Issue 6

the Insider

Spring 2010
Celebrating 25 Years

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Since 1985, GastroIntestinal Endoscopy (GIE) has provided an efficient 'Open Access' service for colonoscopy and upper gastrointestinal endoscopy.

GIE provides an enviable level of medical experience. Our seven Gastroenterologists possess a broad base of clinical expertise in their varied speciality areas of interest.

Currently, GIE operates an 'Open Access' service from four centres:

- **Brisbane Endoscopy Services** – a Day Endoscopy Centre located at the McCullough Centre, Sunnybank which is owned and operated by the GIE partners;
- **Chermside Day Hospital** at Chermside;
- **North West Private Hospital** at Everton Park;
- **The Wesley Hospital** at Auchenflower.

GastroIntestinal Endoscopy

1300 4 GASTRO (Ph: 1300 4 427876)
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GIE Welcomes Dr Hugh Spalding

GIE Welcomes Dr Hugh Spalding to the group following the recent departure of Drs Devereaux and Walsh. We thank Drs Devereaux and Walsh for their service to GIE patients and wish them well with future endeavours.

Dr Spalding brings a wealth of experience and enthusiasm to GIE and will be a valued member of the GIE team. Dr Hugh Spalding graduated from the Melbourne University medical school in 1996 and completed physician training in gastroenterology and hepatology, with rotations in Brisbane at the Mater Adult Hospital, the Princess Alexandra Hospital, and the Gold Coast Hospital. His interests include general hepatology, luminal gastroenterology and endoscopy with a focus on inflammatory bowel disease. Prior to medical training, Dr Spalding studied veterinary science and completed a Ph.D. on aspects of the immune system. Other interests include bushwalking, music, woodwork and fishing.

Dr Spalding consults at:

St Andrew's Hospital
Level 7, Suite 4
St Andrew's Specialist Centre
457 Wickham Terrace
Spring Hill QLD 4000
T: 3831 4044 **F:** 3831 0622

Southside Endoscopy Centre
66 Bryants Road
Loganholme QLD 4129
T: 3801 2233 **F:** 3801 5212

Dr Spalding also holds a VMO role at the public outpatients department at QEII Hospital.

In this issue

GIE Events

Below L–R: Dr Neville Sandford (GIE), Dr Michael Gattas (Brisbane Genetics) and Dr Ian Brown (Sullivan Nicolaides Pathology) were key note speakers at the most recent GIE GP Education Evening.

Nursing staff learning practical tips at the GIE Nurses Education Day held at the Chermside Day Hospital earlier this year.

Annual Report on Colorectal Cancer in the USA and other colonic neoplasia issues

Dr Andrew Bryant *MB BS FRACP Dip Av Med (Otago)*

This report published in Cancer 7 December 2009 has shown a progressive reduction in CRC incidence since 1985. This has accelerated from 1997 with an annual decline in CRC mortality of 2.7% per year. Half of the 22% reduction in CRC incidence from 1975 to 2000 was due to screening, with reduction of lifestyle risk factors explaining the other half. CRC mortality has declined by 26% from 1975 to 2000. It is thought that 35% of this reduction is due to lifestyle factors while 12% is due to improved treatment. If current trends continue, a 36% overall decline in CRC mortality could occur by 2020. If screening accelerates however, a 50% reduction in mortality could be achieved in that time.

However on the other side of the coin, a German group has reported similar data to the Canadian group's report that colonoscopy is much better at reducing the incidence of left sided cancer than right sided ones. It is essential that the colonoscopist is able to identify sessile serrated adenomas as these are often right sided and subtle. I feel this lesion is better understood here in Australia than overseas, judging by the reports from overseas meetings.

Lastly, I would advise strong consideration of endoscopic rather than surgical management of even large and right sided polyps. In recent times the need for surgery for non-malignant neoplasia in the colon has reduced due to improvements in technique, particularly lifting with saline to reduce the risk of full thickness bowel wall damage or perforation. I would advocate discussion of endoscopic resection options prior to committing to surgery. This could be due by photographing any lesion a proceduralist is reluctant to tackle and bringing this to colleagues to review.

GIE GP Education

GIE, in collaboration with Brisbane Genetics and Sullivan Nicolaides Pathology, recently held a GP education evening at the Chermside Medical Complex.

Attendees were greeted at the Chermside Day Hospital (CDH) and treated to a showcase of the CDH facility by Alison Murray (DON- Chermside Day Hospital). Following these brief tours all attendees were provided with dinner and refreshments whilst networking with other attendees; including our guest speakers Dr Neville Sandford (GIE), Dr Michael Gattas (Brisbane Genetics) and Dr Ian Brown (SN Pathology). Dr Andrew Bryant (GIE) also offered valuable contributions, facilitating discussion and answering questions.

GIE would like to thank all doctors and staff who attended and contributed to a successful and enjoyable evening. Thank you to all doctors which provided feedback, ensuring the quality and relevance for future education evenings.

UPDATE: Medicare Referral Requirements

Medicare Australia has greatly increased its audit activities. It has indicated a broad range of specialties and procedures it intends to target in 2010. Included are 'Gastroenterologists – performing and billing procedures that are not clinically relevant'.

Since we do not undertake consultation with patients who are referred to our open access service, we rely on your judgement that the requested procedures are clinically appropriate. The vast majority of referrals are clearly appropriate. We would however, draw your attention to two possible areas of difficulty:

1. Colonoscopy and Endoscopy on the same day

a. There are many situations where it is appropriate to perform colonoscopy and endoscopy on the same day. For example, iron deficiency anaemia; obscure diarrhoea; weight loss; difficult abdominal pain. Medicare will not accept *"if you're having a colonoscopy, they might as well look at the other end while you're at it!"* The patient has to have some upper GI symptom present and stated on the request.

2. Colonoscopy

a. In Medicare parlance, colonoscopy undertaken because of a family history of bowel cancer is **'surveillance of a high risk group'** not **'a screening procedure'**.

b. The Commonwealth Health Departments' position on screening colonoscopy for asymptomatic patients who are not in a high risk group remains somewhat opaque. Following representations from the GUT Foundation there has been a change to the descriptor of levels C and D consultation from the 1st May 2010. *"It is hoped that these changes will encourage GP's to discuss with their patients risk factors… and preventative strategies for diseases such as breast and cervical cancer, hypertension, diabetes and colorectal cancer".*

The preamble to the medicare benefits schedule states 'The Minister has directed that medicare benefits be paid for the following categories of health screening':

"A medical examination or test on a symptomless patient by the patient's own medical practitioner in the course of normal medical practice to ensure the patient receives any medical advice or treatment necessary to maintain their state of health".

We think that it is inadvisable to write indications such as 'over sixty (60)', 'never had a colonoscopy before', 'wants a bowel check'.

We would suggest that with symptomatic patients it is appropriate to indicate the symptom on the request form; for asymptomatic patients, terms such as 'exclude Ca colon' is appropriate.

GIE thanks you for your consideration and looks forward to providing an enviable level of care and service to you and your patients.

Watch this space…

GIE will be hosting a similar event at Brisbane Endoscopy Services, Sunnybank in the coming months.

GIE GP Education attendees

Frequently asked questions

Dr Alistair Cowen, Gastroenterologist, *respondant*

Q. Which lifestyle risk factors should GPs be promoting to their patients, to assist in reduction of colorectal cancer risk?

A. Colorectal Cancer (CRC) incidence is higher in populations with diets high in red meat, saturated fats, high cholesterol foods combined with a low consumption of fibre and vegetables. In some studies rates are higher in the obese and sedentary. The same foods seem to be protective against many conditions including bowel cancer, diverticular disease, Type II diabetes, obesity and coronary heart disease.

A recommended diet includes:

- **Plenty** of vegetables, fruit, legumes, Brassica vegetables (cabbage, cauliflower, broccoli, brussel sprouts, cavolo nero), whole grain cereal and breads.
- **Moderate** quantities of **lean** meat, poultry, seafood, dairy products and alcohol.
- **Restrict** refined carbohydrates, salt and fatty foods – particularly many fast foods.

It is also important to encourage weight reduction in the obese; moderate exercise and a reduction in excess alcohol consumption. Moderate regular aspirin use also reduces the risk of CRC but increases the risk of upper GI ulceration.

Q. Is faecal occult blood testing (FOBT) an adequate screening tool in all populations? When does an asymptomatic patient warrant FOBT or colonoscopy as a screening instrument?

A. Faecal Occult Blood Testing (FOBT) has been around for a long while and still remains controversial. There is no doubt that modern tests based on immuno-chemistry are a big improvement on older chemical tests. However, the following facts must be clearly understood when using FOBT:

- FOBT is **NEVER NEVER** an acceptable investigation in patients with bowel symptoms.
- FOBT is **NEVER NEVER** an acceptable screening tool in groups with increased risk of CRC.
- FOBT use in the active setting (For example, on admission to hospital, generally ill patients etc) is inappropriate and a waste of time and money and likely to be misleading.

Even immuno-chemical FOBT has relatively low sensitivity and specificity. Further, these are reciprocally related; i.e. increasing the sensitivity by lowering the level of faecal haemoglobin used to declare a test positive decreases the specificity i.e. increases the false positive rate. This means when FOBT is used for population screening, the setting of the faecal haemoglobin level used to declare a positive is a political as well as a clinical decision. Problems in this area have already occurred in Australia.

It is therefore important to realise and make sure that people having FOBT screening understand that a negative test does not absolutely exclude the presence of CRC and is unlikely to detect even the majority of colonic polyps, and that a positive FOBT does not necessarily mean that any bowel disorder is present.

For these reasons the best method of screening average risk persons for CRC remains controversial. Colonoscopic screening is much more accurate and has been shown to be cost effective but depends on availability of sufficient numbers of competent colonoscopists. Colonoscopy screening undertaken by the poorly trained and marginally competent endoscopist is a recipe for disaster.

In average risk persons CRC screening should commence around the age of fifty (50).

Q. What are the recent advances in treatment of Ulcerative Colitis and Crohn's disease?

A. The initial and often main treatment of CD and UC remains corticosteroids for acute episodes. Once the acute disease is controlled maintenance therapy with five (5) Amino salicylic acid derivatives is indicated and if inadequate to prevent flare ups should be assisted by immuno suppressants usually Imuran or Mercaptopurine.

Ulcerative Colitis:

For ulcerative colitis the guiding principles are:

- Limit the length of steroid exposure. It is **NOT JUSTIFIED** to use long-term oral steroids in UC.
- Limit systemic exposure to cortico steroids as much as possible. For example, use cortico steroid derivative enemas and suppositories only for ulcerative proctitis where ever possible.
- Add Imuran if frequent relapses occur.
- Consider an appendectomy in refractory ulcerative proctitis.
- Consider Cyclosporin or Infliximab use for non responding severe acute ulcerative colitis.
- Remember that surgery will cure the disease and that it is unjustified to produce serious long-term drug effects.

Crohn's Disease:

For Crohn's disease the guiding principles are:

- Surgery is unlikely to achieve long-term cure, therefore, be more reluctant to intervene surgically than in UC and when surgery is required, limit its extent.
- Steroids and 5ASA derivatives remain the choice for acute treatment but introduce immunosuppressants quickly for difficult disease.
- Enteral diets may be useful in children.

Biological agents have been a huge advance in the treatment of severe and complicated CD. Infliximab and Adalimumab are both antibodies to Tumour Necrosis Factor and effectively interrupt the inflammatory cascade. They have dramatically improved management of severe CD unresponsive to other agents and are major value in CD complications such as fistulae. These biological agents can have severe side effects including overwhelming infection, reactivation of tuberculosis, anaphylactic reactions and lupus like syndromes.

For detailed information see GUT Foundation publications at www.gut.nsw.edu.au

The GUT Foundation of Australia (of which I am a council member) believes the most appropriate screening method for CRC should be decided by one's General Practitioner. Some people want certainty of disease exclusion and are clearly better served by colonoscopic screening. Those with severe co-morbidities or cost restrictions may prefer FOBT screening. Availability of quality colonoscopy, patient's concerns about complications etc are all best assessed by the General Practitioner.

GastroIntestinal Endoscopy

If you require an electronic referral form or A5 referral pads, please contact one of our four practice locations below or download at www.gastros.com.au/doctor_information.shtml

GIE practice locations and contact details

For all appointments, call 1300 4 GASTRO (Ph: 1300 4 427876)

Brisbane Endoscopy Services

Suite 16–18
McCullough Centre
259 McCullough Street
Sunnybank QLD 4109

Phone: 07 3344 1844

Fax: 07 3344 2739

Chermside Day Hospital

Chermside Medical Complex
Level 1, 956 Gympie Road
Chermside QLD 4032

Phone: 07 3120 3407

Fax: 07 3120 3443

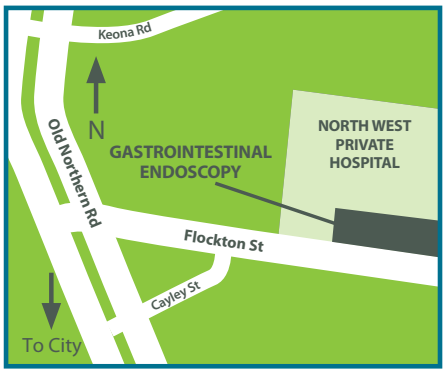
North West Private Hospital

Endoscopy Unit
137 Flockton Street
Everton Park QLD 4053

PO Box 443
Everton Park QLD 4053

Phone: 07 3353 3322

Fax: 07 3353 9325



Wesley Hospital

3rd Floor, East Wing
Endoscopy Unit
451 Coronation Drive
Auchenflower QLD 4066

Phone: 07 3870 3799

Fax: 07 3870 5069

Private practice locations, contact details and special interests

Dr Andrew Bryant MB BS FRACP Dip Av Med (Otago) **Main Rooms:** Level 2, 33 North St, Spring Hill QLD 4000 **T: 3831 7238** F: 3831 7261	**SI:** Endoscopy, endoscopic mucosal resection, advanced polypectomy and hepatology **C:** Spring Hill, Sunnybank, North West Ramsay Place and Prince Charles Hospital Private Practice Clinic **P:** Sunnybank, Chermside Day Hospital, North West Private Hospital, The Wesley Hospital
Dr Alistair Cowen MB BS (Hons) MD FRACP **Does NOT Privately consult.** **Open Access procedures only** **T: 3353 3322** F: 3350 4143	**P:** Sunnybank, Chermside Day Hospital, North West Private Hospital, The Wesley Hospital
Dr Hugh Spalding MB BS FRACP BVSc PhD **Main Rooms:** St Andrew's Hospital, Level 7, Suite 4, St Andrew's Specialist Centre 457 Wickham Tce, Spring Hill QLD 4000 **T: 3831 4044** F: 3831 0622	**SI:** General hepatology, luminal gastroenterology and endoscopy, IBD **C:** St Andrew's, Loganholme, QEII (Public Outpatients) **P:** Sunnybank, Chermside Day Hospital, North West Private Hospital, The Wesley Hospital
Dr Michael Miros MB BS (1st Class Hons Qld) FRACP **Main Rooms:** 66 Bryants Rd, Loganholme QLD 4129 **T: 3801 5200** F: 3801 5212	**SI:** Barrett's oesophagus, gastric intestinal metaplasia, polyp surveillance, capsule endoscopy **C:** Loganholme (Limited consulting – endoluminal gastroenterology only) **P:** Sunnybank
Dr Roderick Roberts MB BS FRACP AGAF **Main Rooms:** Level 2, Suite 62, Ballow Chambers 121 Wickham Tce, Brisbane QLD 4000 **T: 3831 2704** F: 3835 1069	**SI:** IBD, coeliac disease, drug induced liver disease and polyp surveillance **C:** Wickham Terrace, Sunnybank, North West Ramsay Place, Chermside Day Hospital **P:** Sunnybank, Chermside Day Hospital, North West Private Hospital, The Wesley Hospital
Dr William Robinson MB BS FRACP **Main Rooms:** Level 4, Suite 85, Sandford Jackson Building 30 Chasley St, Auchenflower QLD 4066 **T: 3870 7433** F: 3870 7466	**SI:** Gastroenterology and parental nutrition **C:** The Wesley Hospital and Strathpine Specialist Centre **P:** Sunnybank, Chermside Day Hospital, North West Private Hospital, The Wesley Hospital
Dr Neville Sandford BSc (Med) MB BS (1st Class Hons) FRACP AGAF **Main Rooms:** Brisbane Clinic, 79 Wickham Tce, Brisbane QLD 4000 **T: 3270 4593** F: 3270 4588	**SI:** Gastroenterology and hepatitis treatment **C:** Wickham Terrace, North West Ramsay Place **P:** Sunnybank, Chermside Day Hospital, North West Private Hospital, The Wesley Hospital

SI: Special Interests C: Consults P: Procedures