Referral Support Service

General Surgery

GS02
Change in Bowel Habit / Rectal Bleeding

Definition

Definitions vary but chronic diarrhoea can be defined as the abnormal passage of 3 or more loose or liquid stools per day for more than 4 weeks.

IBS is a functional bowel disorder characterised by more than 6 months of recurrent abdominal pain/discomfort which may be relieved by defecation and associated with an alteration in stool form or frequency (**see IBS Guideline**)[1]. Faecal calprotectin may be a useful discriminator and help diagnosis without referral (see below)[2].

Exclude Red Flag Symptoms

Try to establish the most likely diagnosis and refer accordingly as either 2 week wait, urgent or routine referral

2 Week Wait Criteria:

- Definite palpable right-sided abdominal mass (to exclude caecal tumour)
- Definite rectal mass on PR exam
- Unexplained iron deficiency anaemia with:
  - Hb <11g/dl in men
  - Hb <10g/dl in non-menstruating women
- 40-60 yrs old with persistent (> 6 weeks) rectal bleeding and a change to looser/more frequent stools.
- 60 yrs or over with persistent (>6 weeks) rectal bleeding (in the absence of anal symptoms) and/or change to looser/more frequent stools

Urgent Referral:

- Rectal bleeding in the absence of anal symptoms/haemorrhoids
- Blood mixed with stool and or clots
- Rectal bleeding and associated change to looser stool (any age)
- Unexplained weight loss
- Strong family history of colorectal cancer. (1st degree relative with colorectal cancer <50 yrs old or two 1st degree relatives with colorectal cancer at any age)
- Iron deficiency anemia (see separate guideline)

Routine Referral:

- Patients with persistent low-risk symptoms which do not respond to treatment, or which recur after stopping treatment, should be referred - after consideration of IBS.
- Faecal calprotectin can help a positive diagnosis of IBS, without referral. The test costs £27 and should be considered in patients :

©NHS Vale of York Clinical Commissioning Group – Version 2
The on-line version is the only version that is maintained. Any printed copies should, therefore, be viewed as 'uncontrolled' and as such may not necessarily contain the latest updates and amendments.

- aged 18-60 years
- who present with lower gastrointestinal symptoms where you suspect IBS or IBD
- where there is diagnostic uncertainty

Management

Management will depend on the most likely diagnosis of those in the differential. Some of the common conditions and suggested management strategies are outlined below

Irritable Bowel Syndrome (IBS) – see IBS guideline

Inflammatory Bowel Disease (UC and Crohn's)

Consider in any patient with new onset profuse diarrhoea +/- rectal bleeding which does not self-limit. Inflammatory markers are likely to be raised as well as faecal calprotectin. Needs referral or admission (depending on severity) for further investigations to include mucosal biopsy at flexible sigmoidoscopy/colonoscopy for histology.

Diverticular Disease / Diverticulitis[3]

Presents with constant abdominal pain, often left iliac fossa, with associated change in bowel habit. Often accompanied by rectal bleeding which can be either mixed in with stool or sometimes bright red if a vessel at the neck of the diverticulum bleeds significantly. In most cases it is "simple" (75%) and rarely "complicated" 25% (abscess/fistula/perforation). It is rare under 60, common (65%) over 80.

Simple Diverticulitis

Diverticulitis can be managed in primary care if known diverticular disease and a simple presentation:

- Initially just clear fluids for 24 to 48 hrs then low residue diet
- Oral antibiotics – as per the North Yorkshire antibiotic guidance
- **Cefalexin** 500mg tds AND **metronidazole** 400mg tds for 7 days
- Re-examine 48-72 hours. If no improvement, consider admission.
- Advise re avoiding future constipation

Complicated Diverticulitis

Diverticulitis is often more severe in the elderly, immuno-compromised and those with significant co-morbidities. **Admit** if signs of systemic sepsis, peritonitis or an inability to tolerate oral fluids.

Referral Information

- Previous primary care management attempted
- Relevant past medical / surgical history

©NHS Vale of York Clinical Commissioning Group – Version 2
The on-line version is the only version that is maintained. Any printed copies should, therefore, be viewed as 'uncontrolled' and as such may not necessarily contain the latest updates and amendments.

- Current regular medication
- BMI/ Smoking status
- Dependent on most likely diagnosis in the differential (as above) but will usually include FBC, U&E, CRP, coeliac screen

Patient information leaflets/ PDAs

1. Irritable Bowel Syndrome
2. Chronic Diarrhoea in Adults
3. Crohn's Disease
4. Ulcerative Colitis
5. Diverticula including Diverticulosis, Diverticular disease and diverticulitis

NICE CKS guidance

1. IBS assessment and management
2. Crohn's Disease
3. Ulcerative colitis
4. Diverticular disease

References

1. NICE Guidance CG61 Irritable bowel syndrome in adults: diagnosis and management of irritable bowel syndrome in primary care Feb 2008. Updated Feb 2015 http://www.nice.org.uk/guidance/CG61
2. Faecal calprotectin diagnostic tests for inflammatory diseases of the bowel Diagnostics guidance Oct 2013 https://www.nice.org.uk/guidance/dg11
3. NICE CKS Diverticular disease https://cks.nice.org.uk/diverticular-disease
4. Diverticulitis treatment and management Emedicine Medscape Article http://emedicine.medscape.com/article/173388-treatment

©NHS Vale of York Clinical Commissioning Group – Version 2
The on-line version is the only version that is maintained. Any printed copies should, therefore, be viewed as 'uncontrolled' and as such may not necessarily contain the latest updates and amendments.