

# Lower GI Bleeding, Clinical Approach for Outpatient Practice



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[www.ipswichcolorectal.org](http://www.ipswichcolorectal.org)



The National Cancer Institute  
Cairo University  
[www.nci.cu.edu.eg](http://www.nci.cu.edu.eg)



Cairo University      National Cancer Institute



Cairo University

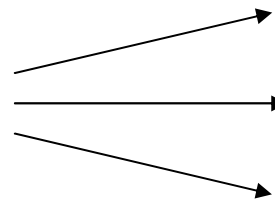


# Clinical Approach

- **Four Main factor** will help to conclude a diagnosis
- A **Differential Diagnosis** must be clear to exclude serious conditions
- We are aiming at focusing on making a **diagnosis**

KEY  
&  
Class

Age

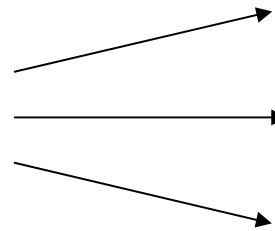


Adolescence

Adult

Elderly

Amount

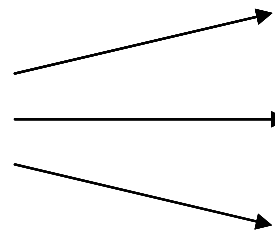


Mild / sporadic

Moderate

Massive

Colour

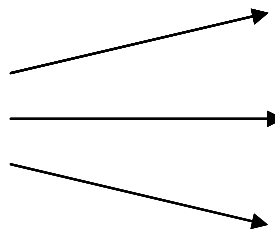


Bright

Dark

Melena

Symptoms



Abdominal

Rectal

systemic

# Differential Diagnosis

## Benign

- Anal:
  - Haemorrhoids
  - Anal Fissure
  - Anal Fistula
- Colonic:
  - Diverticulosis
  - Telengectasis
  - Infections

## Inflammatory

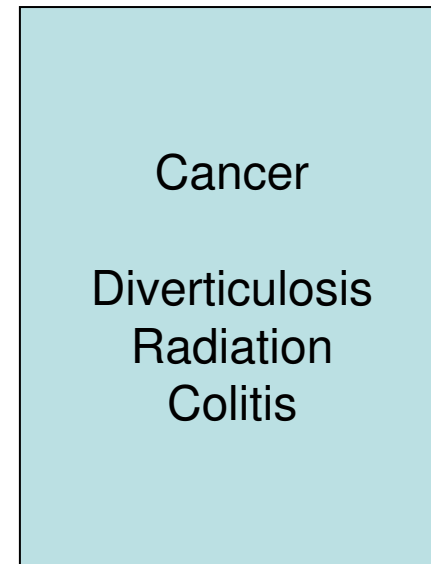
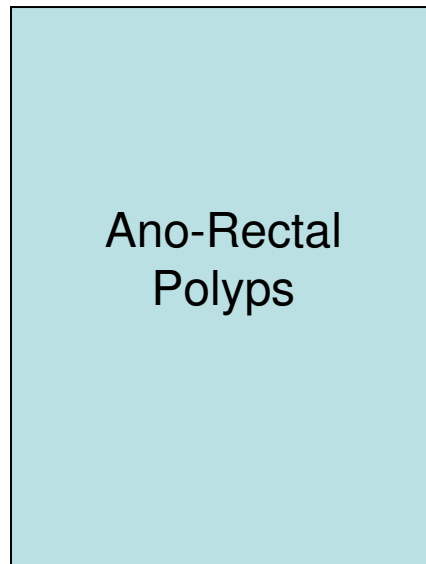
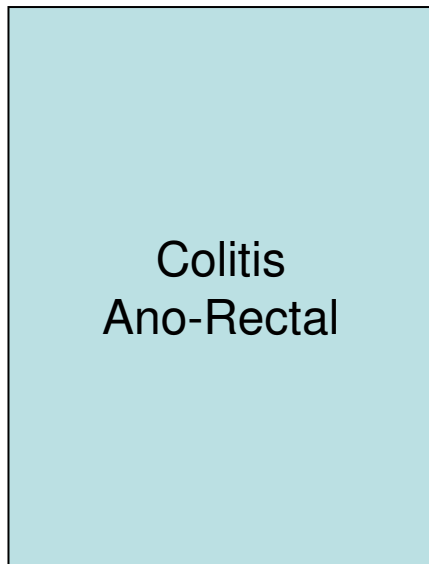
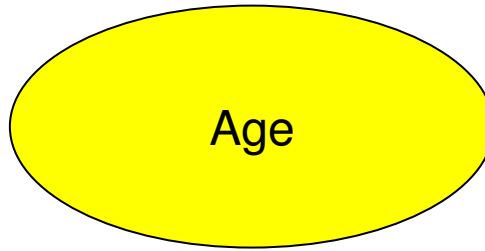
- Crohn's
- Ulcerative Colitis
- Radiation
- Non-Specific

## Malignant

- Polyposis Syndromes
- Polyp
- Polyp Cancer
- Cancer

## Who Knows

- IBS
- UGI Causes
- Ischaemic Colitis



Amount

Mild / sporadic

Moderate

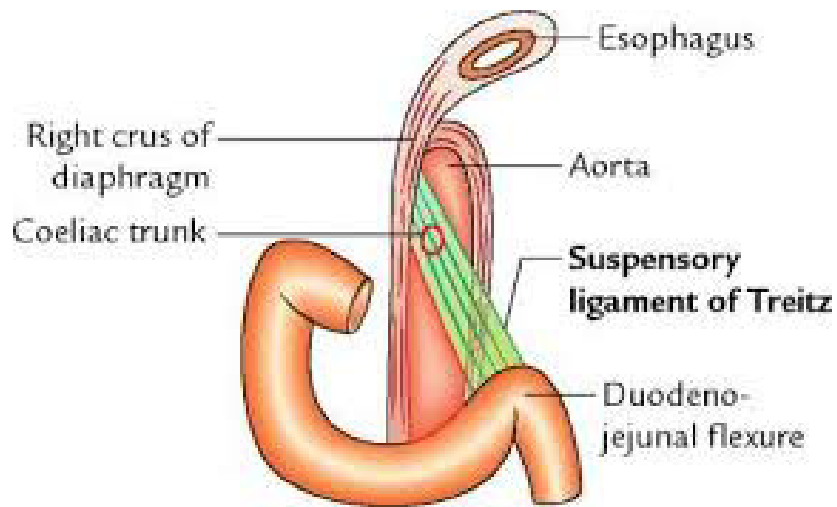
Massive

Ano-Rectal  
Constipation

Colitis: Periodic  
Malignant

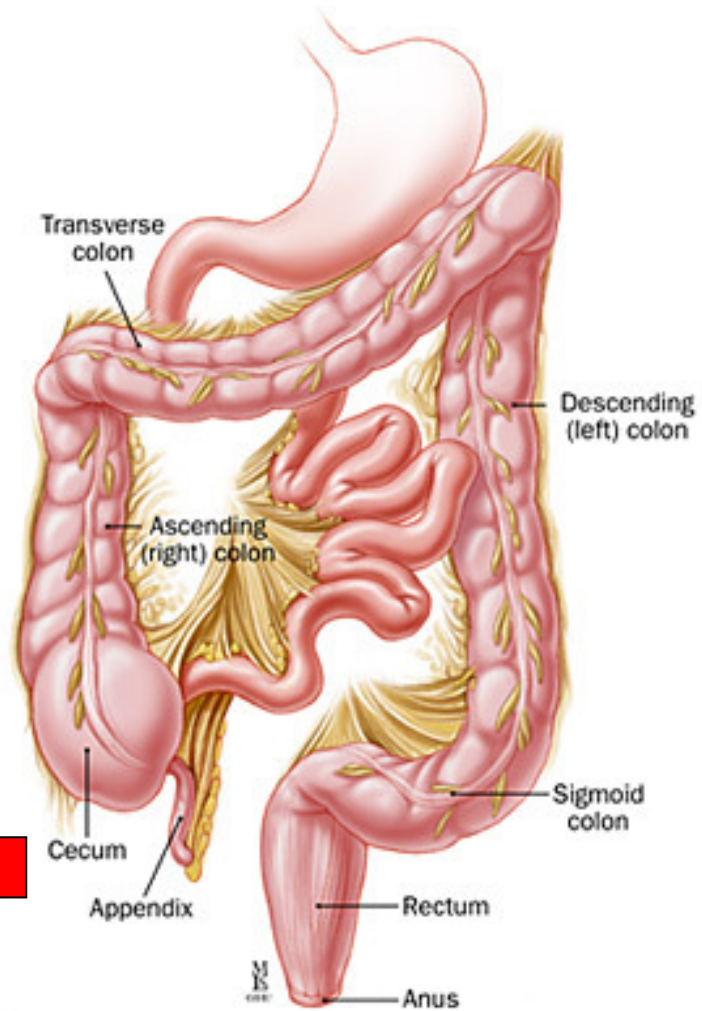
Diverticular  
Radiation  
Vascular  
Cancer

Colour



Dark

Melena



Bright

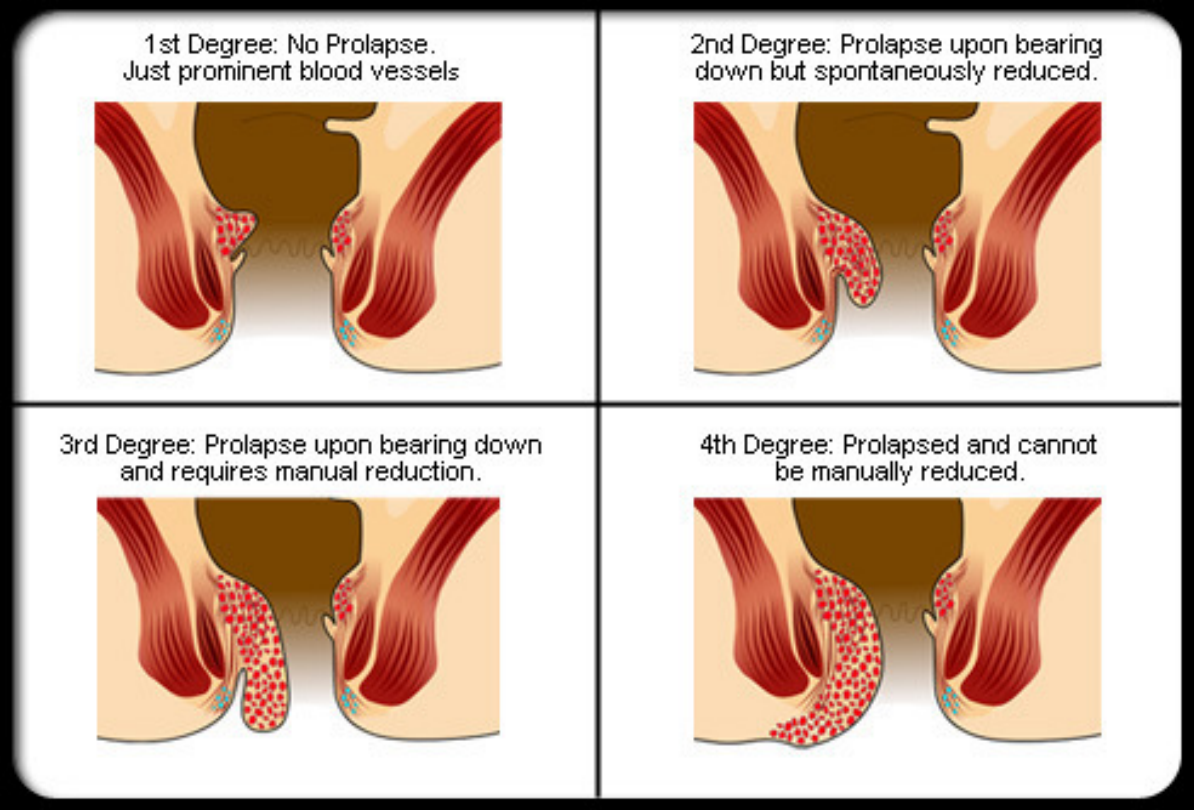


## Benign

## Symptoms

- Anal:
- Haemorrhoids
  - Anal Fissure
  - Anal Fistula
- Colonic:
- Divericulosis
  - Telengectasis
  - Infections

- Haemorrhoids:**
- Not painful  
Exceptions
  - Constipation  
On/Off
  - Investigations:  
F Sigmoid
    - TTT  
Constipation
    - Hospital  
Banding / Injection  
Operation



**Prolapsed Internal haemorrhoids**



## **Anal Fissure:**

### **S:**

- Painful
- Opening Bowel / Passing Glasses
  
- Constipation

### **S: O/E**

- Can not do PR

### **Investigation:**

F Sigmoidoscopy (Routine)

### **TTT:**

- GTN 0.4% / DELTIAZEM 2%

Instruction / Side effects

Duration

- Constipation

- Hospital:

Fissurectomy / Botox

Advancement Flaps



## Anal Fistula:

### S:

- Painful Swelling
- Soiling
- History of I&D
- Periodic / Normal

### S: O/E

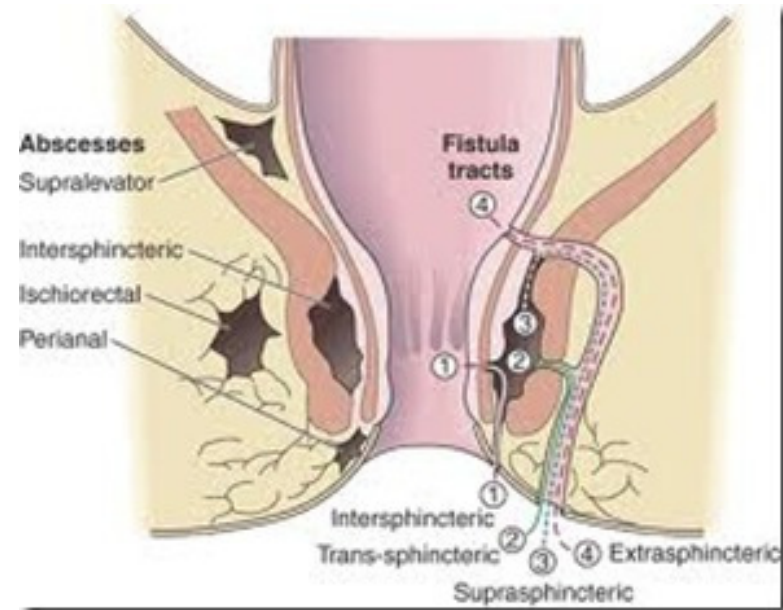
- Can See Fistula

### Investigation:

F Sigmoidoscopy (Routine)

### TTT:

- Hospital Referral
- Hospital:  
Different approach



## Diverticulosis

### S:

- Lt. side pain / Diarrhoea
- Periodic
- Temperature
- Raised Inflammatory markers

### S: O/E

- Tender Left side

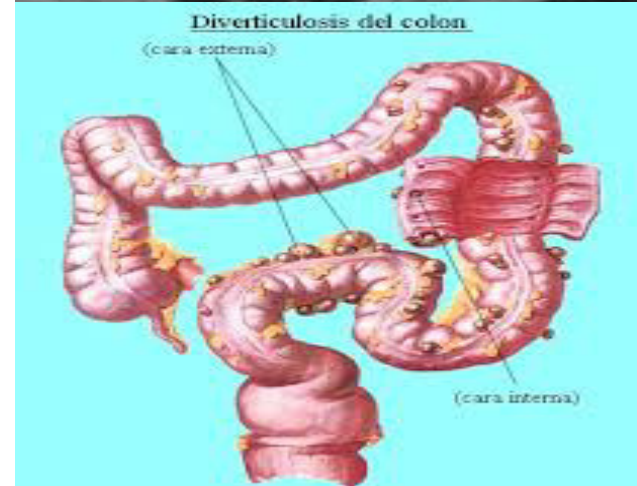
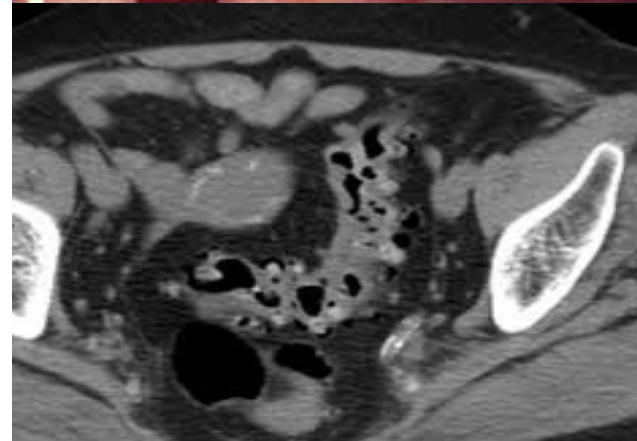
### Investigation:

F Sigmoidoscopy (Routine)  
Exclude malignancy

### TTT:

- Antibiotics

•Hospital: “Complications”  
Over 3 admissions / year discuss Op.  
Increasing aggressiveness Young



Inflammatory

- Crohn's
- Ulcerative Colitis
- Radiation
- Non-Specific

## Crohn's Disease

### S: Smoking

- 2 Peaks : Adolescence / 70
- IBS type: Years before diagnosis
- Family history
- Colonic & Extra-Colonic
- Abdominal pain: Eating

### S: O/E

- Long Term un-well
- Other medical history

### Investigation:

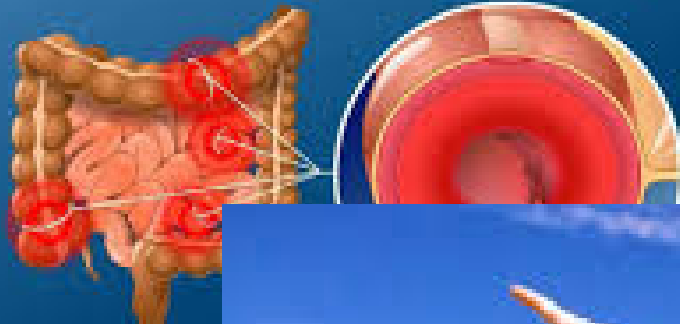
Faecal Calprotectin  
Serum ttg IgA  
Colonoscopy [TI Biopsy]

### TTT:

- Antibiotics / Immunosuppressive
  - Hospital: "Complications"
- Incidental during appendectomy



Immune Response Stays "ON"



Transmural  
Mouth to Anus



tion  
ntestine



THIS BAG IS WHERE I WENT TO  
THE BATHROOM.

© Sara Ringer

Inflammatory

- Crohn's
- **Ulcerative Colitis**
- Radiation
- Non-Specific

## Ulcerative Colitis

### S:

- Mostly bleeding Rectal
- IBS type: Years before diagnosis
- Family history
- Colonic

### S: O/E

- Long Term un-well
- Proctitis on Examination

### Investigation:

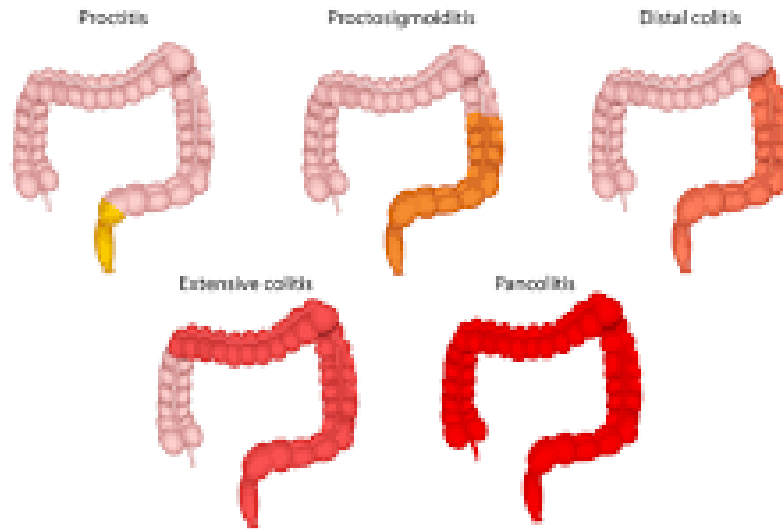
Colonoscopy

### TTT:

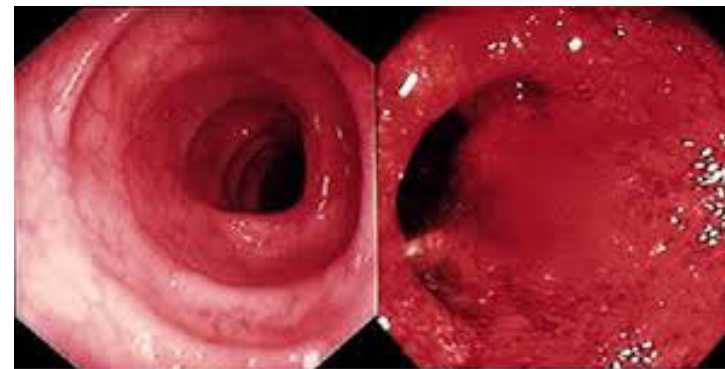
- Antibiotics / Immunosuppressive
- Hospital: "Complications"



## TYPES OF ULCERATIVE COLITIS



- Mucosa Only
- Often Starts at Rectum
- Rare cases : Rectal Sparing
- No Extra Colonic



Healthy Colon

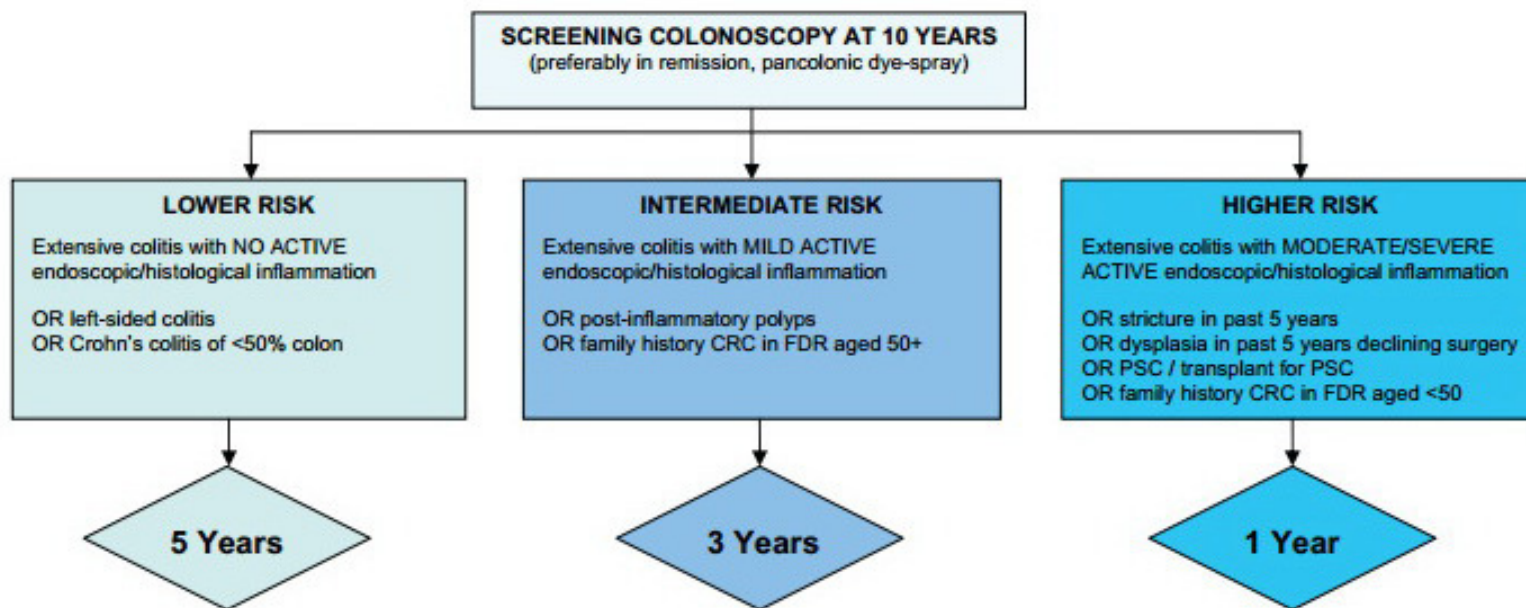
Ulcerative Colon



BRISTOL STOOL CHART			
	Type 1	Separate hard lumps	Very constipated
	Type 2	Lumpy and sausage like	Slightly constipated
	Type 3	A sausage shape with cracks in the surface	Normal
	Type 4	Like a smooth, soft sausage or snake	
	Type 5	Soft blobs with clear-cut edges	
	Type 6	Mushy consistency with ragged edges	
	Type 7	Liquid consistency with no solid pieces	



# COLITIS SURVEILLANCE



**BIOPSY PROTOCOL**  
Pancolononic dye spraying with targeted biopsy of abnormal areas is recommended, otherwise 2-4 random biopsies from every 10 cm of the colorectum should be taken

**OTHER CONSIDERATIONS**  
Patient preference, multiple post-inflammatory polyps, age & comorbidity, accuracy & completeness of examination

*CRC – colorectal cancer*  
*FDR – first degree relative*  
*PSC – primary sclerosing cholangitis*

## Malignant

- Polyposis Syndromes
- Polyp
- Polyp Cancer
- Cancer

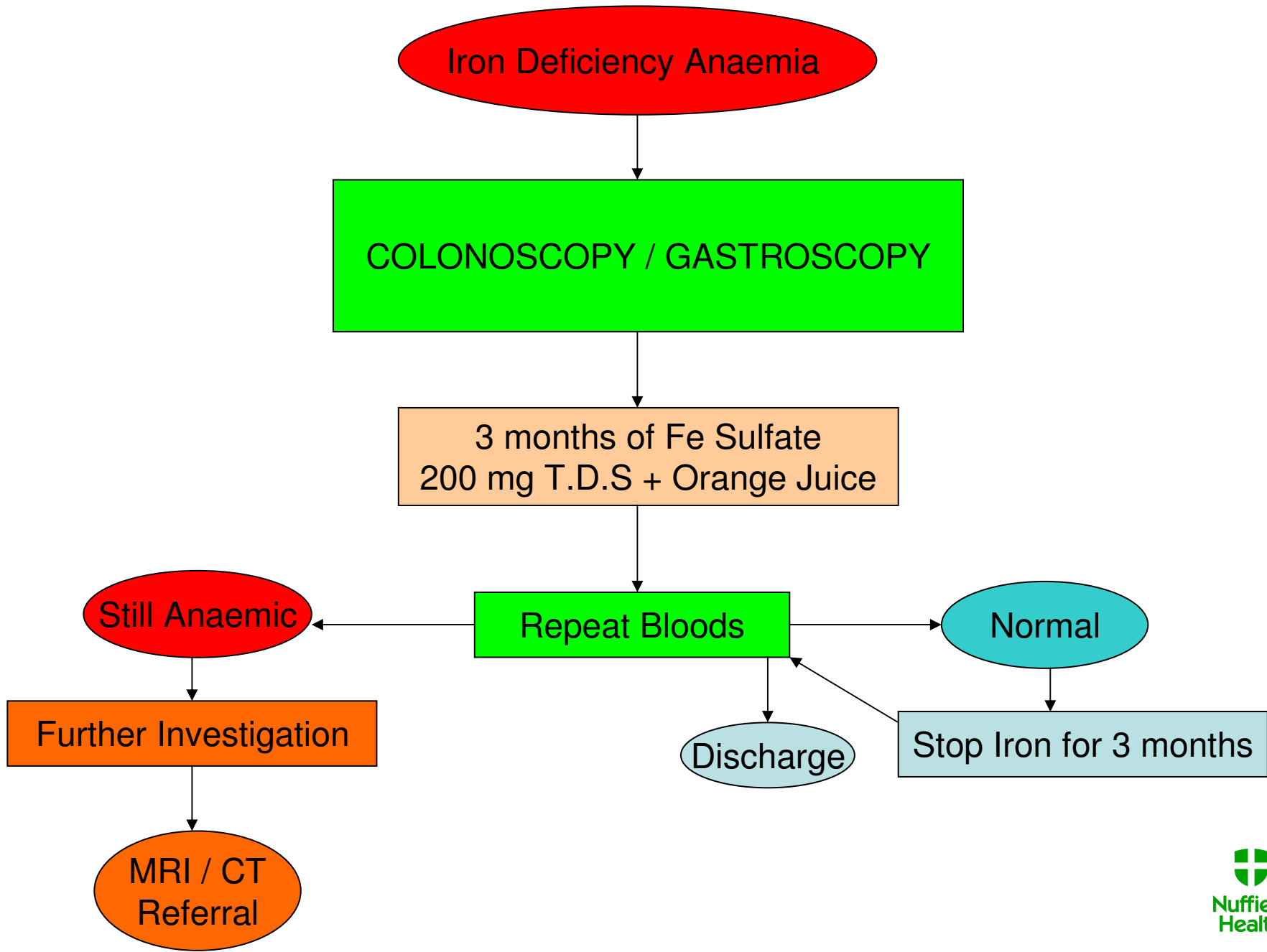
### 2 WW Criteria:

- 60 with:
  - CIBH > 6Weeks
  - Bleeding > 6Weeks
- 40 With:
  - CIBH
  - Bleeding
- Any:
  - I D Anaemia
    - Men:11 g/100 ml
    - Women: 10 g/100

CIBH: Change to **loose** Stools  
And / or  
Increased **Frequency**  
Persisting for **6 weeks** or more

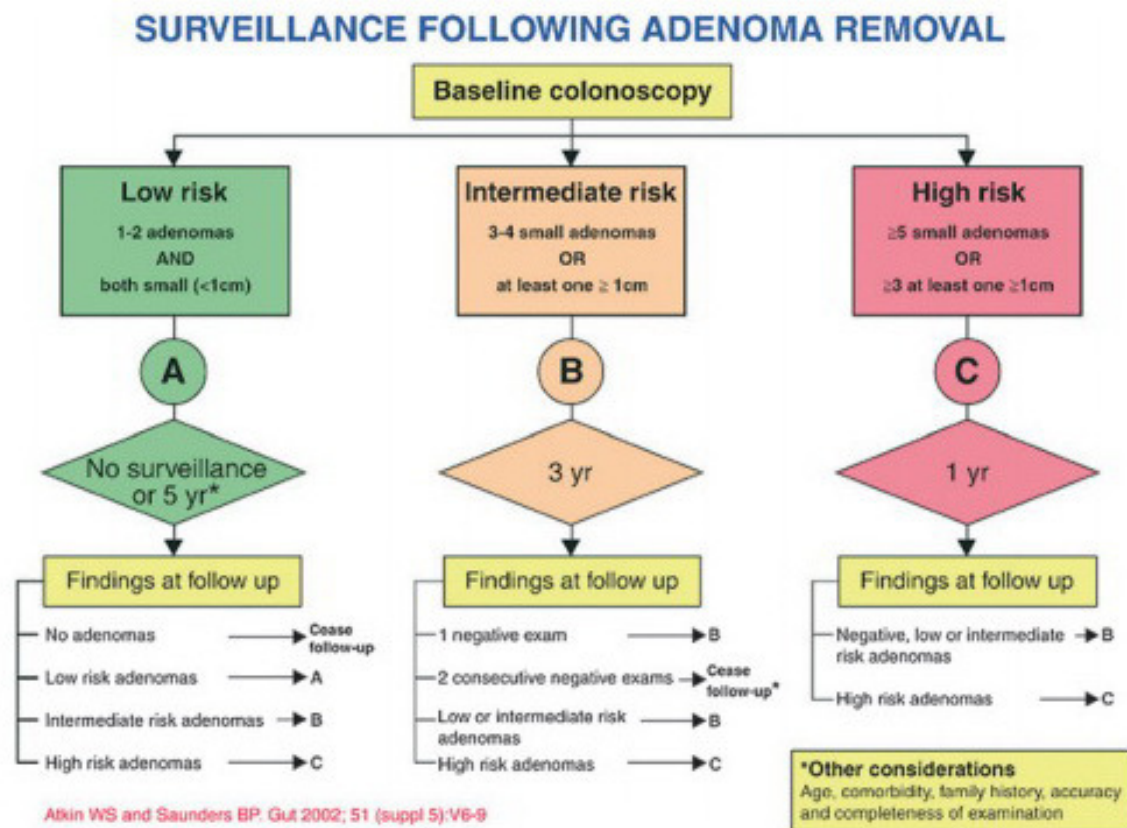
**Significant Weight Loss**

**Iron Deficiency Anaemia**

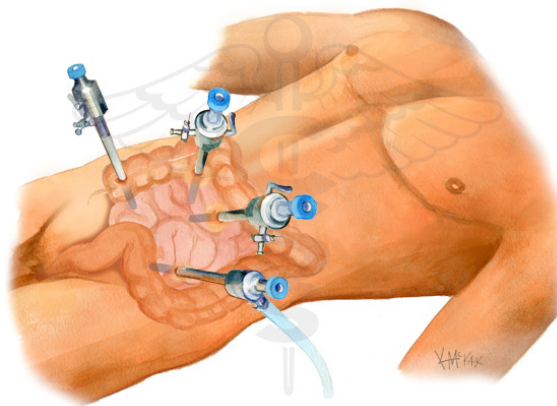
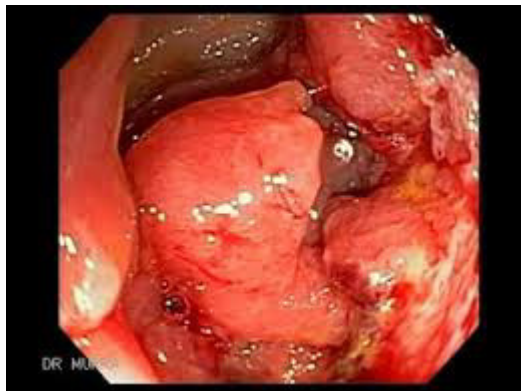
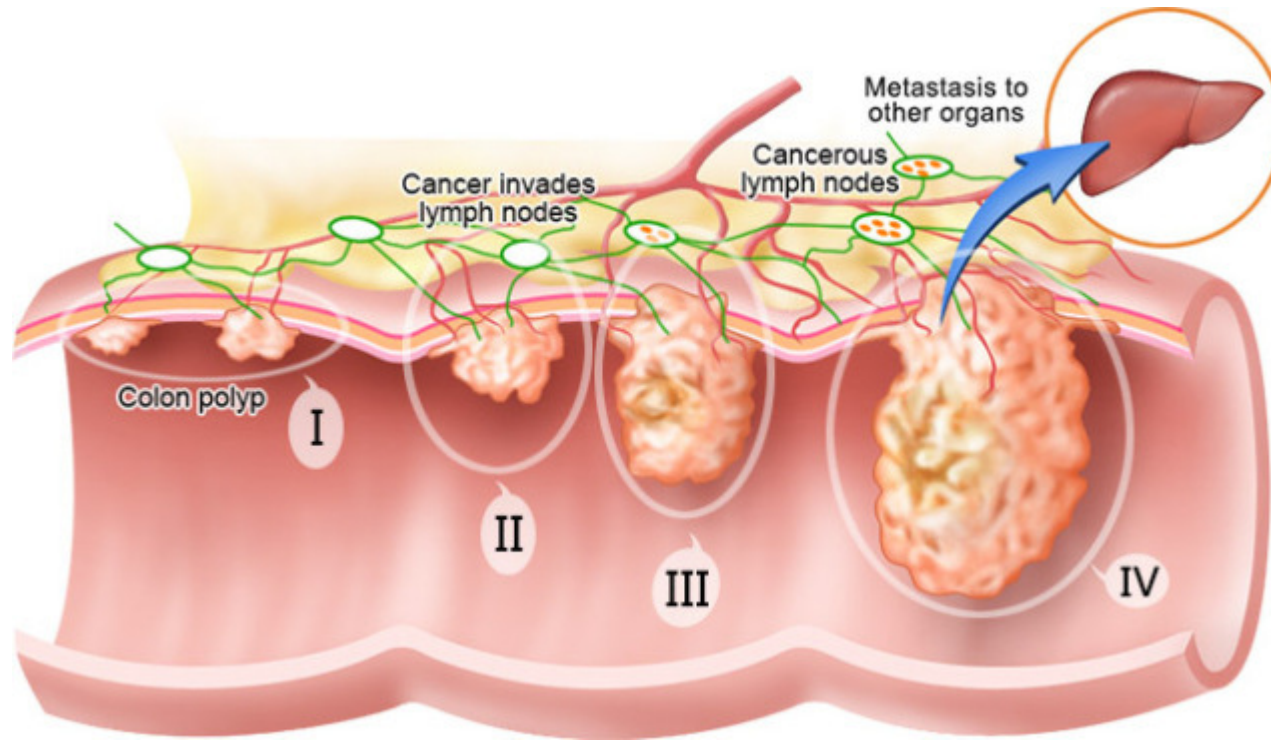


# Adenoma Surveillance

**Figure 1** Surveillance following adenoma removal.















# IBS

## FOODS THAT MAY *TRIGGER* IBS SYMPTOMS

- Apples 
- Beans
- Broccoli 
- Cabbage
- Caffeine
- Cauliflower
- Gum, beverages, or foods sweetened w. fructose or sorbitol
- Chocolate 
- Dairy products 
- Fatty foods
- Margarine
- Nuts 
- Orange & grapefruit juices 
- Wheat products

**AVOID**

ers avoid



## ***Irritable Bowel Syndrome or Small Bowel Tumour , A Mystery Diagnosis***

Al Morgan , JJ Smith .

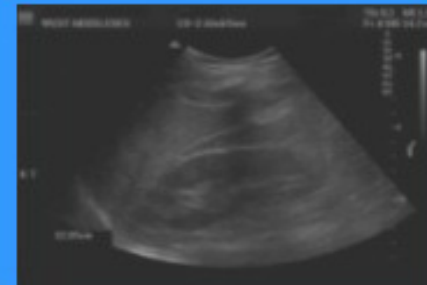
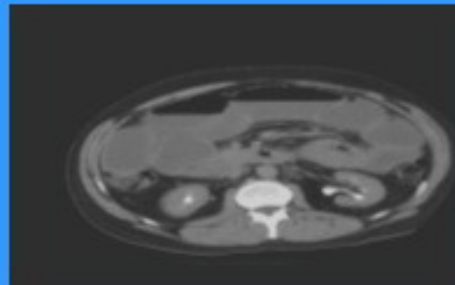
Dept of Colorectal Surgery, West Middlesex University Hospital , London

### ***Background:***

Abdominal Cramps, alternating episodes of diarrhoea and constipation, nausea, vomiting, bloating and abdominal distension are common symptoms in Irritable bowel Syndrome as well as Small Bowel Tumours.

### ***Patients and Methods:***

- 56 years old Male with Positive family history of bowel cancer
- Diagnosed and treated as having Irritable Bowel Syndrome for 3 years
- C/O Recent progression in the frequency and severity of repeated attacks of abdominal cramps, alternating episodes of diarrhoea and constipation, nausea, vomiting, bloating and abdominal distension.
- Radiology : Markedly dilated loops of small bowel distally + sharp narrowing of the lumen of the ileum + ill-defined soft tissue mass 4.5 cm in size
- Exploratory Laparotomy : Metastatic Small Bowel Tumour in both Liver and Mesenteric nodes .



### ***Discussion:***

- IBS is very common affecting 9-12% of population with age onset increasing during adolescence

### **Discussion:**

- IBS is very common affecting 9-12% of population with age onset increasing during adolescence and third and fourth decades while onset after the age of 50 is unusual .
- Tumours of small intestine which represent < two percent of the malignant tumours of GIT , presenting mainly between age of 50 and 59
- Given the lack of a clear biologic marker for IBS, symptoms remain the only method of identifying the disorder .
- The reported case posed a diagnostic problem,
- This patient with a positive family history of bowel tumour had an onset of his symptoms at his early fifties, with worsening of symptoms and changing of nausea into persistent vomiting.
- Though these symptoms themselves are not a sure indicator for the presence of a more serious pathological process, they should have risen the suspicions for the presence of a more serious pathology than IBS and should have become a reason for an early hospital referral for more extensive diagnostic evaluation

### **Conclusion:**

Early Hospital Referral aiming at extensive diagnostic evaluation should be encouraged in all patients who have the onset of symptoms after age of 45.

Though symptoms persistence is not an indication for further testing, it is :

- Worsening or change (Frequency or Severity)
- Alarm symptoms (Weight Loss, Bleeding, anaemia, Nocturnal Symptoms)
- Positive family history (bowel cancer)  
which should be alarming for early hospital referral and further testing

For those patients, tests should include:

- Colonoscopy
- CT of the abdomen and pelvis
- Barium studies of the small and large bowel

It was not until 2008, NICE

- **BSG Guidelines:**
- **Consider** assessment for IBS if for at least 6 months:
  - Abdominal pain or discomfort
  - Bloating
  - Change in bowel habit. [2008]
- **Exclude 'red flag'** indicators and should be referred to secondary care for further investigation if any are present:[4]
  - unintentional and unexplained weight loss
  - rectal bleeding
  - a family history of bowel or ovarian cancer
  - a change in bowel habit to looser and/or more frequent stools persisting for more than 6 weeks in a person aged over 60 years. [2008]
- **Assess and Examine for:**
  - anaemia
  - abdominal masses
  - rectal masses
  - inflammatory markers for inflammatory bowel disease

- **A diagnosis of IBS should be** considered **only** if the person has :
  - abdominal pain or discomfort that is either
    - relieved by defaecation or
    - associated with altered bowel frequency or stool form.
  - This should be accompanied by **at least two** of the following four symptoms:
    - altered stool passage (straining, urgency, incomplete evacuation)
    - abdominal bloating (more common in women than men), distension, tension or hardness
    - symptoms made worse by eating
    - passage of mucus.
  
- **The following tests should be** undertaken to exclude other diagnoses:
  - FBC
  - ESR
  - CRP
  - antibody testing for coeliac disease (endomysial antibodies [EMA] or tissue transglutaminase [TTG]). **[2008]**

- **The following tests are not necessary** to confirm diagnosis in people who meet the IBS diagnostic criteria:
  - ultrasound
  - rigid/flexible sigmoidoscopy
  - colonoscopy; barium enema
  - thyroid function test
  - faecal ova and parasite test
  - faecal occult blood
  - hydrogen breath test (for lactose intolerance and bacterial overgrowth). **[2008]**

Most important red flag !!

**If Concerned : Please refer !!!**



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COLORECTAL NEWS

Robotic assisted dissection of metastatic lymph node recurrence following rectal cancer resection. Report of a case - video vignette  
January 30, 2017

Accuracy of magnetic resonance enterography in the preoperative assessment of patients with small bowel Crohn's disease  
January 24, 2017


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## MEET THE AUTHOR

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### Qualifications

- MBBCh. Cairo University 1995
- MSc. National Cancer Institute, International Directory of Cancer Institutes & Organizations 1999
- Ph.D. National Cancer Institute, International Directory of Cancer

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# ***Any Questions ?!!***



If you have any,  
Please contact me  
through my email,  
personal phone or my  
website. Very happy to  
help and answer any  
question

We need to communicate  
better for our patients

