# When should you call the Gastroenterologist ?

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*Now, here, you see, it takes all the running you can do, to keep in the same place"*.....Red Queen in Alice in Wonderland

# This Presentation

- Our population of patients & resultant activity
- How our service works
- “When to call”
  - Luminal
  - Hepatology
  - Nutrition
  - Endoscopy
- The problems inherent in “calling”
- A summary

# Context NUH1. Patient Population Oncology


- 28,928 Outpatient attendances of which
- 2773 New patients
- 3,300 Admissions
- 8,800 Day case
- 1,880 Radiotherapy

# Context NUH2. Patient Population Haemato-oncology


- Lymphoma 170
- Leukaemia 40
- 170 Bone marrow transplants of which
  - 58 MUD
  - 93 Auto
  - 16 Sibling
- GvHD
- 1,300 Admissions (720 emergency)
- 7,500 Day case

# Context NUH 3. Palliative care


- 1720 Outpatient attendances of which
- 563 New patients
- 350 Admissions

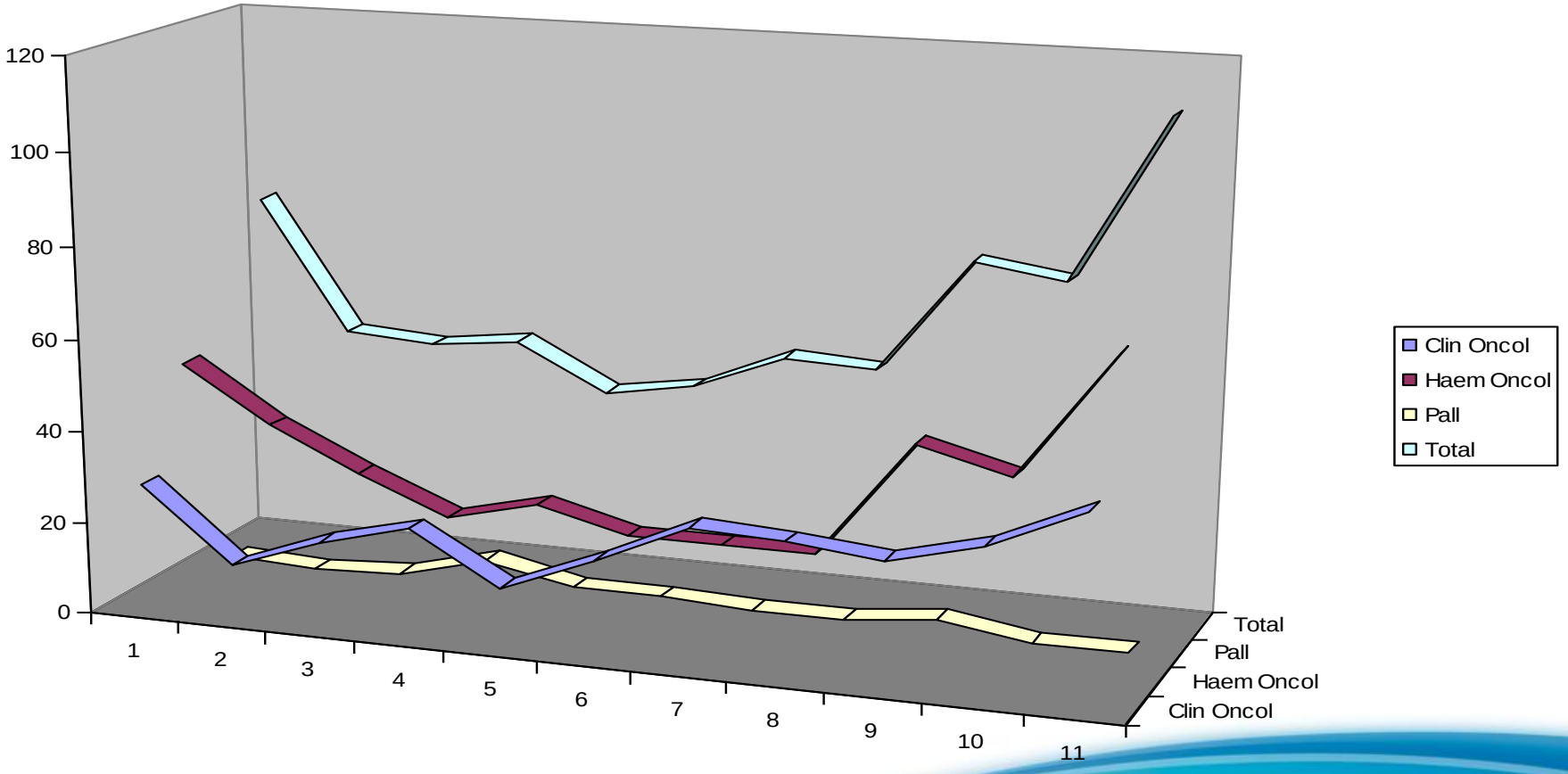
# Context NUH 5. How does GI get “called”?

- Inpatients
  - On-call GI service
  - Electronic “consult” or “procedure” requests
  - Telephone
- Outpatients
  - From on campus oncology clinics
  - Direct referrals
  - Choose & Book

# Context NUH 5. Associated GI activity


- ~ 75 Inpatient consults (next slide)
- ~~ 100 Inpatient endoscopies
- ~80 Patients with pelvic radiation disease in past 15 years
- Unknown to routine Outpatients
- Unknown not referred

# Number of Inpatient referrals to Gastroenterology each year



# The Acute situation:

- Supporting Departmental & Trust based guidance (Cytotoxics associated diarrhoea, (On discharge) Neutropenic sepsis, C.diff diarrhoea, Alcohol, OD, Nutrition)
- Haematemesis, Melaena
- Diarrhoea
  - Bloody
  - Not-responding
  - > 10 / day
  - C diff as per protocol
- Dilated colon
- Pain
  - Assoc with Chemo
  - Late onset radiotherapy symptoms
- Compromised/deteriorating liver function
- Tubes, stomas & nutrition Lines

# The sub-acute situation

- Underlying chronic GI disease (eg Cirrhosis, IBD, Mal-nutrition, Ileostomy, Previous complex surgery, *Alcohol*)
- Nutrition (dietitians at clinic)
- Diarrhoea (plan ahead on discharge)
  - GVHD
  - Other durgs
  - Multiple contributors (Pancreas, SBBO, Bile salt, GVHD, recent C diff)
- Vomiting
- Deteriorating LFTs

# The chronic situation

- Red flags as for “everyone”
  - Dysphagia, unexplained weight loss, vomiting,new onset dyspepsia
  - Rectal bleeding without anal, Change in BH > 6/52, *bloody diarrhoea (Q)*
  - Jaundice
- Symptoms (usually diarrhoea / Pain) which are interfering with QoL (often difficult to identify)
- Chronic underweight

# Most Recent “chronic” patient:

**Diagnosis**: Abdominal hysterectomy & pelvic radiotherapy.
Sub-total gastrectomy for T1 tumour.
CKD 4 due to nsaid, single kidney and reflux.
Hypertension., 40 pack year.
Invasive sq in vault not progressive.
**( 4 hospitals; 6 volumes)**

- **1976**: Hysterectomy & radiotherapy .
- **1979**: VV fistula. closure re-imp. Rt ureter “massive fibrosis”
- **1983**: Breast lump benign.
- **1995**: Vault smears severe dyskeryosis
- **1997**: Ba enema for pain
- **2007**: OGD for pain: T1 partial gastrectomy
- **2007**: Severe pain
- **2008**: Severe pain (urology)
- **2009**: Severe pain (gynae)
- **2009**: Severe pain :As bizarre as it sounds she may be having intermittent urinary leakage into her peritoneum”.
- **2011** *Pain & by the way diarrhoea 10 times and at night but that’s my treatment*

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- Standardized protocol
- New Rx / New patients (eg) Ipilimumab
- CCD
- Tubes & stomas (incl ileostomy)
- GVHD
- Palliative care
  - Disseminated intra-abdominal malignancy
  - Feeding
  - Tubes & stomas, PN
- Endoscopy & Interventional Radiology

# The problems inherent in “calling”

- Inpatients
  - On-call GI service
  - Electronic “consult” or “procedure” requests
  - Telephone
- Outpatients
  - From on campus oncology clinics
  - Direct referrals
  - Choose & Book
- In completely new settings
  - CCD
- Without palliative care (nutrition)

# In Summary: “Calling the GI service”

- The context in which you work
- How you call and who you call
- Bloody diarrhoea, dehydration diarrhoea, distension & continuous pain
- In oncology clinics
- The “chronic” pathway & the “chronic” patient