Management of gastrointestinal disease

Returning it to primary care

Nigel W. Flook, MD, CCFP

Waiting lists across Canada continue to grow for gastroenterology consultations and endoscopies. There are many complex reasons for the long delays our patients experience, but human resources will remain a critical issue in the years to come. Fewer than 500 gastroenterologists are available to assist more than 32 million Canadians.

Chronic gastrointestinal (GI) disorders are common in primary care, and the prevalence of some, such as gastroesophageal reflux disease (GERD), is increasing. The most common gastrointestinal malignancies are colorectal cancer (CRC), gastric cancer, pancreatic cancer, and esophageal cancer. These cancers are rare in younger people, but the incidence of each increases with age. Our population is aging, and Canadians are living longer with chronic illnesses and long-term treatments, many of which can cause side effects, including upper and lower GI symptoms. If these trends continue, Canadian primary care will be increasingly dominated by GI disorders.

This increased workload, along with both legitimate and unrealistic expectations and fears, will increase referrals to gastroenterologists. These fears often centre on the relationships between common GI problems and much less common GI malignancies. The linkage between *Helicobacter pylori* infection and both peptic ulcers and gastric adenocarcinoma (along with limitations in public funds available for noninvasive *H pylori* testing) have shifted patients’ investigations toward endoscopy. The new guidelines for CRC screening will add further pressure to already limited resources as patients line up for screening endoscopies. The relationship between chronic GERD, Barrett esophagus, and esophageal adenocarcinoma will add substantial pressure for consultations. Surveillance of patients with histories of inflammatory bowel disease (IBD) will similarly increase referrals.

Considerable overlap can be found in the symptoms of serious GI diseases and the symptoms of benign or functional GI diseases. Symptoms alone cannot distinguish endoscopy-negative GERD and mild esophagitis from high-grade erosive esophagitis. Symptoms cannot be used to reliably discriminate peptic ulcer disease from functional dyspepsia or GERD. Symptoms of irritable bowel syndrome (IBS) can be difficult to distinguish from IBD, dyspepsia, hepatobiliary disease, celiac disease, or even GI malignancy. This uncertainty does little to boost the confidence of patients or their primary care physicians.

We do have the resources

Despite these concerns, about 30,000 Canadian primary care physicians are able to address these challenges. Clearly articulated clinical practice guidelines, effective medications, accurate noninvasive investigations, and evidence-based primary care management plans are available to support primary care physicians who want to raise their threshold for referring patients with GI symptoms.

The CanDys Working Group published a management plan that supports primary care assessment and management of dyspepsia (Table 1). The Carbon 13 Urea Breath Test (C13UBT) is recommended in cases where testing is required for *H pylori*. Physicians can access the C13UBT throughout Canada, but patients must pay for the test in most parts of the country. The CanDys plan allows primary care physicians to manage most patients without referral, and it helps physicians identify those who would potentially benefit from endoscopy.

An interesting strategy called “once in a lifetime” endoscopy has been developed to determine the need for endoscopy in chronic GERD patients. The strategy calls for endoscopy after 5 to 10 years of GERD symptoms to identify patients who have Barrett esophagus. Patients who have Barrett esophagus...
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Efficient use of gastroenterology resources will be increasingly important if we expect to meet our patients’ needs in the coming years. I believe primary care physicians have the necessary tools and are well positioned to be responsible for assessing and managing most patients with GI disorders without referral. Sensible clinical management plans, effective treatments, and noninvasive diagnostic tests will add confidence to our assessment and management plans while we find the right patients for referral.

We can no longer refer patients with GI symptoms simply because we want to duck responsibility or because we lack quick fixes. This is particularly true when the probability of serious disease is low. We have accepted other equally difficult challenges in prostate-specific antigen testing and breast cancer screening. Assessing and managing IBS and dyspepsia (including chronic GERD), and coordinating screening and surveillance plans for targeted GI diseases are all important activities that must be returned to primary care.

Dr Flook is President of the Canadian Society of Primary Care Gastroenterology.

Competing interests

Dr Flook has received speaker’s honoraria and is on the advisory board of AstraZeneca Canada, GlaxoSmithKline, Pfizer Canada, Novartis Pharmaceuticals Canada, Altana Pharma, and Solvay Pharma, and has received speaker’s honoraria from Abbott Laboratories.

Correspondence to: Dr Nigel Flook, University of Alberta Hospital, 1A.1.11, 8440-112 St, Edmonton, AB T6G 2B7

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References


Table 1. Primary care dyspepsia assessment

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<td>1. Thumb: is the symptom source the upper gastrointestinal tract? (is it cardiac or other?)</td>
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<td>2. Alarm features: “VBAD”—Vomiting, Bleeding or anemia, Abdominal mass or unexplained weight loss, Dysphagia</td>
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Three key decision points

1. Are acetylsalicylic acid or nonsteroidal anti-inflammatory drugs involved?
2. Is GERD (heartburn or acid regurgitation) probable?
3. Is Helicobacter pylori test positive or negative?