Issue 7

Autumn 2011

the Insider

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Dr Roderick Roberts MB BS FRACP
Dr William Robinson MB BS FRACP
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Dr Michael Miros MB BS FRACP
Dr Andrew Bryant MB BS FRACP
Dr Hugh Spalding MB BS FRACP

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 five 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;
- **St Andrew's War Memorial Hospital** at Spring Hill;
- **The Wesley Hospital** at Auchenflower.

GastroIntestinal Endoscopy

1300 4 GASTRO (Ph: 1300 4 427876)
www.gastros.com.au

In this issue

Open Access Endoscopy at St Andrew's War Memorial Hospital

We are very pleased to announce we have launched a new open access facility offering colonoscopy and upper gastrointestinal endoscopy based in the Endoscopy Centre at St Andrew's War Memorial Hospital, Spring Hill. Drs Andrew Bryant and Hugh Spalding will be conducting the procedure lists, ably assisted by the Endoscopy Centre's excellent nursing team. Rebecca Mitchell, a highly experienced and valued team member who was based at Sunnybank, has been appointed as Team Leader to manage day-to-day administration.

We are pleased to offer an additional choice of location to patients and their referring doctors, as well as being associated with a hospital that has an outstanding reputation in maintaining the highest standards in patient care.

For information related to GIE – St Andrew's, please contact Rebecca Mitchell on:

T: 3834 4499 E: rebecca@gastros.com.au

St Andrew's War Memorial Hospital
Endoscopy Centre
457 Wickham Terrace
Spring Hill QLD 4000

A summer of challenges

This summer has seen a number of natural disasters with earthquakes in both New Zealand and Japan, fires in Western Australia, cyclones in North Queensland and the floods in Victoria and Queensland.

In Brisbane, the January floods certainly had a significant impact on staff and patients alike. Like all major hospitals within Brisbane, elective procedure lists within GIE – North West and Chermside were cancelled for two days.

The most significant impact was experienced at the Wesley where all procedures and clinics were cancelled until the following Monday. The Wesley hospital was isolated by flood water and many hospital staff were stranded on site. Pleasingly, with the hard work provided by our dedicated staff across all sites, GIE was able to reschedule all cancelled appointments within a relatively short time to minimise inconvenience to you and your patients.

Our sympathy is with all individuals and families who have suffered from these events during the last few months. Donations continue to be made to:

- **The Premier's Disaster Relief Appeal** – www.qld.gov.au/floods/donate.html
- **The Red Cross** – for the New Zealand and Japan earthquakes – www.redcross.org.au
- **iTunes** – for the Japan earthquake – www.apple.com/itunes.

Screening for colorectal neoplasia in patients with inflammatory bowel disease

Dr Hugh Spalding *MB BS FRACP*

Inflammatory bowel disease confers an increased risk of developing colorectal cancer (CRC). The risk in Ulcerative Colitis (UC) and Crohn's Colitis is similar and is influenced by several factors, the most important of which is the duration of disease. The cumulative risk of CRC may be as high as 8% at 20 years after diagnosis of UC. Most cancers arise in patients with sub-total or pan-colitis and patients with pan-colitis generally develop CRC a decade earlier than those with left-sided colitis. The greatest endoscopic or histologic extent the disease attains defines the extent thereafter. There is little or no increase in risk of CRC with proctitis or proctosigmoiditis.

Increased severity of colitis also increases the risk of CRC; markers of severe colitis include strictures, pseudopolyps and possibly backwash ileitis. Other risk factors are family history of sporadic CRC, early age of onset of Inflammatory Bowel Disease (IBD), and coexistent primary sclerosing cholangitis (PSC) – the latter conferring a 33% cumulative risk of CRC at 20 years after diagnosis of UC.

It is generally accepted to commence a screening program 8–10 years after the diagnosis of IBD. Whether age of onset of IBD is an independent risk factor of CRC is debated but it is advised to perform screening based on the duration of illness not age. Patients with extensive left-sided UC or pan-colitis should have a colonoscopy every 1–2 years initially. The interval may be extended to every 3 years after two examinations without dysplasia, depending on other risk factors such as family history and ongoing inflammation. Patients with Crohn's Disease (CD) involving one third or more of the colon are treated similarly.

Patients with PSC and colitis may have had subclinical colitis for many years prior to diagnosis and should have annual colonoscopy from the time of PSC diagnosis. PSC should be suspected in any patient with IBD and persistent elevation of liver function tests.

It is preferable for the patient to be in clinical remission at the time of screening colonoscopy to reduce the incidence of biopsies showing reactive atypia which can be confused with dysplasia.

Several studies have shown a higher detection of dysplasia with target biopsies (such as with dye spray) and there is a trend towards this strategy rather than four-quadrant biopsies at every 10 cm along the colon which is the traditional method.

Dysplastic polyps arising in areas of mucosa not involved in the IBD are presumed to represent sporadic adenomas and are treated with polypectomy and ongoing surveillance.

In areas of the bowel which has been affected by colitis, Dysplasia-Associated Lesions or Masses (DALMs) can be grouped into adenoma-like DALMs and non-adenoma-like DALMs. There is evidence that the former can be treated by polypectomy and continued surveillance. Non-adenoma like DALMs are poorly circumscribed irregular lesions, which generally are not able to be resected at endoscopy and are strongly associated with CRC (38–83%). These patients should be considered for colectomy.

If flat dysplasia is encountered in an area of colitis, especially if it is not able to be removed at endoscopy, consideration should be given to colectomy, particularly if there is high grade dysplasia in which case up to two thirds may already have colon cancer. The situation is more vexed with low grade dysplasia with wide variation among studies on the progression to high grade dysplasia or CRC ranging from <4% over 10 years, to 54% over 5 years. Intensive surveillance may be an option.

Colonoscopy – *how safe and what do we find?*

Dr Alistair Cowen *MD FRACP*

Gastrointestinal Endoscopy (GIE) has an extensive quality assurance program. Part of this program involves an extended audit program. We have introduced a 30 day phone audit for patients with high risk colonic conditions (eg. very large polyps). Each year a partner conducts a full procedure audit. The first audit results are now available. The caecum was reached in 99.6% (excluding only six obstructing carcinomas from analysis). There were no deaths, perforations, haemorrhage requiring re-examination, hospitalisation, transfusion or surgery. No anaesthetic complications occurred. Two patients developed post procedural fever without other symptoms or signs. After investigation the most likely diagnosis appeared to be intercurrent viral infection.

A surprising finding was a polypectomy rate of 34%, a rate double that of the partners' last self audit. This massive increase appears to be the result of technical improvements in colonoscopic imaging. A superb clarity with high definition systems, magnification, Narrow Band Imaging and dye spraying techniques have all resulted in much easier detection of small polyps. Surprisingly, tubular adenomas of only 3 to 6 mm are frequently reported as showing dysplastic changes.

There has been a major increase in the number of morbidly obese patients presenting for examination. In patients that are 150kg and over, applying abdominal pressure to assist in the passage of the instrument in those with long bowels is difficult to impossible. In addition, there are often severe co-morbidities, anaesthetic risks and health and occupational safety risks. Queensland Health will not allow patients with a BMI greater than 45 to have examination in day surgery or day endoscopy centres.

The internet is a useful tool

Just a reminder that GIE has a very user friendly website which provides comprehensive information that patients and referring doctors may find useful. Some of the subjects included on our website include procedural information, gastrointestinal conditions, useful links, information about the 'Open Access' system and a description of our sites. Our referral form can also be directly accessed and downloaded from the website **www.gastros.com.au**

Frequently asked questions

Dr Alistair Cowen, Gastroenterologist, *respondant*

Q. Are low volume colonoscopy preparations appropriate for use in morbidly obese individuals?

A. Elsewhere in this newsletter I detailed the problems associated with low volume colonoscopies preparation. Exactly the same considerations apply in the morbidly obese.

Q. Given the Qld Health directive that all patients with a BMI >45 are not allowed to have gastrointestinal scoping in day surgery or day endoscopy centres, should GPs refer these obese individuals to hospital OPDs in the first instance? Or would it be preferable for morbidly obese patients be referred to hospital OPDs by specialists?

A. Patients with a BMI >45 but without major co-morbidities are suitable for open access procedures. The health departments' ruling simply means that they have to be done in a hospital providing full inpatient services. For GIE this means centres at Wesley, North West and St Andrew's Hospitals.

Where there are major co-morbidities eg. severely limited mobility, insulin dependent diabetes, serious cardiac , respiratory or renal disease, the patient should be seen by the endoscopist for a full consultation before the procedure.

If it is obvious that the patient will require in-patient preparation (eg. unstable insulin dependent diabetes, gross limitation of movement) and the patient is unable to afford a hospital charge for overnight stay then a referral to a public outpatient facility is appropriate.

Q. What are the side effects or possible medical complications from use of the conventional large volume bowel preparations?

A. The disastrous complication of colonoscopy preparation can occur with **any** preparation. This is of course giving the preparation to a patient with bowel obstruction. There is a serious possibility of bowel perforation with massive faecal peritonitis and probable death. **If there is any possibility of bowel obstruction, obtain erect x-ray of the abdomen, CT scan or request consultation before colonoscopy.**

Conventional large volume colonoscopy preparation (3 Bisacodyl tablets, a sachet of Magnesium citrate followed by 3 litres of a PEG base preparation eg. Glycoprep) is remarkably safe and free of serious side effects.

The common side effect is nausea with or without vomiting. Vomiting can of course have secondary complications eg. Mallory Wise tear, dehydration, precipitation of migraine etc. Elsewhere in this issue I deal with the low volume bowel preparation and, while they are certainly useful in those who can not tolerate the large volume preparations, the best preparation for a clean colon is still large volume preparation.

Q. Should those at risk of side effects from bowel preparations, regardless of whether they are low or large volume preparations, have their preparations supervised and procedures conducted in hospital rather than in day surgery or day endoscopy centre?

A. GIE patients are seen by a nurse to assess their medical history and appropriate bowel preparation. Our nurses have standard protocols which cover most clinical situations and allow the preparation to be tailored to individual needs eg. longer and increased bowel preparation for those with major constipation, inpatient preparation for the frail and elderly etc. Low volume preparations for those who have previous intolerance to large volume preparations are available.

In general we prefer inpatient supervision of bowel preparation where patients have insulin dependant diabetes (not always), previous significant problems with bowel preparation, the very elderly particularly if they live alone, those with serious mobility limitations, serious co-morbidities including renal disease or other considerations where it is important to avoid dehydration. **YOU** are often the best person to assess if inpatient care is required – we are always grateful when referring doctors indicate this.

Low volume colonoscopy preparations – *be careful what you wish for!*

Dr Alistair Cowen *MD FRACP*

We are receiving increasing numbers of requests from patients wishing to use small volume bowel preparations for colonoscopies. Some patients state that their referring doctors have suggested they ask for these preparations.
We do not routinely use these short preparations for the following reasons:

1. Accuracy of Examination

There is an increased percentage of less than optimum bowel preparations. This means that the risk that polyps and even small cancers can be missed is increased.

2. Safety

There are 2 main types of low volume bowel preparations, phosphate based preparations and Picolax sulphate based preparations:

(a) Phosphate Based Preparations:
Within 3 years of introduction of these preparations to Australia, 12 deaths and numerous complications have been reported to ADRIAC. Patients at the greatest risk of complications are the elderly and those with serious disease such as heart failure, kidney disease, poorly controlled hypertension and diabetes.

(b) Picolax Sulphate Based Preparations:
Numerous cases of prolonged fitting due to low sodium levels have been reported to ADRIAC. There have been some deaths and a number of patients have required prolonged treatment in intensive care. Those at greatest risk are on SSRI antidepressants, diuretic/ antihypertensive combinations, kidney disease, diabetes, salt losing syndrome and inappropriate antidiuretic hormone secretions syndrome.

The Moviprep bowel preparation has a volume somewhere between the conventional long and short preparations. Serious side effects appear to be rare with this preparation. For patients who are not willing or able to take the conventional large volume preparation (Magnesium Citrate, 3 Bisacodyl tablets plus 3 litres of Glycoprep), we would suggest that Moviprep is the best alternative. For patients who feel that even this reduced volume is too difficult to take, we can provide Picolax preparations provided patients have none of the above risk factors and are prepared to accept the increased risk that small polyps and cancers could be missed and that they may suffer significant side effects.

GastroIntestinal Endoscopy

If you require an electronic referral form or A5 referral pads, please contact one of our five 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

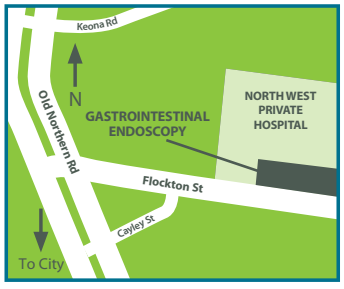
Suites 16–18
McCullough Centre
259 McCullough Street
Sunnybank QLD 4109

Phone: 07 3344 1844
Fax: 07 3344 2739

Chermside Day Hospital

Level 1
Chermside Medical Complex
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

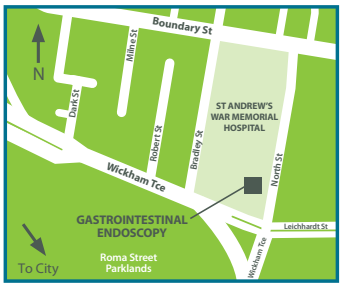
PO Box 443
Everton Park QLD 4053

Phone: 07 3353 3322
Fax: 07 3353 9325

St Andrew's War Memorial Hospital

Endoscopy Centre
457 Wickham Terrace
Spring Hill QLD 4000

Phone: 07 3834 4499
Fax: 07 3834 4503



Wesley Hospital

3rd Floor
East Wing
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, St Andrew's Place,
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: Brisbane Endoscopy Services, Chermside Day Hospital, North West Private Hospital, St Andrew's, The Wesley Hospital

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Dr Alistair Cowen MB BS (Hons) MD FRACP
Does NOT Privately consult
Open Access procedures only
T: 3353 9325
F: 3350 4143

P: Brisbane Endoscopy Services, Chermside Day Hospital, North West Private Hospital, The Wesley Hospital

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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: Brisbane Endoscopy Services, Chermside Day Hospital, North West Private Hospital, St Andrew's, The Wesley Hospital

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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: Brisbane Endoscopy Services

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, polyp surveillance and capsule endoscopy
C: Wickham Terrace, Sunnybank, North West Ramsay Place, Chermside Day Hospital
P: Brisbane Endoscopy Services, Chermside Day Hospital, North West Private Hospital, The Wesley Hospital

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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: Brisbane Endoscopy Services, Chermside Day Hospital, North West Private Hospital, The Wesley Hospital

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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: Brisbane Endoscopy Services, Chermside Day Hospital, North West Private Hospital, The Wesley Hospital

SI: Special Interests C: Consults P: Procedures