Do we care enough?

Solutions for GI symptoms before, during & after GI cancer

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Consultant Gastroenterologist in Pelvic Radiation Disease

Jane

28, hedge fund manager
felt really unwell “for ever”
bowels open 2-6 times / day +/- urgency
stool constipated → normal → pellety → loose
pains helped by bowels being open
pain associated with loose stool
no weight loss
no bleeding
examination normal
recently split up with long term partner
can’t concentrate
stress makes things worse
father and brother - Crohn’s disease
mother (27) and grandmother (45) bowel cancer

What is your diagnosis?

1. IBS
2. IBD
3. Cancer
4. Bile acid malabsorption
5. All of the above
6. Impossible to say
Jane

GP -> professor of gastroenterologist

• Blood tests/ gastroscopy/ colonoscopy/ CT scan
• 3 conclusions

1: no cancer
2: no IBD
ipse facto: = IBS

• Offered antidepressant
• Refused antidepressant

Are symptoms reliable?

Systematic review:
“Accuracy of symptom-based criteria for diagnosis of IBS in primary care”

Conclusions: organic disease cannot be accurately excluded

Jellema, Van der Windt, Schellevis, Van der Horst 2009

“It has become appallingly obvious that our technology has exceeded our humanity.”

Albert Einstein
Mr B

- 46 year old banker
- Stage IV low rectal cancer
- Neoadjuvant chemoradiation
- Low anterior resection with J pouch
- 2 years out from treatment
- 3 different clinicians involved in follow up

- 2 CT scans
- 3 MRI scans
- 1 colonoscopy
- 13 follow up appointments
- CEA checked 7 times
- No medication

Cured!

But does anybody care?

Mr B

- Bowels open 10-18 times / day
- Normal - liquid stool
- Unable to attend meeting > 20 minutes
- Bowels open 3 times per night
- Tenesmus +++
- Wears nappies

It is no-one’s job to manage quality of life

Truth no. 1
Henry B

- 72 year old
- Long history of reflux
- 3mm cancer in a 5cm Barrett’s segment
- Ivor Lewis Oesophagectomy
- Feeding jejunostomy

Henry B

- Oesophagectomy
- Jejunostomy failure
- Repeated biliary obstruction
- Emergency cholecystectomy
- Nasogastric feeding started
- Nasogastric feeding stopped

Henry B

In the GI clinic
- depressed
- severe nausea
- retching
- severe pain / bloating on eating
- frightened to eat
- bowels erratic (constipation to diarrhoea)
- severe flatulence
- borborygmi

Medication
- lansoprazole
- metoclopramide
The only aim of healthcare should be health gain

Surviving cancer

- UK: 2 million
- Increasing > 3% per year (UK)
- 11% increase per year in USA
- 4 million in the UK by 2030?


Rectal cancer

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Surgery alone</th>
<th>Preoperative radiotherapy</th>
<th>Post operative radiotherapy</th>
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<tbody>
<tr>
<td>Any incontinence</td>
<td>5-38%</td>
<td>51-72%</td>
<td>49-60%</td>
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<tr>
<td>Toilet</td>
<td>6%</td>
<td>30%</td>
<td>53%</td>
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<tr>
<td>Excellent function</td>
<td>32%</td>
<td>14%</td>
<td>N/A</td>
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</table>

Curing cancer inevitably risks damage to normal tissues.
Long term

20-25% experience a physical ongoing consequence of cancer treatment

Armes, 2009; Dell, 2010; NCSI, 2011
UK hospitals with ≥1 gastroenterologists with a specialist interest in IBD

- 8,500 moderate or severe GI dysfunction after pelvic radiotherapy / year
- 7,000 GI cancers with toilet dependency / year
- 12-15,000 IBD / year

Mean 7 appointments

The Royal Marsden

Numbers of patients per 6 month period

Workload in GI late consequences clinic at The Royal Marsden

So what do I do?

I manage symptoms.

How?
Introducing:
The GIANTs
the GI And Nutrition Teams
The Royal Marsden
The multidisciplinary team

Team approach

Holistic assessment

What do symptoms mean?

- very little!
### Chronic loose stool / Diarrhoea 1:2

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### GI symptoms:
The Royal Marsden GI Unit algorithmic approach

### Patients have more than one symptom

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Men</th>
<th>Women</th>
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</thead>
<tbody>
<tr>
<td>Median 11 symptoms (range 1-16)</td>
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<td>Median 12 symptoms (range 4-16)</td>
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<tr>
<td>Rectal bleeding</td>
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<tr>
<td>Menstrual need to defecate</td>
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<tr>
<td>Abdominal pain - distension</td>
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<tr>
<td>Change in bowel habit</td>
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<td>Pain - back (new onset)</td>
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RMHI algorithm v8 2013 Bentin 2011, Mals 2013
2 principles of clinical management?

1. Patients have more than one symptom and they all need to be actively managed

2. Abnormal physiology causes symptoms

The physiological model

Any insult → Inflammatory changes → Oedema → Ischaemia → Fibrosis → Potentially alter specific GI physiological function(s) → Atrophy / loss of stem cells → Cell death → Oedema → Potentially alter specific GI physiological function(s) → Symptoms

Unrelated factors:
- medication side effects
- stress
- sepsis
- premorbid conditions
Using the concept of physiological algorithmic approach

Management of symptoms becomes straightforward

Identify each symptom accurately

Arrange appropriate tests to identify which physiological deficits are present

-> obvious treatment options

Henry B

In the GI clinic
• depressed
• severe nausea
• retching
• severe pain / bloating on eating
• frightened to eat
• bowels erratic (constipation to diarrhoea)
• severe flatulence
• borborygmi

Medication
• lansoprazole
• metoclopramide

Henry B

Most overlooked causes for upper GI symptoms
• Gastric bile reflux
• Small bowel bacterial overgrowth
• Delayed gastric emptying
Henry B

Immediate treatment
- sucralfate suspension
- ciprofloxacin 500mg bd for 1 week
- pro-motility regimen
  - paroxetine syrup 20mg od
  - erythromycin syrup 250mg bd
  - domperidone suspension 10mg qds 30 mins before food

Henry B

5 weeks later
- 2kg weight gain
- nausea / retching settled
- pain settled
- erratic bowel function settled
- wind disappeared
- VERY happy!

Mr B

- Bowels open 10-18 times / day
- Normal – liquid stool
- Unable to attend meeting > 20 minutes
- Bowels open 3 times per night
- Tenesmus +++
- Wears nappies
Mr B

- Some inflammation in his pouch
- No other abnormalities

Treatment given
- Normacol
- Toileting exercises
- Glycerine suppositories

After 6 weeks
- Bowels open 4 times a day
- No urgency incontinence
- No nocturnal defaecation

Jane

- 28, hedge fund manager
- Felt really unwell “for ever”

3 further key facts in the history:
- Woken from sleep x1 / week to defaecate
- Rich food “a nightmare”
- Intermittent steatorrhoea

- Obviously, bile acid malabsorption!
Jane

- SeHCAT scan
- moderate bile acid malabsorption
- given colesevelam 2 tds with food

5 weeks later
- “I feel great”
- “My friends say that I’m a different person”
- “Your patients must love you”

6 months later
- “You have transformed my life”

Organic disease misdiagnosed as IBS-D

1. Bile acid malabsorption (32%)  
2. Small bowel bacterial overgrowth (10-65%)  
3. Pancreatic insufficiency (6%)  
4. Coeliac disease (4%)  
5. Inflammatory bowel disease (0-1%)  
6. Cancer (<0.5%)

Conclusions

1. Loads of patients  
2. In loads of trouble  
3. Need referral pathways for expert care  
4. GI symptoms after cancer treatment… make no assumptions….  
5. If you diagnose BAM…… They will LOVE you!