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PRIMARY CARE SOCIETY FOR GASTROENTEROLOGY

MANAGEMENT OF COMMON GASTROINTESTINAL DISORDERS IN GENERAL PRACTICE

PCSG NATIONAL SURVEY 2004

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MANAGEMENT OF COMMON GASTROINTESTINAL DISORDERS IN GENERAL PRACTICE

SUMMARY

Digestive disorders account for about one in ten of all consultations with general practitioners (GPs), and are often expensive to investigate and look after. There is wide variation in the way that GPs approach these problems, although many organisations have attempted to develop guidelines designed to improve and, to some extent, standardise patient care. Although there is some evidence that these guidelines are often not very effective, we know very little at present about the range of approaches that GPs in England take to managing digestive disorders.

Aims

- Describe current practice in the management of selected, common GI problems
- Define sources of information used as a basis for management
- Develop educational interventions (eg recommendation for structured care) based on results of survey

Questionnaires were sent to 1790 GPs in 16 Primary Care Trusts (PCTs) selected as geographically representative across England. There was a poor response rate of 25% (447) and 435 usable questionnaires after one reminder.

General practitioners and their practices. 63% of replies came for urban practices, 23% from mixed urabn & rural, and 13% from rural locations. 56% from male GPs. Replies came from a similar proportion of large, medium and small practices across the different locations. 38% of GPs worked in practices that were both teaching and training practices, and 30% came from practices that did neither. 18% of GPs said they had no open access to four listed GI diagnostic procedures, 52% had access to one or two, 19% had access to three and 10% access to all four.

Sources of information. Awareness of guidelines on the management of gastrointestinal problems ranged fro 19% who were aware of none, to 15% who were aware of them all. 28% of GPs came from practices where no guidelines were used. The most used guidelines were for dyspepsia and HP infection. GPs sourced information most usually from peer reviewed journals, specialist or PCT guidelines, review publications and local educational activities and CPD.

Clinical management

Gastro oesophageal reflux disease: 88% knew the difference between ‘step up’ and ‘step down’ approach, and 66% of these used ‘step down’. 51% recognised the concept of PPI testing for GORD, and a number of different PPIs were ‘prescribed’ with 53% selecting one month duration for medication

Dyspepsia: The most popular diagnostic/management procedures were ‘empirical PPI’ and ‘test & treat HP positive’ although a number of GPs felt that decisions would be ‘age dependent’. 90% said they eradicated HP infection if present. 81% prescribed according to BNF, or said they would look it up in the BNF. The most commonly prescribed regime for HP eradication was ‘Heliclear’. 48% thought that <75% would remain symptom free for 1year and another 40%, though it would be <50%. 88% of GPs did not know the local prevalence of metronidazole resistance.

Irritable bowel syndrome: Only 18% of GPs were familiar with the formal criteria for diagnosing IBS. Causes of IBS were seen by 60% as equally physical and psychological, with the reminder biased towards a physical explanation. Number or type of Investigations for causes of IBS was not influenced by the presumed cause.
Rectal bleeding: 26% of GPs worked in practices with a protocol for assessment of colorectal cancer risk. 49% were aware of guidelines. Investigations for 'low risk' patient were predominately abdominal and rectal examination with FBC/ESR. Management of a 'high risk' patient - 94% said they would invoke the two week rule and refer urgently.

Conclusion

1. Poor response possibly related to level of interest/importance and new GP Contract targets
2. Reasonable awareness of upper GI and colorectal cancer guidelines
3. Little awareness of guidelines or diagnostic criteria in IBS
4. Dissonance between expert thinking and primary care practice
   - GORD
   - HP infection/dyspepsia
   - IBS diagnosis (and management?)
5. Emphasise need to understand primary care practice
6. Implications for design of future educational/management interventions and for approaches taken by pharmaceutical industry

MANAGEMENT OF GASTROINTESTINAL DISORDERS IN GENERAL PRACTICE

1 BACKGROUND (RESEARCH PROTOCOL)

Gastrointestinal disorders are common in the general population and in primary care, where they account for some 10% of workload and 18% of prescribing costs. The most common conditions presenting to general practitioners are dyspepsia, gastro-oesophageal reflux symptoms, irritable bowel syndrome and lower bowel disturbances, notably changed bowel habit and rectal bleeding. Because all of these conditions can signal the presence of serious disease or, more often, indicate self-limiting conditions for which symptomatic treatment without investigation may be appropriate, and because of wide variation in clinical practice, guidelines for their management have been developed over recent years. Despite the proliferation of guidelines, little is known about their impact on practice and still less is known about the practices of clinicians not taking part in studies of guideline implementation.

The Primary Care Society for Gastroenterology (PCSG) was founded in 1985 to act as a focal point for general practitioners and others in the UK interested in the management of digestive disorders in primary care. One of its missions is to provide evidence-based educational interventions for general practitioners, including guidelines. The PCSG has produced guidance on the management of a range of conditions, including dyspepsia, Helicobacter pylori infection, irritable bowel syndrome and coeliac disease, and is currently publishing guidance on the early detection of colorectal cancer. Because little is known about current practice in these important areas, it is timely to undertake a national survey of clinical practice in the management of digestive disorders. The 'PCSG Survey' has been conceived and designed to collect information about the way that GPs manage common digestive disorders.

Guidelines have a chequered history. In an early study in Southampton Jones and colleagues (1) were unable to show a positive impact of guidelines but a better-designed trial undertaken recently in Manchester (2) concluded that educational outreach needs to be added to passive guideline dissemination if clinical behaviour in managing dyspepsia is to be changed. A more salutary report, appearing in May 2003, (3) described a world-wide survey of the management of upper gastrointestinal disorders, and found that the majority of general practitioners were not following guidance on the investigation and management of dyspepsia, particularly in relation to testing for Helicobacter pylon infection and treating positive patients, as recommended in the recent Maastricht Consensus Conference. An earlier study from the Netherlands (4) had found similar lack of concordance with previous recommendations from an earlier Maastricht Helicobacter pylon consensus meeting.

Guidelines for clinicians in the management of gastro-oesophageal reflux disease have been published in Australia (5) and in Europe (6), but little is known about their effects on practice. We do, however, know that proton pump inhibitor prescribing in general practice, which accounts for as much as 14% of the drug bill in primary care, often falls outside guideline recommendations. (7),(8)

Irritable bowel syndrome has often been an elusive diagnosis to make and sustain in primary care, and expert groups have elaborated complex criteria (Rome I and Rome II) to aid, at least in specialist practice, in diagnosis. However, Thompson and colleagues, in studies in the UK (9) and in Europe (10) have shown that general practitioners are rarely aware of these specialist criteria and are able to make reasonably well-informed diagnoses of functional bowel disorders without reference to them.

Finally, there is accumulating evidence that guidance on early cancer detection, developed from the 'two-week wait rule', which specifies that patients suspected of having cancer must be seen by a specialist for investigation within two weeks, is not having the desired effect. Papers are appearing that suggest that most cancers are still being diagnosed outside the two-week system (11),(12).

For all these reasons the PCSG wishes to obtain a 'map' of current practice in the management of common gastrointestinal disorders, and to use the information collected in the survey as the basis for the design of educational interventions in the future.

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2 AIMS

- Describe current practice in the management of selected, common GI problems
- Define sources of information used as a basis for management
- Develop educational interventions (eg recommendation for structured care) based on results of survey

3 METHOD

A three page questionnaire was designed for mailing to a sample of general practitioners in England. The topics of the questionnaire and some of the questions emerged initially from group discussions between members of the PCSG and the draft questionnaire was piloted twice amongst general practitioner colleagues, to ensure face validity and comprehensibility.

The questionnaire was designed to collect demographic data about individual doctors, some characteristics of their practice, their sources of information and evidence in the management of gastrointestinal disorders and the to find out about the clinical management of patients with reflux disease, dyspepsia, irritable bowel syndrome and rectal bleeding.

General practitioners were drawn from the lists of 16 PCTs selected to be geographically representative across England. The locations were chosen to reflect urban, mixed and rural locations, as well as reflecting the socio-economic characteristics of the UK population.

Each PCT was contacted by telephone and an up-to-date mailing list of the general practitioners in that PCT obtained. These lists were entered onto a database and every general practitioner in each of the selected PCTs (1790) was mailed a copy of the questionnaire and explanatory attached covering letter emphasising anonymity and non-attributability, with a freepost return envelope. After two weeks all the non-responders were sent a reminder, and a duplicate questionnaire and freepost return envelope.[1]

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[1] The first questionnaires were posted by the 26th January, and the reminders were posted by the 13th February 2004. Data collection was for the purposes of this report considered complete on 1st March.

4 RESULTS

4.1 RESPONSE RATE

Table 1 Primary Care Trusts - numbers of questionnaires sent and returned

PCT	Questionnaires sent	Qs returned un-usable	Qs returned usable	response rate
N. London (1)	223	0	60	27%
Bristol South West (2)	134	2	42	33%
Barnsley (3)	111	1	32	30%
Bristol North (4)	146	2	50	36%
Central Liverpool (5)	139	0	27	19%
E. Cambs & Fenland (6)	82	1	17	22%
Eastbourne Downs (7)	89	3	22	28%
Cotswold and Vale (8)	124	1	34	28%
Halton (9)	70	0	12	17%
Hounslow (10)	123	0	26	21%
Huntingdonshire (11)	108	0	25	23%
N. Norfolk (12)	61	1	19	33%
N. Sheffield (13)	84	0	15	18%
Solihull (14)	122	1	27	23%
W. Norfolk (15)	90	0	12	13%
South Tyneside (16)	84	0	15	18%
Total	1790	12	435	25%

Figure 1 shows the percentage response from each PCT.

Figure 1 Percentage response within each PCT (n=435)

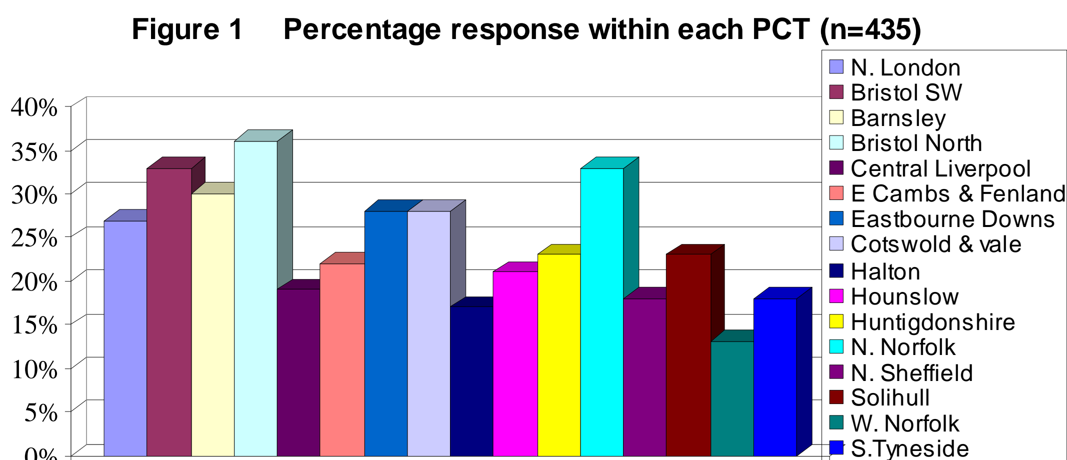
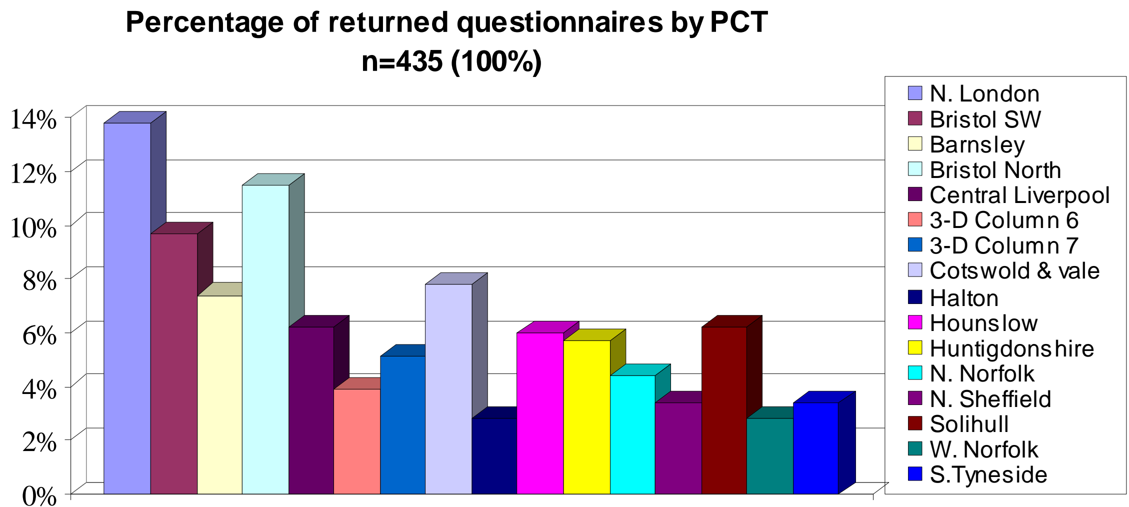


Figure 2 shows the usable questionnaires from each PCT as a percentage of the total returned (n=435)

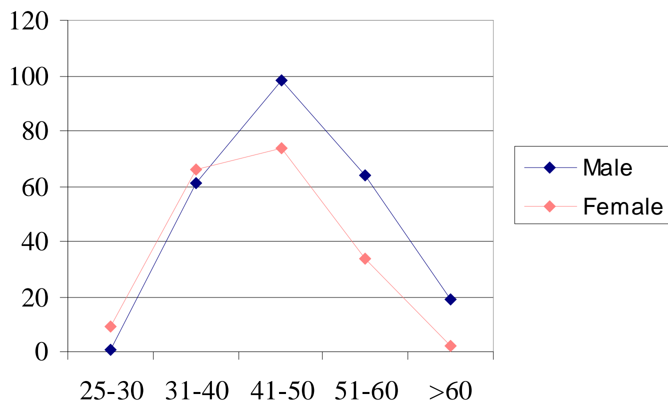
Figure 2



4.2 GENERAL PRACTITIONERS AND THEIR PRACTICES

Questionnaires were returned from 243 (56%) male and 185 (43%) female general practitioners (7 missing). It can be seen in Fig 3 that male doctors tended to be older; there was a significant correlation between age and sex (Pearson .290 p<.01)

Figure 3



4.21 Location of practice.

Two hundred and seventy five (63%) general practitioners worked in urban locations. One hundred (23%) worked in a 'mixed' rural and urban location and 56 (13%) defined their location as purely rural. (4 missing)
Breaking down age and sex by location of practice, in urban and in 'mixed areas responses came from 54% male and 46% female doctors; in rural areas from 77% male and 23% female doctors.

4.22 Size of practice.

Respondents were asked how many whole time equivalent doctors there were in their practice. Practices ranged from 'single handed', to those with 13 practitioners. (table 2)

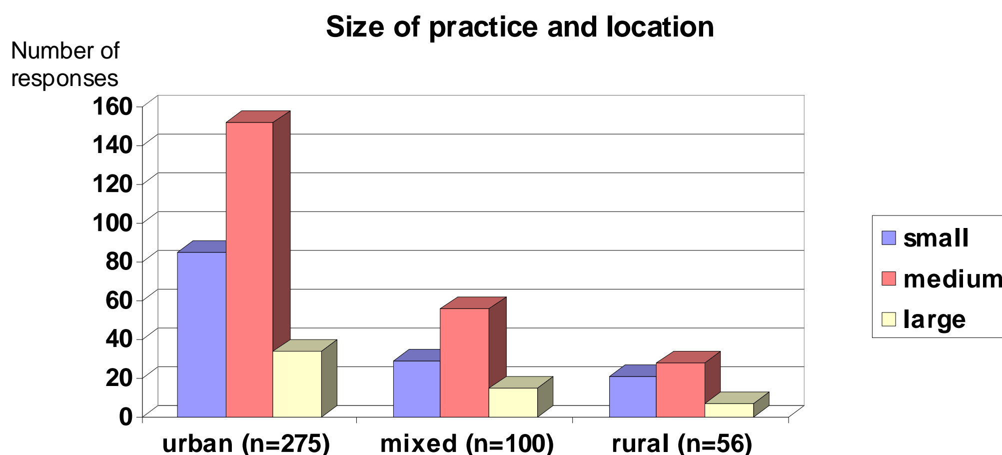
Table 2

Number of FTE GPs (n=428 7 missing)

GPs	frequency	percent		GPs	frequency	percent
1	26	6.0		8	19	4.4
2	52	12.0		9	12	2.8
3	58	13.3		10	2	.5
4	108	24.9		11	1	.2
5	72	16.6		12	1	.2
6	56	12.9		13	2	.5
7	19	4.4		Total	428	98.4

Grouping these into small (1-3 FTEs), medium (4,-6 FTEs) and large (7+ FTEs) practices, it can be seen that while there are more responses from urban general practitioners the proportion of replies from different sized practices is similar for the different locations

Figure 4

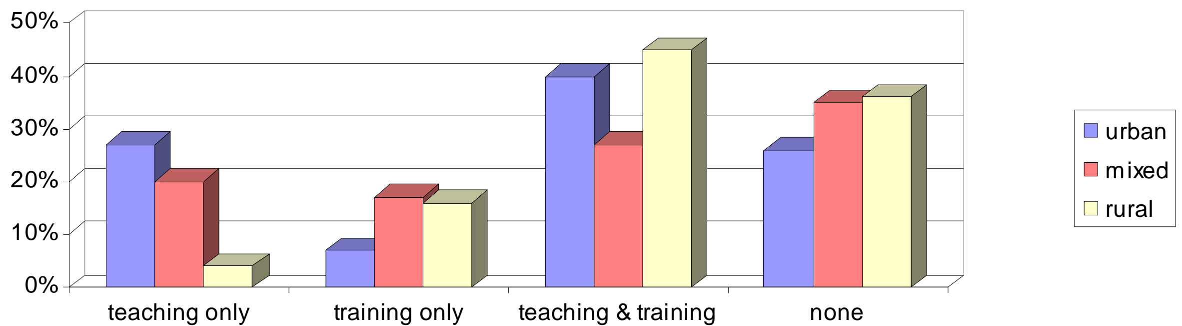


4.23 Training and teaching practices.

One hundred and sixty two (38%) general practitioners came from practices that were training practices and also did undergraduate teaching. One hundred and twenty eight (30%) general practitioners belonged to practices that did neither. Ninety six (22%) only undertook undergraduate teaching and 44 (10%) were only training practices. (5 missing)
Looking at the proportion of practices in each location that were teaching and/ or training practices it can be seen that the general practitioners from the rural areas were unlikely to be involved in teaching only, and that those from urban areas were less likely to come form a practice which did neither.

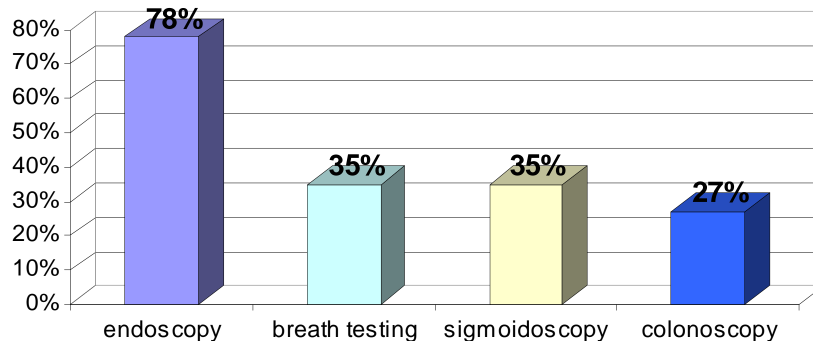
Figure 5

% of responses from teaching & training practices in each location
(n=430 5 missing)



4.24 Open access.

Figure 6 General practitioners with open access to:
(n=432 3 missing)



Overall there were 77 (18%) general practitioners who said they had no open access to upper GI endoscopy, urea breath testing, flexible sigmoidoscopy or colonoscopy.

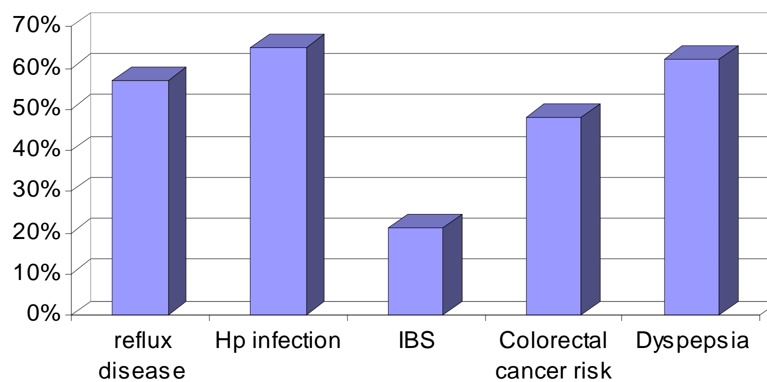
Two hundred and twenty six (52%) said they had access to one or two open access services, 84 (19%) had access to three, and 45 (10%) had access to all four services.

4.3 INFORMATION AND EVIDENCE

4.31 Awareness of Guidelines

General practitioners were asked if they were aware of UK or European guidelines on the management of 5 gastro intestinal problems. Eighty two (19%) said 'no' to awareness of any of the guidelines, and 66 (15%) said 'yes' they were aware of them all. One hundred and seventy five (40%) were aware of 3 or 4 guidelines, and 112 (25%) aware of only 2 or 3 guidelines.

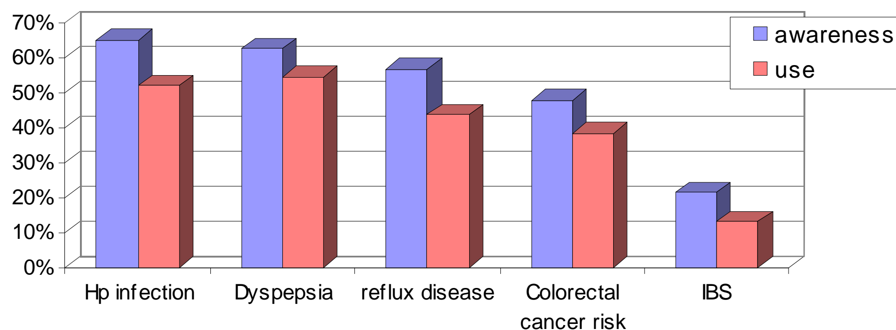
Figure 7 General practitioners aware of UK or European Guidelines on the management of: (n=435)



4.32 Use of guidelines

No guidelines were used by, or by the practice of, 123 (28%) of the general practitioners, whereas 42 (10%) used guidelines for all the problems presented in the questionnaire. One hundred and thirty three (31%) used one or two guidelines and 137(32%) used 3 or 4 guidelines. The relationship between awareness and use of guidelines is significant. (Spearman .673 $p<.01$).

Figure 8 Use of guidelines compared with awareness of UK or European guidelines on the management of: (n=435)



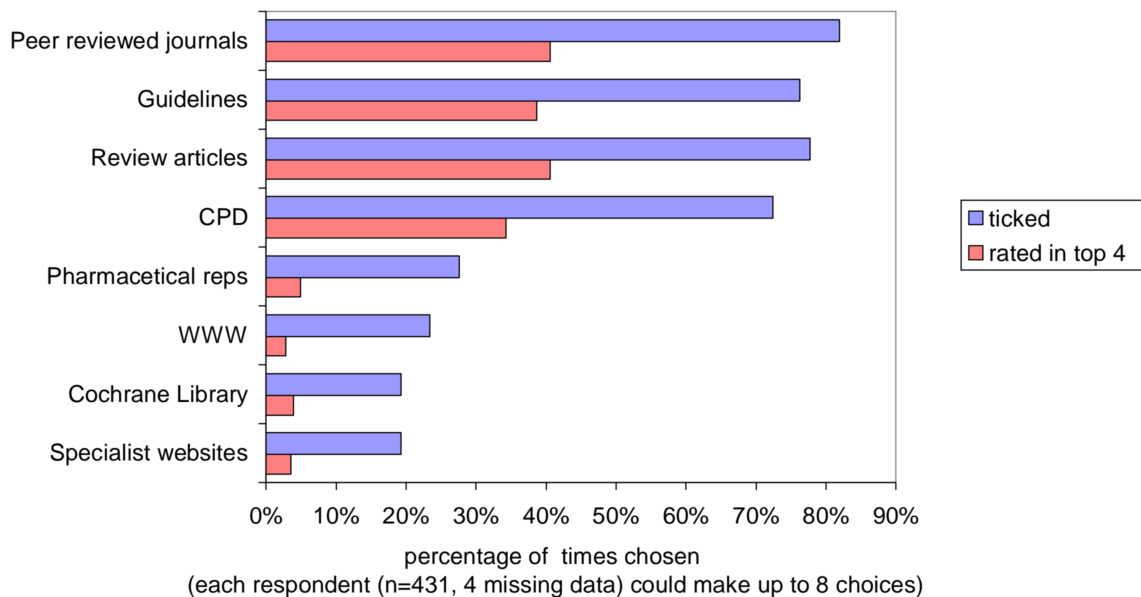
4.33 Sources of information

Asked what the main sources of information were some of the respondents rated them in order of importance, and some just ticked them if they were used.

For those who rated the sources, the top two first choices at 82 (19%), were the specialist or PCT guidelines, and local educational activities (and/or CPD). Peer reviewed journals were the first choice for 49 (11%) and review publications for 32 (8%) Four respondents did not choose any sources of information; 55% chose 3 or 4 sources, while 18% chose under 3, and 26% chose 5 to 8 sources.

Figure 9 shows, for those who rated their choices, the numbers choosing the item as one of their top four, and for those who didn't rate their choices, the numbers ticking that item

Figure 9 Sources of information



Respondents were asked to list any other sources of information that they used, and 80 (18%) did so. More than a quarter mentioned the local consultants - 'specific access to local consultants', 'directives from consultants at local hospitals', 'I seek advice from consultant colleagues', 'hospital consultant letters'. The next most frequently mentioned source of information was partners or colleagues in general practice, often those with a 'special interest' - 'main resource is our GP specialist', 'other doctors in the practice'. There were also a number of occasionally mentioned further sources of information - local forums and discussions, other journals such as Pulse, Update, and Prescriber, NICE and its publications, software such as PRODIGY and EMIS mentor, the BNF, the Oxford handbook of General Practice and the Primary care Society for Gastroenterology.

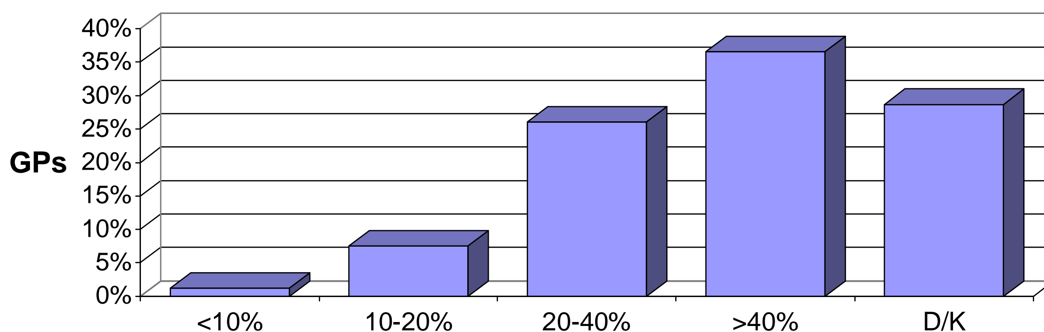
4.4 CLINICAL MANAGEMENT

4.41 Gastro-oesophageal reflux disease

Diagnosis
General practitioners were asked if they knew the difference between 'step up' and 'step down' as an approach to therapy in gastro-oesophageal reflux disease (GORD). Three hundred and eighty three (88%) said they did. Of these, 103 (27%) said they used 'step up', 253 (66%) said 'step down', and 24 (6%) used both. (3 missing).

Figure 10 shows what the respondents thought would be the proportion of patients in primary care with typical reflux symptoms who would have a normal looking oesophagus at endoscopy.

Figure 10 Percentage thought to have normal looking oesophagus at endoscopy (n=429)



General practitioners were evenly divided over recognition of the concept of a PPI test for diagnosing GORD - 51% recognised the concept and 48% did not. (n=432)

Two hundred and eight itemised the drug, dose, and duration they would use as a PPI test for diagnosing GORD.

There were 25 different combinations of drug, dose and length of time. The most popular 'prescription', (33%), was Lansoprazole 30mg for 28days/ 1 month, with another 14% using Lansoprazole for 14days; a further 5% used the same dose of Lansoprazole for two months.

Omeprazole 20mg for 28days/1month was selected by 20% and another 5% selected this for 14days. Only 3% chose Omeprazole 20mg for two months.

Pantoprazole 40mg, Rabeprazole 20mg & 10mg, and Esomeprazole 20mg & 40mg were all prescribed; the shortest time any PPI was 'prescribed' was 7 days, and the longest was for 6months.

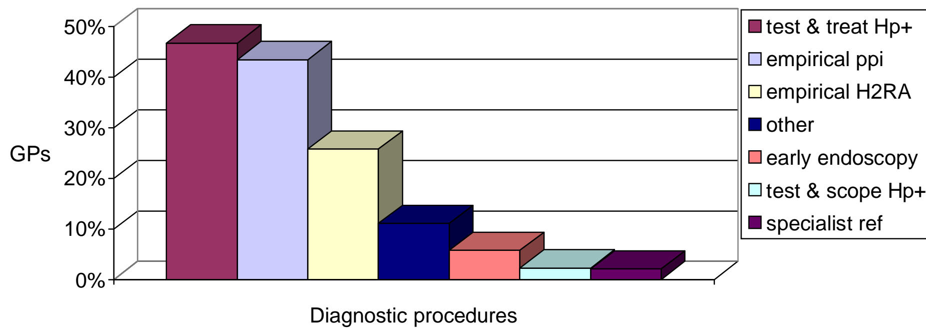
One prescribed Heliclear, another PPI plus two antibiotics, and another Ranitidine.

4.42 Dyspepsia

Diagnosis

General practitioners were asked ‘In patients with uninvestigated dyspepsia, without alarm symptoms, which first line diagnostic and management approach do you use?’ and were offered six diagnostic / management procedures.

Figure 11 Diagnostic / management procedures selected by GPs (n=434 1missing)

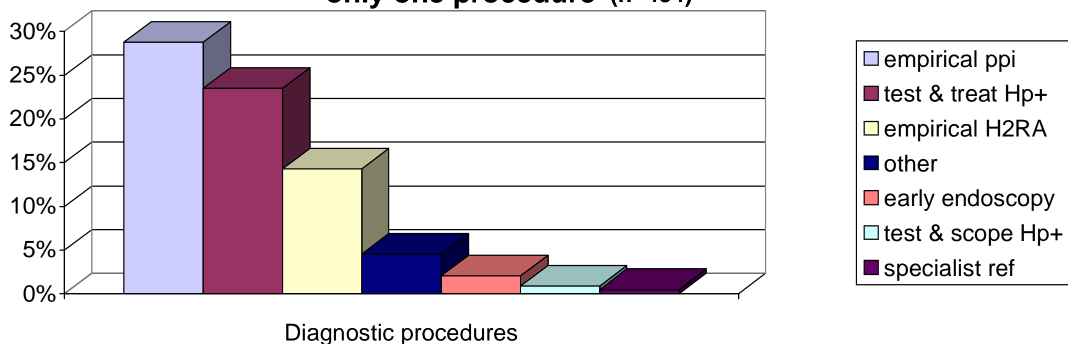


Three hundred and four (70%) selected just one procedure, 96 (22%)selected two and (87) 91% of these selected ‘test & treat Hp+’ as one of their choices. 14(3%) selected 3. The remaining three selected 4, 5 and all 6 procedures.

Eighteen (4%) did not select any but did 17 of these did choose to comment. (see end of this section)

Those who chose just one procedure chose as follows.

Figure 12 Procedure chosen by general practitioners chosing only one procedure (n=434)



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There were comments from 48 respondents and 65% of these mentioned age as being a factor in deciding treatment. For example; 'depends on age', 'depends on age and whether first episode or not', 'depends on patient, age, and circumstances', 'specialist referral if over 50y and new symptom'.
Others suggested a 'barium meal'; 'advice plus H2 antagonist and antacid', 'treat for 4 weeks with ppi and then review'.

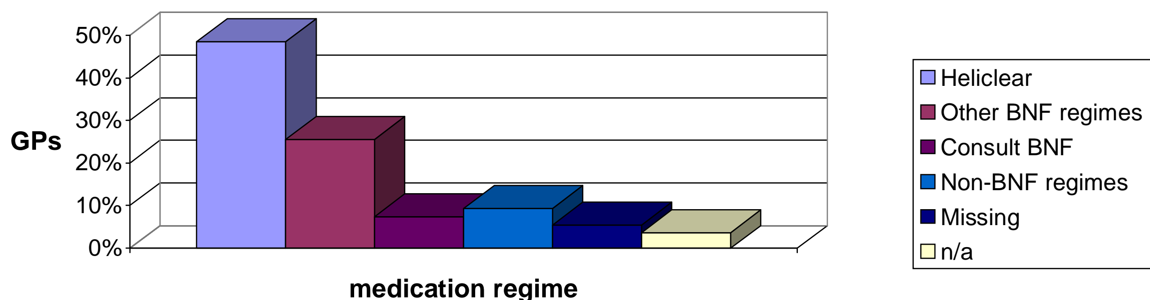
Eradicating Helicobacter pylori infection
General practitioners were asked whether they eradicated HP infection, if present, in patients with non-ulcer dyspepsia, Three hundred and eighty nine (90%) said they did, and 41 (10%) said they did not.(n=431) One person said they 'did when it was recommended.'

The HP eradication regime used varied and in all there were 36 different combinations of medication. (This excludes those who did not specify a dosage - in those cases they were allocated to a 'correct regime' for those drugs.) Three hundred and twenty two general practitioners (74%) 'prescribed' one of eleven possible combinations of PPI and antibiotics which were recommended in the British National Formulary (BNF). A further 32 (7%) said they would use the BNF, and did not specify drugs and dosages. Twenty five who had said they would not eradicate HP answered the question on medication, 16 did not, and a further 24 who had said they would eradicate HP left this blank.

The 25 non-BNF regimes 'prescribed' by 41 (9%) respondents generally had different dosages to those recommended. Most commonly there was under prescribing of Amoxycillin, occasionally there was a non-recommended combination of dosages of the two antibiotics, and sometimes an antibiotic dosage that would have been correct with another PPI. Only one 'prescription' had no PPI, and one 'prescription' no antibiotics.

The most commonly used PPI was Lansoprazole. Amoxycillin and Clarithromycin were

Figure 13 Medication regime choices to eradicate HP
(n=435)

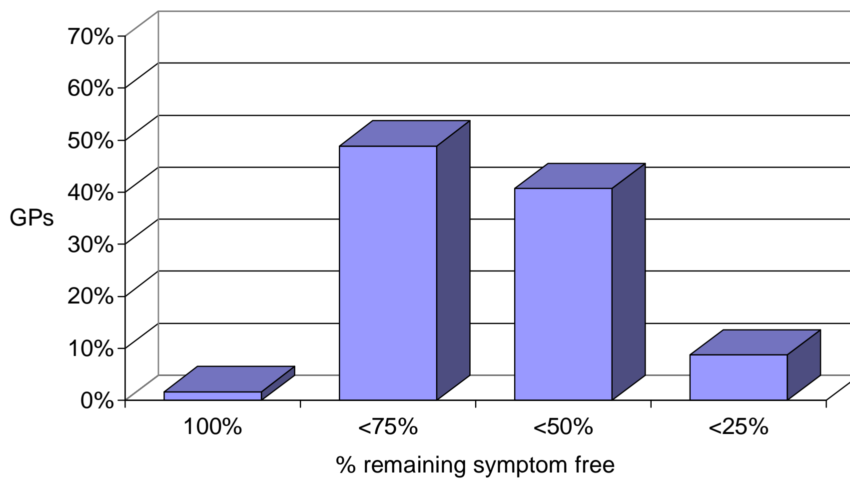


the most usual combination of antibiotics used in 87 'prescriptions'; (Heliclear is also this combination) Metronidazole was used with Amoxycillin in 50 'prescriptions' and with Clarithromycin in 14. Helimet was mentioned as an alternative to Heliclear, and comments were made regarding the need to be aware of allergies.

The duration of treatment was given as 7days by 129 respondents. (282 missing &17n/a) . Heliclear was often given without duration specified. Four gave 14 days and two suggested treatment for 5months. Occasionally different treatment durations were written in next to specific drugs - usually this was the PPI being given 2 or 4 weeks and the antibiotics 1 week.

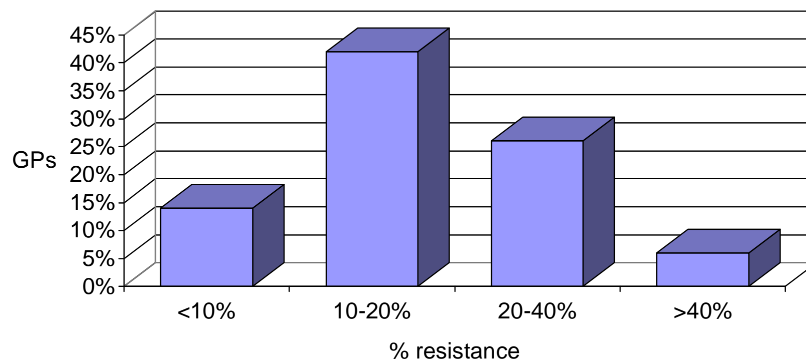
The percentage of patients general practitioners thought would remain symptom free for one year following eradication treatment is shown in Figure 14.

Figure 14 Symptom free for 1yr after treatment (n=423 2missing)



Prevalence of Metronidazole resistance was estimated by only 50 respondents. Three hundred and eighty three (88%) said they didn't know.

Figure 15 Estimated prevalence of local metronidazole resistance (n=50)

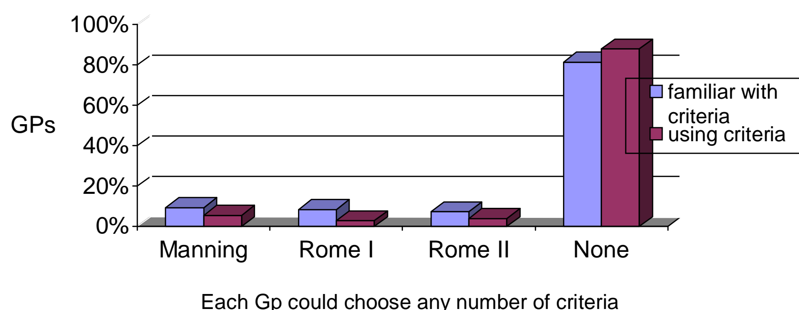


4.43 Irritable Bowel Syndrome (IBS)

Diagnosis

Respondents were asked if they were familiar with any of three criteria for diagnosis of IBS, and then whether they used any of them in practice.

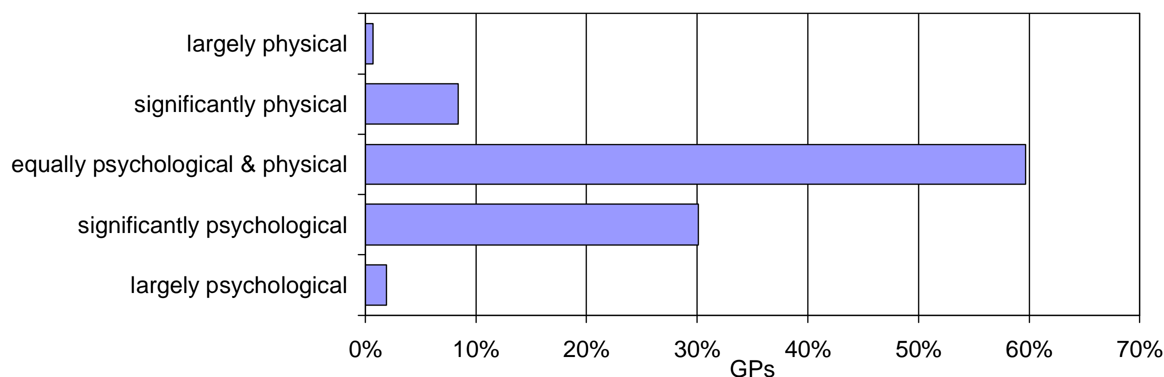
Figure16 Familiar with, and using, diagnostic criteria



Eighty respondents (18%) in all were familiar with one or more of the criteria for diagnosing IBS. Fifty nine were familiar with one of the criteria, 15 were familiar with two, and 6 were familiar with all three. Fifty one general practitioners said they used at least one of the criteria for diagnosing IBS.

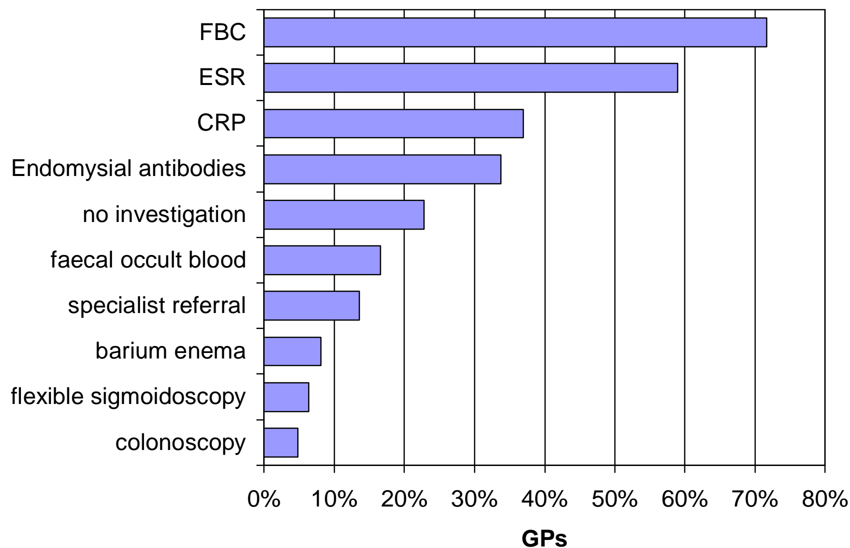
General practitioners were asked to think about the possible causes of IBS, and offered the range of options in figure 17

Figure 17 Possible causes of IBS (n=429)



Investigations undertaken before diagnosing IBS (figure 18) Respondents could select any number of investigations.

Figure 18 Investigations before diagnosis of IBS



Some did not select any investigations leaving all the selections blank, and some selected ‘no investigation’; together these made up 23%. Another 20% chose 1 or 2 investigations, 47% chose 3 or 4 investigations, and 10% 5 to 8 investigations.

Respondents were offered the option of adding any other investigation and 76 respondents qualified their choices and added some alternatives. As before many qualified their choices and felt that what investigations they did would depend on the ‘patient’s age’, ‘the patient’, ‘the context’, ‘severity of symptoms’, and ‘duration’.

Other procedures / investigations suggested were ‘LFTs’ ‘glycoprotein’ ‘FOB’, ‘food allergy testing’, ‘Barium Enema sometimes’, ‘antispasmodic agents’, ‘trial of fibre in diet’, ‘mental state examination’ ‘plasma viscosity’, and ‘stool culture’. Some would have considered a specialist referral and some a rigid sigmoidoscopy.

One respondent had bracketed a number of investigations and commented ‘Depends on how bad the symptoms are, and how worried the patient is, and how typical they are of IBS’.

It could be suggested that GPs who classified IBS as significantly psychological would order a different number of tests from those who saw IBS as significantly physical. This was tested using a Mann Whitney U. and there was no significant difference between the two groups in number of tests ordered.

4.44 Rectal bleeding

Protocols and guidelines

One hundred and thirteen (26%) general practitioners worked in practices that had a protocol for the assessment of colorectal cancer risk. Two hundred and thirteen (49%) were aware of guidelines on the early detection of colorectal cancer. One hundred and thirty nine gave details of guidelines.

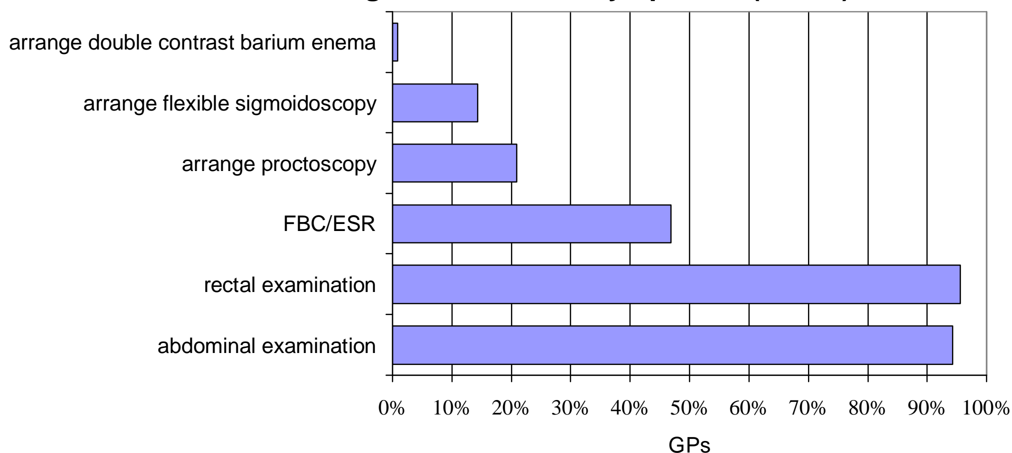
There were local guidelines, - 'from local NHS Trust', 'local PCT' , local hospital fast track guidelines', 'local colorectal clinic guidelines', 'local proforma for 2 week cancer waits', and just some respondents just specified 'local'.

There was the two week referral criteria, - '2 week referral guidelines', ' 2 week wait guidelines', '2 wk referral form from hospital' '2 week rule form I guess is it', 'cancer 2 wk wait forms list alarm signs'.
There were among others, PCT guidelines and hospital guidelines, 'Institute Cancer guidelines', 'Gut guidelines 2002', 'NICE guidelines', 'PRODIGY guidelines', 'government guidelines'
Then a miscellany of symptoms to look out for and a range of other sources of information and guidance: - an 'article in Gut' Addenbrookes website', 'North London Cancer Network', 'Primary care society for gastroenterology', 'Protocol discussed in practice', 'British Society Gastroenterology' and 'local meeting with consultant colorectal surgeon'.

Diagnosis

Next the respondents were asked: 'In patients presenting with rectal bleeding, without other alarm symptoms, and under the age of 50, which of these do you usually or always do at the first consultation.'
Three hundred and ninety seven (91%) chose to do both an abdominal and a rectal examination, and 46% of those also did a FBC/ESR.

Figure 19 Investigations done at first consultation for rectal bleeding 'without alarm symptoms' (n=435)

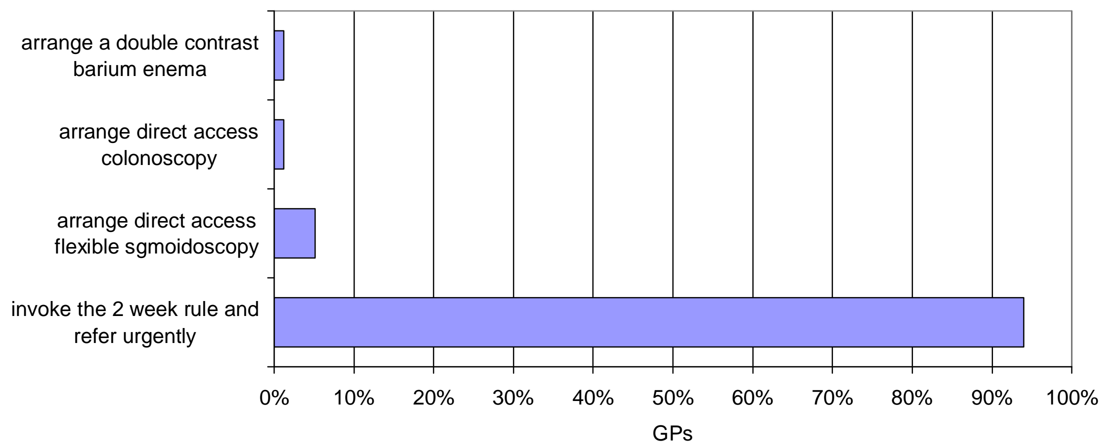


Sixty (14%) of respondents added a comment to clarify what they would do at this first consultation. Some said they would refer the patient to 'colorectal surgeons' or in one case to the 'rectal bleeding clinic if not haemorrhoids'; others said they would to do an 'in house' proctoscopy; refer for a (rigid) sigmoidoscopy - 'could not 'arrange' as it was not available on open access'. Another suggested a 'FOB after a white diet for 3/7'; DRE, Biochemistry; LFTs; and arranging a follow up consultation, or review as 'mandatory'.

Other qualified their choices ; depends on age; depends on type/pattern of bleeding; depends on history.

Finally, respondents were asked about their mangement of rectal bleeding in association with alarm features; eg mixed with stool, in patients over 50 with a change in bowel habit.

Figure 20 Investigations done at first consultation for rectal bleeding 'with alarm symptoms'.



Four hundred and nine respondents (94%) said they would invoke the two week rule and refer urgently. The 26 (6%) who were not taking this management decision arranged for sigmoidoscopy, colonoscopy or Ba enema. Six did not select any management action but did propose alternatives. Two said they would refer to ' Fast track rectal bleeding clinic', another that they would do an 'in house sigmoidoscopy followed by Ba enema, one would 'refer to colorectal surgeon - history & clinical details'; another 'Urgent OPD, not 2 weeks' and one said 'we don't have patients over 50y. (University Students Health Practice)'.

5 Conclusion

- Poor response: related to level of interest/importance? New GP Contract targets?

- Reasonable awareness of upper GI and colorectal cancer guidelines

- Little awareness of guidelines or diagnostic criteria in IBS

- Dissonance between expert thinking and primary care practice

    - GORD

    - HP infection/dyspepsia

    - IBS diagnosis (and management?)

- Emphasise need to understand primary care practice

- Implications for design of future educational/management interventions and for approaches taken by pharmaceutical industry