



SPA PCP Treatment & Referral Guidelines
GI

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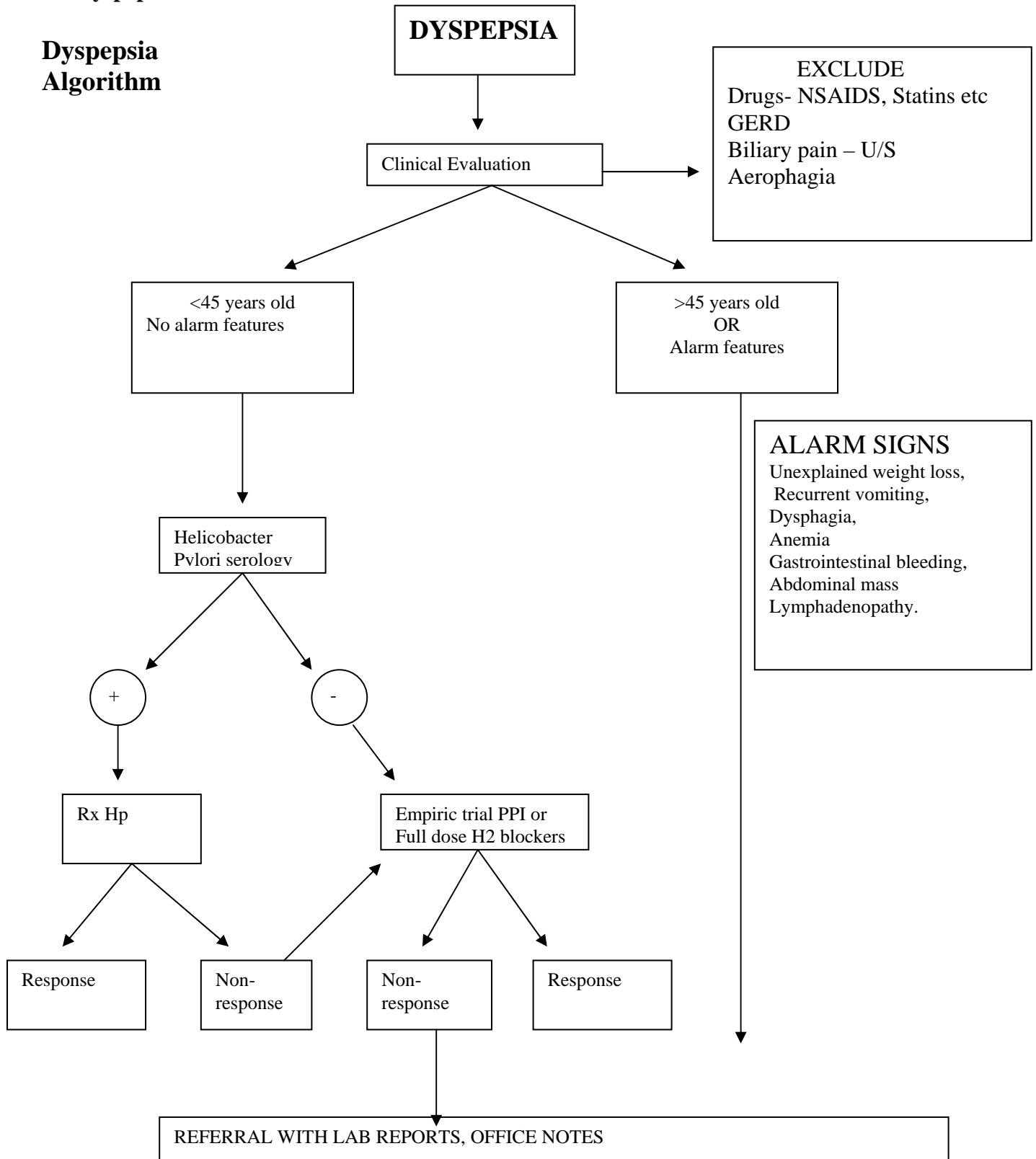
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ALL PATIENTS REFERRED FOR GI CONSULTATION MUST BE EVALUATED FIRST BY THEIR PRIMARY CARE PHYSICIAN. DIRECT NP AND PA REFERRALS ARE NOT ACCEPTABLE.

ALL REFERRALS MUST BE ACCOMPANIED BY RELEVANT AND LEGIBLE OFFICE NOTES, MOST RECENT H&P, LAB/X-RAY REPORTS AND FILMS. A BRIEF REFERRAL NOTE WILL FACILITATE OPTIMAL CONSULTATIVE SERVICE.

I. Dyspepsia

**Dyspepsia
Algorithm**



II. Inflammatory Bowel Disease (Ulcerative Colitis & Crohn's)

- A) If symptomatic or patient new to the plan, consider referral to Gastroenterologist (GI) after they are initially seen by Primary Care Physician (PCP)
- B) PCP should send any records they may have, copies of old records especially previous endoscopy and pathology report, along with detailed history and physical
- C) All patients with either of these conditions should typically be seen at least once every six months, alternating with the PCP and GI specialist only after achieving complete remission. During the acute stage of the disease or flare-up, patient needs to be seen much more often and as their disease requires by GI. All patients on Prednisone and/or immuno-suppressants are to be followed by a gastroenterologist

III. Diarrhea

- A) Primary Care Management
 - a) Focused History and Physical (H & P) with particular reference to medications and herbal supplements, exposure to diarrheal illness, recent antibiotics, foreign travel
 - b) Screening labs to include:
 - 1) CBC with differential / electrolytes
 - 2) Stool culture & sensitivity and C. difficile toxin
 - 3) Ova and parasite (O & P) studies (X3) and Giardia Antigen, (prior to any barium)
 - 4) Stool Hemocults and Stool WBC
 - 5) If Hemocult negative stool and other studies are also non-diagnostic, a flexible sigmoidoscopy by the PCP (if the PCP feels comfortable performing exam)
 - 6) Medication as appropriate
- B) Referral to GI
 - a) If diarrhea persists without specific diagnosis despite above work up, or after appropriate treatment

IV. New Onset Constipation

- A) Primary Care Management
 - a) Focused H & P with particular reference to medications, and exclusion of alarm symptoms such as weight loss, rectal bleeding
 - b) CBC, Chem panel, Calcium; Consider TSH measurement, if any suspicion of hypothyroidism
 - c) Stool Hemocult, if positive refer directly to GI. If negative proceed with additional testing
 - d) Flexible Sigmoidoscopy (if PCP performs) rule out obstructive lesion
 - g) Consider Barium Enema to rule out obstructing lesion or referral to GI for colonoscopy especially over the age of 50 and if screening examination has not been done within the past few years
- B) Referral to GI

- a) If PCP is unable to do flexible sigmoidoscopy adequately
- b) If all of above is negative and diagnosis is questionable

V. Rectal Bleeding

- A) Primary Care Management for Patient less than 40 years old
 - a) No family history of colon polyps/cancer
 - b) History consistent with distal rectal source (i.e. peri-anal pain, blood on tissue, prior history of hemorrhoids)
 - c) No alarm symptoms (anemia, iron deficiency, weight loss, change in bowel habits)
 - d) Sigmoidoscopy recommended
 - e) PCP should be able to diagnose and treat symptomatic or bleeding hemorrhoids / rectal fissure
 - f) Treatment
 - 1) High fiber diet with adequate fluid intake and stool softeners
 - 2) Suppositories or anal creams
 - 3) sitz baths
 - g) Persistent bleeding from fissure or hemorrhoids may require colorectal surgery evaluation
- B) Refer to GI or Colorectal Surgery
 - a) If patient more than 40 years old, or
 - b) Persistent or unexplained rectal bleeding, or
 - c) Presence of alarm symptoms (see above)

VI. Iron Deficiency Anemia (suspected GI blood loss)

- A) Primary Care Management
 - a) Focused H & P
 - b) CBC with MCV, reticulocyte count
 - c) Chemistry panel
 - d) TIBC, iron saturation
 - e) Serum ferritin
 - f) No radiologic exams are necessary
 - g) Do stool for occult blood
 - Note:** Negative FOB does not exclude GI bleeding as a cause for iron deficiency
 - h) If iron deficiency documented, start oral iron at the time of diagnosis and repeat blood count in 6 weeks. This should not delay referral to GI
- B) Referral to GI
 - a) Patients with *unexplained iron deficiency* anemia should be referred to GI with all above laboratory studies and copy of detailed H & P

VII. Irritable Bowel Syndrome

- A) Patients with a history of chronic alternating diarrhea and constipation and abdominal pain of variable intensity. Frequently reported associated symptoms include bloating and

flatulence.

- B) Primary Care Management (usually a minimum of four visits)
 - a) Focused H & P; CBC, Chem panel, ESR, fecal occult blood
 - b) Stool for O & P (X3), Giardia antigen, C. difficile toxin (if antibiotic exposure within 3-4 months), fecal leukocytes, fecal occult blood. Consider celiac antibody panel (anti-endomysial antibody, anti-TTG antibody) to exclude celiac disease. Patient should be on a diet that includes gluten for at least a month before these labs are drawn
 - c) Trial of lactose free, caffeine free diet; eliminate alcohol, sorbitol, raw fruit, vegetables and salads
 - d) Flexible sigmoidoscopy
 - e) Consider air-contrast Barium Enema
 - f) Consider dedicated small bowel follow-through (if patient has diarrhea or persistent pain in particular looking for Crohn's disease or small bowel neoplasm)
 - g) Trial of medications
 - 1) Bulk agents (Citrucel, Metamucil, Benefiber, etc.) with adequate fluid intake
 - 2) Antispasmodics (Bentyl, Levsin, etc.)
 - 3) Tegaserod (Zelnorm), Glycolax or Amitiza for constipation predominant symptoms
 - h) Patient education
 - 1) Documented discussion of irritable bowel syndrome
 - 2) Written information is helpful
- C) Referral to GI
 - a) Refer for flexible sigmoidoscopy if PCP cannot do adequately, or
 - b) If patient does not respond to conservative care over a several weeks and multiple visits, or
 - c) Labs or X-rays are abnormal, or
 - d) Alarm symptoms including new onset over age 50, weight loss, nocturnal symptoms, positive fecal occult blood, and anemia

VIII. Chronic Liver Dysfunction / Jaundice

- A) PCP Management
 - a) Focused H & P, with attention to medications and herbal supplements, CBC, PT, **Liver Enzyme Tests** including GGT and bilirubin
 - b) Exclude hepatotoxins- medications, alcohol. Discontinue hepatotoxins if possible, and repeat LFTs after a few weeks
 - c) Iron Saturation/Ferritin, blood glucose
 - d) Hepatitis serologies (A, B, C)
 - e) If cause for liver abnormality is not identified above, may proceed to:
 - 1) ANA, Actin Antibody /Anti-Smooth Muscle Antibody, and Antimitochondrial antibody

- 2) Ceruloplasmin if patient under 60 with persistent unexplained LFT elevation
- 3) Consider U/S of liver

Any patient with chronic liver disease should be checked for Hepatitis A immunity (+ Hep A **IgG** antibody) and vaccinated against Hep A if negative. Hepatitis B vaccination should also be offered if patient non-immune (Negative Hep B surface Ab) and there is any risk of transmission (sexually active, high risk behavior)

B) Referral to GI

- a) If worsening LET's or deteriorating clinical status
- b) If patient has acute hepatitis, may call GI for telephone consult
- c) If patient has non-acute (> 6 weeks) hepatitis, PCP should order ultrasound. Refer to GI immediately if bile ducts are dilated or liver mass seen
- d) If above screening labs are abnormal
 - 1) If + Hep C antibody
 - Obtain Quantitative Hep C RNA
 - Hep C Genotype
 - Recommend checking spouse or sexual partner for Hep C
 - 2) If Hep B Surface Antigen +
 - Obtain Hep B DNA, Hep B e Antigen; Hep B e Antibody
- e) If LFT's are stable but persistently abnormal for more than six months, refer to GI even if asymptomatic.

IX. Gastroesophageal Reflux Disease (GERD)

A) Primary Care Management

- a) Comprehensive H & P
- b) CBC to exclude anemia or iron deficiency
- c) Therapeutic trial
 - 1) Anti-reflux measures
 - Elevation of head of bed on blocks or use of a sleeping wedge
 - Avoidance of spicy, fatty and acid foods, onions, caffeine, chocolate, and alcohol
 - Review medications – avoid Calcium blockers if possible
 - Avoid eating three hours before bedtime
 - Weight reduction
 - 2) Patient literature is helpful
 - 3) Trial of medications
 - H2 Blockers bid
 - Proton Pump Inhibitors every A.M. before eating
 - For atypical chest pain thought to be related to GERD, a one-month trial of b.i.d. PPI's is recommended, ***after cardiac disease has been confidently excluded***
 - For ENT symptoms thought to be related to GERD (hoarse voice, cough etc.), a three month trial of b.i.d. ac PPI's is recommended, ***after excluding***

allergy, laryngeal neoplasia etc.

- B) Referral to GI
 - a) Persistent symptoms / symptoms unresponsive to anti-secretory agent management
 - b) Alarm symptoms (weight loss, dysphagia, odynophagia, iron deficiency anemia, GI bleeding)
 - c) Chronic symptoms (to exclude Barretts esophagus)
 - d) Prominent atypical/ supra-esophageal symptoms of GERD

X. Dysphagia (difficulty swallowing)

- A) PCP Management
 - a) Complete history and physical
 - b) Barium swallow and Upper GI series for minor symptoms or for dysphagia sensation at the level of the neck

- B) Refer to GI all patients with symptoms of more than two weeks duration, progressive symptoms, weight loss or hematemesis

XI. Colon Cancer Screening and Surveillance

- A) Average Risk Screening
 - a) Sigmoidoscopy every 5 years plus FOB testing annually starting at age 50 **OR**
 - b) Screening Colonoscopy

- **PLEASE SEE THE SPA REFERRAL AND AUTHORIZATION SPECIALTY ROSTER UNDER GASTROENTEROLOGY FOR THE CURRENT PRIOR AUTHORIZATION REQUIREMENT FOR SCREENING COLONOSCOPY.**
- **AN ATTESTATION FORM MUST BE COMPLETED FOR EACH SCREENING.**

- B) Polyp Surveillance
 - a) Screening sigmoidoscopy finds a polyp
 - 1) Perform a biopsy if polyp <5mm
 - If biopsy reveals hyperplastic pathology, Colonoscopy is not indicated
 - Adenomatous pathology should be referred for full colonoscopy
 - 2) If polyp >5mm, refer for colonoscopy
 - b) Patients with h/o adenomatous polyp may be referred for colonoscopy
 - 1) 5 years after a negative colonoscopy
 - 2) 3 years after a colonoscopy showing adenomatous polyps especially if large polyps (>1cm) or multiple polyps removed

- C) Cancer Screening and Surveillance
 - a) The following patients may be referred for a colonoscopy:
 - 1) Within 1 year after curative-intent resection of a colon cancer
 - 2) Family history of colon cancer /polyps
 - Colon cancer or adenomatous polyps in a first-degree relative younger than age 65 or

- Patients suspected to be at risk for Hereditary Non-Polyposis Colon Cancer (HNPCC) by Amsterdam or Bethesda criteria (see below), should be referred to GI
 - In two or more first-degree relatives of any age.
 - ❑ Begin screening colonoscopy at age 40 or 10 years before the youngest case
 - ❑ If the Index colonoscopy is normal, it may be repeated every five years
- 3) Personal history of Inflammatory Bowel Disease (IBD)
- 8 years after the start of pancolitis IBD
 - 12 years after the start of left sided colitis
 - ❑ The colonoscopy may be repeated every 1-2 years

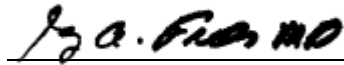
D) Amsterdam Criteria for HNPCC

- a) At least 3 relatives have either colorectal cancer or endometrial cancer or one of the other cancers seen with HNPCC
- b) Two successive generations are involved
- c) At least 1 relative had their cancer when they were younger than age 50
- d) At least 2 of the people are first-degree relatives

E) Bethesda Criteria for HNPCC

- a) Individuals with cancer in families that meet the Amsterdam criteria; OR
- b) Individuals with two HNPCC-related cancers, including synchronous and metachronous colorectal cancers or associated extra-colonic cancers (endometrial, ovarian, gastric, hepatobiliary, small bowel or transitional cell cancer of the renal pelvis or ureter); OR
- c) Individuals with colorectal cancer and a first degree relative with colorectal cancer and/or HNPCC-related extracolonic cancer and/or a colorectal adenoma. One of the cancers must have been diagnosed at age < 45 years and the adenoma at age < 40 years; OR
- d) Individuals with colorectal cancer or endometrial cancer diagnosed at age < 45 years; OR
- e) Individuals with right-sided colon cancer with an undifferentiated pattern (solid/cribriform) diagnosed at < 45 years; OR
- f) Individuals with signet ring cell type colorectal cancer (> 50% signet ring cells) diagnosed at < 45 years; OR
- g) Individuals with colorectal cancer diagnosed at < 40 years

APPROVAL:



SPA/SMF Medical Director

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SMF QM Committee

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