studies, HFE gene test (if iron sat>45%), liver USS, careful alcohol and drug history)
#=Evidence of cirrhosis- clinical (jaundice, ascites, spider naevi, gynaecomastia), laboratory (thrombocytopenia, low albumin, abnormal INR), radiological (splenomegaly, ascites, varices)
$=Repeat HCV RNA is advised as there can be false negative tests.

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# 2. Constipation and diarrhoea

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## Gastroenterology

| Clinical problem | Management in primary care | Referral criteria |
|---|---|---|
| Constipation | Rectal examination to exclude impaction, prolapse or fissure<br>Blood tests: Calcium, TFTs, FBC and glucose<br>Avoid medications which cause constipation<br>Fibre supplements and laxatives:<br>• osmotic/fibre laxatives e.g. Mucilax, lactulose preferable for chronic use<br>• stimulants e.g. senna, docusate and senna should be used intermittently | Refer to gastroenterology clinic if:<br>• recent change in bowel habit (CIBH) suspicious of malignancy (age>50, bleeding, iron deficiency) |
| Chronic diarrhoea | Check diet (consider lactose intolerance, sorbitol, alcohol, caffeine)<br><br>Exclude organic disease*** | Refer gastroenterology clinic if:<br>• abnormal blood or stool tests |
| Irritable Bowel Syndrome<br>*Rome III criteria: recurrent abdominal discomfort 3 days/month in last 3 month and 2 of: relief on defaecation/change in frequency/change in form*<br>*Longstreth, GF, et al. Gastroenterology 2006; 130:1480* | Reassurance, education<br>Lifestyle and dietary advice<br>For constipation try fibre e.g. Mucilax<br>For diarrhoea try antispasmodics (e.g. mebeverine) or antidiarrhoeal medication (e.g. loperamide)<br>Treat psychological contributors<br>Antidepressants (e.g. amitriptyline) are useful if pain predominates<br><br>Exclude organic disease*** | Refer to gastroenterology clinic if "Red flags":<br>• weight loss<br>• nocturnal symptoms<br>• blood in stools<br>• FHx colorectal cancer<br>(specificity of Rome III criteria in absence of red flags= 98%) |
| Rectal bleeding without change in bowel habit (CIBH) | Referral is unnecessary if there is minimal bleeding and rectal examination/proctoscopy confirms a bleeding source (e.g. haemorrhoids) provided the patient is young (<50yrs) and there is no weight loss, anaemia or family history of colorectal cancer | Refer to surgical clinic for sigmoidoscopy (+/- banding of haemorrhoids) if age<50yrs and bleeding persistent or of uncertain origin<br><br>Refer for colonoscopy if age >50yrs |

***= Exclusion of organic disease (FBC, Iron studies, B12, folate, Ca, CRP, LFTs, coeliac serology and TFTs), Stool tests (MCandS)

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# 3. Dyspepsia

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## Gastroenterology

| Clinical problem | Management in primary care | Referral criteria |
|---|---|---|
| Reflux (GORD)<br>*Burning pain in the upper abdomen radiating into the neck sometimes associated with regurgitation* | • Lifestyle (antacids prn, weight loss, stop smoking, smaller meals)<br>• Ranitidine 150-300mg daily, Omeprazole 20mg daily or Pantoprazole 40mg daily initially increasing to bd if necessary<br>• Addition of domperidone 10-20mg tds po | Refer to gastroenterology clinic if treatment unsuccessful or “alarm symptoms”**** |
| Stratify all patients with dyspepsia by testing for H Pylori by serology | | |
| Dyspepsia- HP positive | Triple therapy<br>(i) Losec Hp7 OAC<br>(ii) Penicillin allergic: omeprazole 20mg bd, metronidazole 400mg bd, clarithromycin 500mg bd for 7 days | If symptoms continue, and HP stool antigen subsequently negative, treat according to “dyspepsia - HP negative” guideline below. |
| Dyspepsia - HP negative<br><br>(i)dysmotility type (bloating)<br><br>(ii)ulcer type (mainly epigastric pain) | Lifestyle (avoiding fatty foods, coffee, chocolate, alcohol and smoking)<br><br>Domperidone 10mg tds increasing to 20mg tds<br><br>Omeprazole 20mg or Pantoprazole 40mg daily increasing to bd if necessary | Refer to gastroenterology clinic if symptoms continue and ultrasound excludes biliary disease |

| ****Alarm symptoms<br>-refer for consideration of gastroscopy |
|---|
| Anaemia<br>Weight loss<br>Dysphagia<br>Persistent vomiting<br>Haematemesis<br>Melaena<br>NSAID, steroid or anticoagulant use<br>Recent onset if age>45yrs |

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# 4. Colonoscopic surveillance of groups at increased risk or colorectal cancer (CRC)

**Date: October 2009**
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## Gastroenterology

**These guidelines apply to asymptomatic patients.**

| Personal history | Recommendation |
|---|---|
| Colorectal cancer | Completion colonoscopy within 1 year if not done preoperatively. Subsequent colonoscopic surveillance at 3 years and then 5 yearly. |
| Adenomatous polyps | Repeat colonoscopy at 5 years and no further colonoscopy if normal -unless high risk features.<br><br>High Risk Features are: Family history CRC, adenoma>1cm, more than 3 adenomas, severe dysplasia or villous histology. |
| Inflammatory bowel disease | Reassess all patients with IBD for 8-10 years with colonoscopy. If extensive disease they will be offered colonoscopic surveillance. |

| Family history | Risk of CRC by 75yrs | Recommendation |
|---|---|---|
| Moderate risk<br><br>1 FDR with CRC<55yrs<br>2 FDRs with CRC | 17-34% | Colonoscopy 5 yearly from age 50 or from 10yrs before earliest CRC in family |
| Potentially high risk<br><br>1 FDR with CRC<50yrs<br>1 FDR and 1 SDR with CRC<55yrs<br>1 FDR and 2 SDRs with CRC<br>Familial CRC syndrome | 50% or greater | Refer to bowel cancer specialist or familial cancer clinic for further management |

FDR=first degree relative (sibling, parents, children). SDR=second degree relative (grandparent, aunt, uncle, nephew or niece). The relatives need to be on the same side of the family to infer increased risk.

Note: When considering colonoscopic surveillance, the individual's age and comorbid conditions are important. The recommended upper age for surveillance is 75 years. Please refer to New Zealand Guidelines Group Summary 2004 (www.nzgg.org.nz) for further details.

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