Have you got the guts for it? Showcasing the role of an FCD working in gastroenterology

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Introduction

- First contact dietitian since 2022
- Recently qualified Advanced Clinical Practitioner (gastro focused in secondary care)
- Previous roles in gastro inpatient/community
- BDA Specialist Group Practice Officer

- How about you?

Learning outcomes

- Scope of practice for gastro FCDs
- Different presentations in primary care
- Difference between FCD and gastro dietetics
- Example job plans
- Tests, orders and referrals
- Case studies
- Current challenges

Scope of practice in primary care

- Gastroenterology - functional bowel disorders, irritable bowel syndrome and coeliac disease (BDA)

-Synthesise knowledge of appropriate treatments for FBD, IBS and coeliac disease.

-Synthesise information around current pharmacological treatments for FBD and irritable bowel syndrome.

-Synthesise knowledge of the role that diet and lifestyle plays in managing gastrointestinal conditions.

-Critically analyse the severity and impact of related symptoms on clinical, nutritional and mental health status (HEE Roadmap to Practice, 2021)

Is anyone working any differently?

How do FCDs work differently?

- Need to establish diagnosis
- Ruling out red flags
- Onward referrals
- Wider thinking
- Extended assessment skills
- May not discuss dietary advice!
- Discuss with colleagues, duty doctor, seek advice when needed
- Need to know your local guidelines for referrals
- Safety netting

Example Gastro FCD roles

- Diagnosis of functional bowel disorders and referring on to local pathways
- Diagnosis and management of functional bowel disorders
- Management and advice for already established gastro conditions
- Management of coeliac disease including bloods/prescriptions/referrals

Example criteria

Condition	Patient presentation	Action
Functional bowel disorder	A change in bowel habit (frequency, diarrhoea, constipation) Abdominal bloating, distension, tension or hardness, excess gas Heartburn/reflux Food intolerance or allergy	Book into embargoed slot either same day or same week
Other gastrointestinal	**Nutritional support for colostomy/ileostomy, liver disease, diverticulitis, reflux, inflammatory bowel disease, coeliac disease**	**Clinicians - Book into any slot (depending on urgency)** **Reception staff – book into embargoed slot**

Gastro:

- new & established presentations e.g. abdominal pain / abdominal
- discomfort / bloating / change bowel habit / indigestion / constipation / diarrhoea
- new and established conditions e.g. IBS, diverticular disease, coeliac disease, pancreatic insufficiency, liver disease

Example clinic

	Reason	Source of referral	Outcome
0800	Admin / prep for the day		
0845	Weight Management	Follow up –Orlistat review	Review booked
0915	IBS	Follow up FODMAP diet	Symptom improvement – d/c
0945	Diverticular Disease	New – booked by clinician	Advice provided
1015	Admin		
1030	Loose stools	New – booked by reception same day	Bloods, faecal calpro and FIT ordered
1100	Suspected food intolerance	New – booked by reception same day	Bloods and stool test ordered, diet advice given
1130	Lipid lowering advice	New – booked by clinician	Advice provided
1200	Discuss with colleagues/admin		Discuss 1030 patient
1230	Lunch		

Example projects

- Kim Bowra - Frequent Attenders Project

-A pilot in FCD assessment and support of ‘frequent attender patients that have gastro conditions’ such as diverticular disease or IBS

-Offer enhanced assessment, advice and sign posting for patients with unmet needs and recurrent GP contacts

-Initial project results show positive impact of FCD input including improvement in symptoms and quality of life

- GORD
- Diverticular disease

Presentations

- Abdominal pain
- Abdominal bloating/ distension
- Constipation
- Incomplete evacuation
- Diarrhoea/loose stools
- Nausea/vomiting
- Urgency to open bowels
- Excessive wind/flatulence
- Indigestion/heartburn

Presentations – thinking as an FCD

Abdominal pain :

- IBS
- Appendicitis
- Diverticulitis
- Bowel obstruction
- Pregnancy

Bloating:

- IBS
- Ovarian cancer
- Bowel obstruction

Indigestion/heartburn:

- IBS / GORD
- Upper GI cancers
- H. Pylori

Diarrhoea:

- IBS
- IBD
- Bowel cancer
- Diverticulitis
- Infection
- Malabsorption

- We don’t necessarily need to TREAT these conditions but know how to IDENTIFY or RULE OUT
- Even if not seeing as a ‘first contact’ these are still useful skills to have working independently in primary care

Tests in Primary Care

- From the Roadmap:
- Temperature, • Pulse rate • Blood pressure • Respiratory rate • Blood tests – FBC, LFT, U&Es ESR, CRP, coeliac screen, haematinics, amylase, hepatitis and human immunodeficiency virus (HIV) screening, Imumoglobulins test (may include IgM, IgG, total IgA, IgA tTGA), CA125, nutritional deficiency screening
- Stool sample – culture and sensitivity, faecal calprotectin, helicobacter-pylori testing, faecal elastase, Faecal Immunochemical Testing (FIT), Faecal Occult Blood depending on local availability
- Referrals – abdominal Ultrasound, X-Ray • Referral for specialist nutritional management, as appropriate • Recognises need for direct referral for colonoscopy, gastroscopy and endoscopy.

NICE Clinical Knowledge Summaries CKS

- Provides bitesize advice on assessment, tests and when to refer
- Diarrhoea (acute and chronic) - Diarrhoea - adult's assessment | Health topics A to Z | CKS | NICE
- Suspected cancer recognition and referral - Recommendations organised by site of cancer | Suspected cancer: recognition and referral | Guidance | NICE
- Changes in 2023 to lower GI guidelines – more emphasis on using FIT rather than referral to urgent pathway
- When would you use FIT vs straight to test?
- Refer if abdominal/rectal mass, FIT result of at least 10 micrograms of haemoglobin per gram of faeces

Clinical Examination

- Abdominal examination
- Assessment for lymphadenopathy – is anyone doing this?
- Digital rectal examination – is anyone doing this?

- How do I get trained?
- Focus on abdo during stage 2 training
- Additional clinical skills module training
- Keep upskilled
- Only use in practice if you feel confident in what you are looking for!

Abdominal Examination - OSCE Guide | Geeky Medics

Less Common GI conditions

- Bile Acid Malabsorption
- - There is not enough evidence to recommend routine adoption of SeHCAT (tauroselcholic [75 selenium] acid) for diagnosing bile acid diarrhoea in people with:
- chronic diarrhoea with an unknown cause, suspected or diagnosed diarrhoea-predominant irritable bowel syndrome (IBS-D) or functional diarrhoea
- Crohn's disease without ileal resection who have chronic diarrhoea. (NICE DG44)
- Treated with Bile Acid Sequestrants - colestyramine, colesevelam.
- Primary care challenges – BNF suggest monitoring of fat-soluble vitamins, needs to be arranged in secondary care

Less Common GI Conditions

- Small Intestine Bacterial Overgrowth

-Difficult to diagnose (lack of test available / accuracy of tests)

-Treated empirically with non-absorbed abx e.g. Rifaximin (BSG, 2020) however database is limited for this and risks of long-term broad abx use need to be considered (Eamonn et al, 2020)

-Amber drug so needs initiation in secondary care

-Newer developments suggest the likelihood of functional SIBO is low and it is more common alongside conditions such as IBD, PEI, and that initial management should be to correct the cause (BSG, 2021)

-FODMAP diet will not treat but may help improve symptoms (BSG, 2020)

AGA Clinical Practice Update on Small Intestinal Bacterial Overgrowth: Expert Review - Gastroenterology (gastrojournal.org)

Small-intestinal bacterial overgrowth treatment case study (bsg.org.uk)

Vasant DH, Paine PA, Black CJ*, et al,* British Society of Gastroenterology guidelines on the management of irritable bowel syndrome *Gut* 2021;**70:**1214-1240.

Case example 1

- 39yo female
- Presenting complaint: bloating, abdominal discomfort. Booked into FCD clinic.
- Further history from patient: nausea, poor appetite, excess burping. Symptoms occurred 6 weeks ago and have been worsening
- What further history would you like to ask?
- Family history (Grandmother ovarian ca)
- Bowels (BNO for 3/7, previously no issues)
- Recent investigations (nil)
- Red flags (weight stable, no PR bleeding, feeling generally well)

- What are your differentials at this stage and how would you rule these in/out?
- -Bowel obstruction (abdo examination/general obs/x-ray)
- -Ovarian cancer (CA125)
- -IBS (FBC, TTG/IGA, CRP/ESR, CA125, ?Faecal calprotectin)
- -Coeliac disease (TTG/IGA)
- -H.Pylori (stool test)
- -Pregnancy (pregnancy test!)

Case Example 1

- What examinations would you perform?
- -General obs (normal BP, HR, temp)
- -Abdominal examination (distention, tender. No guarding/rigidity/rebound tenderness. Bowel sounds present.)
- -PR exam (some stool noted in rectum)
- -On further discussion patient reports has been passing flatus
- What do these examinations make unlikely?
- Bowel obstruction

- How would you end the consult?
- Advise on reasons for tests and await results
- Dietary advice / laxatives for bowels
- Safety net – vomiting / fever / BNO and no flatus emergency presentation

Case example 2

- 65 yo male
- Presenting complaint – loose stools. Booked into FCD clinic
- Symptoms: bowels opening 3-5 times daily, loose-watery. Normal in colour. Noticed some blood on wiping.
- Weight history: 6 months ago 90kg. Now 78kg, unintentional loss
- What are the red flags in this case?
- -Unintentional weight loss
- -Change in bowel habit
- -Age
- -Blood?

- What actions would you take?
- -DRE
- -Abdominal examination
- -Blood tests – anaemia screen
- -FIT
- -Fast track referral for suspected cancer?
- -NICE suggests FIT testing in the first instance for patients with weight loss, change in bowel habit, unexplained rectal bleeding
- -NICE suggest fast-track referral for suspected cancer in patients with raised FIT or with an identified abdominal mass
- -Discuss with colleagues if unsure

Case Example 2

- As you are ending the consultation, the patient mentions that ‘he won’t be able to carry on’ if the results are bad news. How do you respond to this?

-Counsel patient on reason for tests

-Explore patients current feelings – safety net for suicidal thoughts – what are his protective factors? Does he have any intent to harm himself?

-Safety net with crisis line and advise A&E if feels unsafe

-Direct to local support services if appropriate

Current challenges

- PERT Shortages – how can we manage this in Primary care?
- PERT Position Statement: Position Statement: Pert Shortage | Pancreatic Society of Great Britain and Ireland (psgbi.org)
- Includes advice for prescribers (conversion charts)
- Clinical management suggestions (other meds)
- If patients are unable to access any PERT and are losing weight or have intractable or unmanageable abdominal symptoms, we suggest reducing their oral intake of food significantly and prescribing peptide based oral nutritional supplements
- Advice for dietitians (PERT education, suitable ONS, fat/fibre manipulation)
- Patient information leaflet available

Questions