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Primary Care Society for Gastroenterology

Sample Article

SAMPLE ARTICLE

Cancer focus:

Screening acceptability: more than the public can swallow?

Pancreatic cancer: tracking a silent killer

Beyond our scope:

Endoscopy special

Block busters:
Treating constipation

Functional illness training -
Patients deserve more

Welcome

In my early years in practice I looked after a young woman with primary liver cancer. Her family were Irish and in her last weeks of life, a seemingly endless stream of relatives moved in and shared the nursing care. She died late one night and the family called me. When I got to the house the priest was already there. I suspected that they called him first.

The next day I returned to complete the death certificate. There was a stream of visitors at the front door where murmured condolences were said. They then went upstairs to see the body. She was still in her bed and her eight-year-old sister was brushing her hair. A moment's silence with heads bowed; then down to the kitchen where a party, led by the priest, seemed in full swing.

Death rituals can be deeply ingrained. And if behaviour around death can be culturally specific, perhaps other behaviour can be, too; something demonstrated in this issue of *The Digest*, which focuses on gastrointestinal cancer and screening.

Though perhaps less ritualistic, there may nevertheless be deep-rooted attitudes around accepting advice and health messages especially: taking up screening, presenting a worrying symptom to a doctor, complying with treatment and approaching the last stages of life. All the stages that can affect cancer outcomes, in fact.

Culture can be defined as 'the way we do things around here' and can be at a family and social grouping level, as well as a racial and national one. As doctors, we need to be aware of the unwritten, and usually unconscious, rules that our patients live their lives by, and tailor our messages accordingly.

In this issue we have major articles on gastrointestinal cancer topics by leading figures. The national bowel cancer screening programme has the opportunity to significantly reduce mortality from colorectal cancer. However, it is not without contentious areas: consent, especially for those with limited capacity, being one of them. How can the benefits and risks (physical and psychological) of entering a screening programme be ethically communicated? And is the fact that the take-up of screening is only a little over 50 per cent down to people voting with their feet, or a lack of knowledge and awareness? These and other issues are discussed.

Other topics covered touch on the role and provision of endoscopy, especially in community settings. Sophie Summers' account of training as a GP endoscopist (almost an endangered species) relates the story of how hard it is to swim against the tide in the current training set-up.

Attitudes to functional disorders may be ingrained early, and this is examined in medical student Lydia Yarlott's challenging account. It is worth remembering that, taken literally, functional means 'working and in order, i.e. it functions'.

As always, comments, criticism, compliments and contributions are most welcome. *The Digest* editorial team is always happy to receive, discuss and help with ideas for articles and contributions. Whether you have a special interest in the area or not, a major part of your work will be dealing with gastrointestinal problems. Our aim is therefore to produce a lively and readable journal that is stimulating to all GPs.

Richard Stevens
Editor-in-Chief

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Hepatitis C in context:

A rapid guide for GPs

BRIEFING

RICHARD STEVENS
Editor-in-Chief, The Digest

The global problem

With 3 per cent of the world's population living with the disease, Hep C – a major cause of cirrhosis and liver cancer – is a significant global problem. Infection rates vary significantly from country to country. Hep C affects 2 per cent of the USA population, 3 per cent in China and 5 per cent in Pakistan. In Egypt, the figure rises to 22 per cent of the population (probably as a result of a schistosomiasis vaccination programme with contaminated instruments).

In the UK, the numbers of those infected is believed to be 200,000–400,000. London accounts for 26 per cent of all hepatitis C diagnoses, according to a report published by Public Health England, while Scotland has an estimated 37,500 carriers (about 0.8 per cent of the population). The vast majority of those with hepatitis C, however, are unaware that they are infected.

Natural history

The natural history is slowly progressive, with a median time to cirrhosis of 28–32 years. Risk factors for acquiring the disease include blood-to-blood, IVDU, transfusion (pre-1992) haemodialysis, tattooing and body piercing, and medical (and dental) equipment as well as 'not known'. It is estimated that 50 per cent of prisoners are exposed to IVDU or tattooing.

Vaginal sexual contact in the absence of ulcers, broken skin or bleeding probably does not result in transmission.

In the case of vertical transmission, the mother to child transmission rate is low (<10 per cent), although a long labour does increase the risk. Breast feeding is usually not contraindicated (in the absence of cracked nipples or similar problems) and there are high rates of up to 50 per cent of spontaneous clearing of the virus in babies.

Acute infection is asymptomatic (85 per cent), or may present as a mild illnesses characterised by nausea, myalgia, fatigue and occasionally jaundice (which is associated with a better outcome).

Between 15 and 20 per cent of adults and up to 50 per cent of children clear the virus. The remainder go on to be chronically infected. Of these, around half will go on to develop fatty liver disease, a risk factor for progressing to cirrhosis. Liver function tests are normal in about half of cases.

Many of these will go on to develop fibrosis of the liver with a median time of 30 years from infection. Concurrent Hep B, HIV and alcohol use are risk factors for progressive disease.

Cirrhosis can lead to portal hypertension and varices, liver failure, hepatic encephalopathy, and is a risk factor for primary liver cancer (an annual ultrasound may be recommended.) Liver transplantation is sometimes performed. The re-infection rate after surgery, however, is high (80 per cent).

People who experience a needle stick injury from someone with HCV have a 1.8 per cent chance of subsequently contracting the disease, greater if the needle is hollow and the puncture wound deep, though there is only a small risk from mucosal exposure to blood and no risk from blood exposure to intact skin.

Diagnosis

Detection of HCV antibodies by enzyme-linked immunosorbent assay (ELISA) is used for screening. There are some false positives, especially in low prevalence populations. Dried blood testing is possible and is especially useful for patients who have injected intravenously in the past and in whom venepuncture is difficult or impossible. Confirmatory PCR testing of the serum for HCV RNA may be followed by a liver biopsy.

Selecting patients for treatment

Fewer than 3 per cent of known Hep C patients are treated. Practical difficulties arise as they need to be stable enough to attend for testing, discussion of the results, OPD, further investigations such as ultrasound and liver biopsy. They must also commit to treatment which can last for between 6 and 12 months, with side effects.

HCV sub-types

There are 11 major genotypes, numerous sub-types (designated by numbers and letters respectively) and an estimated 100 or so strains, and considerable geographic variation.

Types 1 to 3 have a worldwide distribution, with the most common, 1a (predominant in northern Europe and America) and 1b (south and east Europe and Japan), responsible for around 60 per cent of all infections.

The identification of the genotype will guide the treatment regime as it provides a prediction of a patient's likely response to antiviral treatment[1].

Treatment

Treatment consists of mono or combination therapy with one or more interferon and/or ribavirin, lasting, usually, for between 24 and 48 weeks. Combining pegylated interferon-a with ribavirin results in a significant improvement for all genotypes.

Success rates can be high – over 75 per cent for patients with genotypes 2 and 3, and 40–50 per cent for those with for genotype 1. Against this, however, other patients, including those who have not responded with prior treatment, have severe liver fibrosis or cirrhosis, or comorbidities – such as alcohol consumption, fatty liver or insulin resistance, can be far harder to treat[2].

Side effects are common, most commonly fatigue, together with flu-like symptoms and mild psychological reactions, while florid neuropsychiatric reactions can occasionally occur. Pre-treatment screening of mental illness risk is important.

Two recently published studies[3] focusing on the difficult-to-treat hepatitis C genotype 1 (the most common in Europe as well as in the USA, north Asia, Australia and South America) suggest that two new oral antiviral drug treatments are shorter, more effective and have fewer side effects.

In the first study, 645 patients from 18 countries received a 6-month course of treatment with two oral DAAs, asunaprevir and daclatasvir, with a placebo control group consisting of 102 treatment-naïve patients.

Ninety per cent of patients who not previously been treated, and just over 80 per cent of patients where either previous treatment had failed or were intolerant, were cured.

In the second study, 167 patients with HCV genotype

"People who experience a needle stick injury from someone with HCV have a 1.8 per cent chance of subsequently contracting the disease"

1a and 1b received either a 12 or 24-week course of once-daily sofosbuvir plus simeprevir with or without ribavirin. The cure rate, after just 12 weeks of treatment without ribavirin, was 93 per cent. Fewer than two per cent of patients reported any adverse effects.

The GP's role

GPs have five roles in Hepatitis C:

- Screening and counselling. Hep C is a significant disease and informed consent and counselling are needed before testing.
- Case finding in at-risk groups. Members of at-risk populations should be sought out and counselled.
- Re-testing at intervals if indicated by ongoing high-risk behaviour (such as continued injecting of drugs)
- Harm minimisation in those not ready for treatment.
- Preparing and counselling patients, family and carers for treatment and supporting them throughout.

Conclusion

With HCV-related disease and morbidity rates predicted to rise and no vaccine as yet available, the short-term goal is to develop new treatments with fewer side effects, while GP education and knowledge of this complex disease also need to be improved.

1. www.who.int/csr/disease/hepatitis/whocdscsrlyo2003/en/index3.html
2. www.natap.org/2008/HCV/nrd2411.pdf
3. www.eurekalert.org/pub_releases/2014-07/tl-tln072414.php