Issue 5

Autumn 2010

# the Insider

Dr Alistair Cowen MD FRACP
Dr Roderick Roberts MB BS FRACP
Dr William Robinson MB BS FRACP
Dr Neville Sandford MB BS FRACP
Dr Michael Miros MB BS FRACP
Dr Benedict Devereaux MB BS FRACP
Dr Patrick Walsh BSc MB ChB FRACP
Dr Andrew Bryant 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 eight 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)
**www.gastros.com.au**

# GIE celebrating 25 years in 2010!

**GastroIntestinal Endoscopy is celebrating 25 years of open access gastroenterology service in the Brisbane region. GIE was the first company to establish an Open Access service in Brisbane.**

GIE Gastroenterologists have built their values and high level of patient care around the experiences they have gained over the past 25 years of providing gastrointestinal endoscopy services. GIE will be celebrating with a Black Tie Ball to raise money for Crohn's and Colitis Australia, who are also celebrating their 25th year of establishment.

2010 is well and truly underway and GIE would like to extend our best wishes for a successful year to all doctors, staff, family and friends involved with GIE in one way or another. GIE looks forward to building on a successful 2009 and continuing to offer exceptional patient care, supporting the wider Brisbane community.

The New Year has brought in some new changes and a fresh start in the newly-developed East Wing of the Wesley Hospital. GIE has relocated to the new third floor Day Surgery and Endoscopy Unit.

Dr Roberts was the first GIE doctor to experience the new facility (image below), which is a part of a $102 million, nine-level hospital expansion that has set the standard for 21st Century health care developments.

*Dr Rod Roberts, GIE specialist (left) and Dr Luis Prado, Wesley Hospital – Director of Medical Services, on the opening day of the new facility.*

## In this issue

GIE celebrating 25 years in 2010!.....1
Microscopic Colitis.....2
FAQs.....3
GP Education Evenings.....3
Practice locations, contact details and special interests.....4

## GIE supporting Nurse Education

GIE is proud to conduct a Gastroenterology Nurse Education Day on the 17th of April, 2010.

The full day program includes talks from GIE Specialists, an Anaesthetist and a pathology scientist, and will feature several interactive work stations whereby the attending nurses will have the chance to teach, learn and network.

The invitation has been extended to all gastroenterology nurses in hospitals, where GIE maintains an associate relationship.

# Microscopic Colitis

**Dr Neville Sandford** *BSc (Med) MB BS (1st Class Hons) FRACP AGAF*

## Case history

A 57-year-old woman is referred for colonoscopy for investigation of watery diarrhoea of three months duration. She is generally in good health apart from osteoarthritis for which she takes Voltaren. She is otherwise on no medication. Her bowels move four to six times per day with some urgency, and the motions are watery without blood. She has had no weight loss or abdominal pain. There is no family history of bowel disease. Examination is normal. Her full blood count, ESR, biochemistry and thyroid function tests are normal. Stool microscopy and culture is negative.

Colonoscopy is normal to the terminal ileum. Random colonic biopsies show a thickened subepithelial collagenous band. This lady has collagenous colitis.

## Definition

Microscopic colitis is characterised by chronic watery diarrhoea with a normal appearing colon at colonoscopy. Colonic biopsies show either increased intraepithelial lymphocytes and infiltration of the lamina propria with mononuclear cells (lymphocytic colitis) or thickening of the subepithelial collagen band (>10µm) (collagenous colitis) or a mixed pattern. There is no associated mucosal ulceration or crypt architectural distortion.

## Epidemiology and pathogenesis

The incidence increases with age, and occurs in about 10 per 100,000 people per year. It is more frequent in females (collagenous colitis F:M::15:1, lymphocytic colitis F:M::3:1). The pathogenesis is unknown. It is uncertain whether these two entities are related, and histologic overlap may occur. Familial cases have been described. Long term follow-up shows no transformation from one type to another.

In collagenous colitis, there is abnormal collagen metabolism in the subepithelial extracellular matrix, with increased fibrogenesis (increased transforming growth factor (TGF) beta-1 and vascular endothelial growth factor (VEGF)) and decreased fibrinolysis (restricted matrix metalloproteinase (MMP) 1 & 13 RNA expression and enhanced expression of TIMP-1 (tissue inhibitor of metalloproteinases)), resulting in accumulation of collagen in the tissues.

It has been suggested that the inflammation and collagen deposition may result from bacterial toxins that cause mucosal injury, which is supported by the fact that cholestyramine (which binds bacterial toxins) resulted in improvement in symptoms and histology in one case report. Cholestyramine may also work by binding bile acids, as bile acid malabsorption is common in microscopic colitis.

Another proposal is that non-steroidal anti-inflammatory drugs (NSAIDs) may cause microscopic colitis which is more common in patients using NSAIDs for greater than six months. In addition, some patients improve on withdrawal of NSAIDs. Other drugs including aspirin, carbamazepine, simvastatin, lansoprazole, omeprazole, esomeprazole, ranitidine, ticlopidine, gold salts and sertraline have also been implicated as possible causes.

Some patients with Coeliac disease have lymphocytic colitis, and thickened subepithelial collagen has been found in some diabetics with diarrhoea.

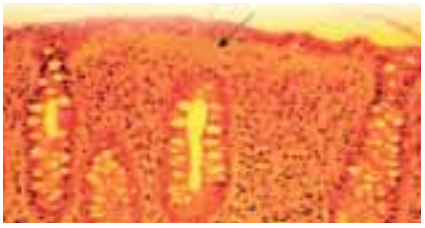


***Figure 1: Colonic biopsy from a patient with collagenous colitis showing a thickened subepithelial collagen band (arrow).***

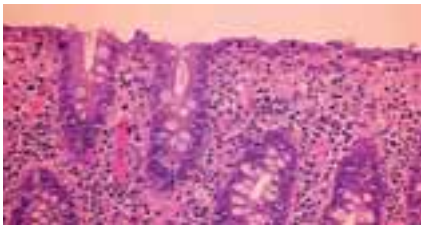


***Figure 2: Colonic biopsy from a patient with lymphocytic colitis showing intraepithelial and lamina propria lymphocytic infiltrate.***
***Neville Sandford, December 2009***

## Clinical Manifestations

The typical patient with microscopic colitis is a middle-aged woman in her sixth decade with non-bloody chronic watery diarrhoea, but childhood cases do occur. Non-specific symptoms such as nausea, abdominal discomfort or faecal urgency sometimes occur, as can extraintestinal symptoms such as arthritis or uveitis. The diarrhoea is usually intermittent, but can be continuous. General health and laboratory parameters are usually unaffected, apart from mild anaemia or slight elevation of the ESR. Auto antibodies (antinuclear and antimitochondrial antibodies, rheumatoid factor, and ANCA) are positive in 50% patients. Symptoms resolve or improve significantly within three to five years in 75-85% patients. Diagnosis is made on colonoscopic biopsies in patients with a macroscopically normal colon. The changes are more severe in the right colon, so full colonoscopy is required. Rectosigmoid biopsies are normal in 40% cases. Rarely the small bowel is involved and very occasionally patients may progress to inflammatory bowel disease. Associated Coeliac disease needs to be excluded in all patients.

## Treatment

Except for budesonide, most treatments in microscopic colitis have not been studied in controlled trials. A meta-analysis of 10 randomised studies of budesonide in collagenous colitis showed an odds ratio for a clinical response of 12.3, and of maintaining response of 8.8. There is one controlled study of a similar response (OR 9.0) with budesonide in lymphocytic colitis. There is also some evidence of efficacy with bismuth subsalicylate, mesalazine, cholestyramine and prednisone, but not in controlled trials.

If Coeliac disease is found, a gluten-free diet should be commenced. Because budesonide is expensive and not covered by the PBS, my approach is to cease NSAIDs and all other drugs if possible, and treat the patient symptomatically with loperamide. In those patients with persistent diarrhoea, I try sulphasalazine or an aminosalicylate, and then cholestyramine (4g/day), before using budesonide (9mg/wk for four weeks, 6mg/wk for two weeks, 3mg/wk for two weeks). Unfortunately relapse is common once budesonide is stopped, and repeat courses may be required. Long term treatment with budesonide is not only expensive but associated with steroid-related side effects. In severe refractory cases, corticosteroids or immunosuppression with azathioprine may be required. Natural remedies and probiotics have not been shown to be of benefit.

## Natural history

The majority of patients resolve symptomatically, with or without therapy in three to five years. Microscopic colitis is not associated with increased risk of colorectal cancer, so surveillance colonoscopy is not required.

*Dr Alistair Cowen*

# Frequently asked questions

## Dr Alistair Cowen, Gastroenterologist, *respondant*

**Q. In general practice, what are reasonable tests, apart from faecal microscopy and culture, to request prior to referral for endoscopy and colonoscopy in a patient suspected of having microcytic colitis?**

**A.** Patients with lymphocytic colitis, microscopic colitis and collagenous colitis (essentially all the same condition) usually present with diarrhoea. If the diarrhoea is persistent and faecal microscopy and culture are normal then the patient should proceed to colonoscopy. The diagnosis is made by right colonic biopsies.

**Q. In addition to prescription of Loperamide for the symptomatic management of lymphocytic colitis, what other supportive measures can the general practitioner provide to a patient with this diagnosis?**

**A.** Presuming the patient has had other causes of diarrhoea excluded and a diagnosis confirmed by colonic biopsy then mild cases can be managed symptomatically by Loperamide. However, if the diarrhoea is more severe then they may need a short course of steroids. Often 20mgs of Prednisone per day decreasing by 5mgs second weekly will be enough to put the patient into remission. Approximately one third of patients have recurrent disease requiring repeated therapy. A wide variety of other agents including bismuth and flagyl have been used but the response is quite variable.

**Q. Should a patient with lymphocytic colitis have follow up colonoscopy once symptomatic resolution has occurred?**

**A.** Routine follow up colonoscopy would not be recommended. Colonoscopy would only need to be repeated if there was doubt about the diagnosis or the previous colonoscopy had been incomplete or there has been no response therapy.

**Q. Is there any evidence that lymphocytic colitis has a familial or hereditary component?**

**A.** There is a significant association between lymphocytic colitis and Coeliac disease which can of course be hereditary. However, the majority of patients with lymphocytic colitis have no family history. In patients with established lymphocytic colitis it is useful to exclude Coeliac disease and if patients with lymphocytic colitis fail to respond to a course of steroids then a small gut biopsy to exclude Coeliac disease should be considered.

## Practice Management Tips

With new nursing and clerical awards currently being introduced, it can be easy to get caught out. Check the Fair Work Australia website to see how your practice is situated. The website can be viewed at **www.fwa.gov.au** and follow the links to 'Health Professionals & Support Services Award'. The AMA also have some fantastic Modern Award related material. **www.amaq.com.au**

# General Practitioner and Specialist Education Evenings

**For General Practitioners and Specialists interested in learning more about GIE and the services offered, as well as having the opportunity to discuss cases with our Gastroenterologists and other Specialists, please register to attend one of our education evenings.**

Education evenings will be conducted in conjunction with National Crohn's and Colitis Awareness Week 2010 (16–22 May) and act as a follow up to National Bowel Cancer Awareness Week (8–14 June).

**Brisbane Endoscopy Services**
**Sunnybank** – 17 May 2010
**Chermside Day Hospital** – 23 June 2010

Each event will be an informal evening with light food and drinks provided, enabling attendees to relax and discuss the cases under review.

Over the course of the evening, GIE doctors will be joined by Dr Ian Brown – Histopathologist, *Sullivan Nicolaides Pathology* to expand on discussions surrounding the case studies and general conversation. Education events provide an opportunity for attending GPs and Specialists to ask specific questions of GIE doctors to provide further insight into the GIE 'Open Access' process.

There are some limitations when utilising the Open Access service. Patients must have minimal or nil co-morbidities to undertake an Open Access procedure through GIE.

GIE doctors also encourage registrars and interns to attend these evenings to provide fantastic networking and education opportunities. If you would like more information on the education evenings or wish to register, please email **manager@gastros.com.au**.

Alternatively, if you would like a GIE doctor or staff representative to visit your practice, please call **1300 4 GASTRO**. For updated referral templates, which can be downloaded via Practix and Medical Director Software applications, please access our website at **www.gastros.com.au**

## Coming next issue…

Feature article from **Dr Andrew Bryant**, *GIE Specialist*. More Practice Management Tips, FAQs and further updates on GIE events and how you can participate

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

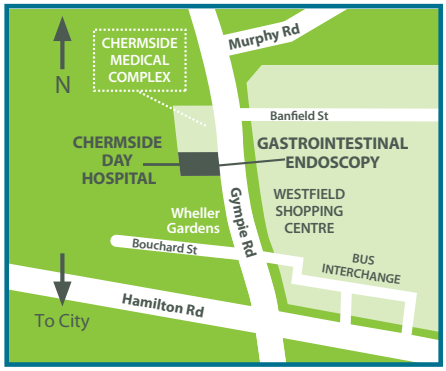
Suite 16–18
McCullough Centre
259 McCullough Street
Sunnybank QLD 4109

**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

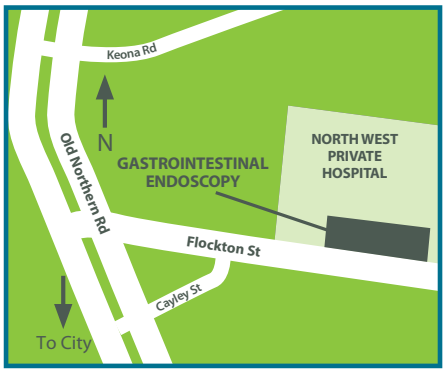



## North West Private Hospital

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 Q 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)<br>**Main Rooms:**<br>Level 2, 33 North St, Spring Hill QLD 4000 | **T: 3831 7238**<br>F: 3831 7261 | **SI:** Endoscopy, endoscopic mucosal resection, advanced polypectomy and hepatology<br>**C:** Spring Hill, Sunnybank, North West Ramsay Place and Prince Charles Hospital Private Practice Clinic<br>**P:** Sunnybank, Chermside Day Hospital |
| **Dr Alistair Cowen** MB BS (Hons) MD FRACP<br>**Does NOT Privately consult.**<br>**Open Access procedures only** | **T: 3353 3322**<br>F: 3350 4143 | **P:** North West Private Hospital, The Wesley Hospital, Sunnybank, Chermside Day Hospital |
| **Dr Benedict Devereaux** MB BS MPhil FACG FRACP<br>**Main Rooms:**<br>Holy Spirit Northside Hospital<br>Level 1, Medical Centre, 627 Rode Rd, Chermside QLD 4032 | **T: 3861 4866**<br>F: 3861 4897 | **SI:** Gastroenterology, ERCP, EUS, therapeutic endoscopy, IBD and polyp surveillance<br>**C:** Holy Spirit Northside, Manor Apartments – City, Chermside Day Hospital<br>**P:** Chermside Day Hospital, North West Private Hospital |
| **Dr Michael Miros** MB BS (1st Class Hons Qld) FRACP<br>**Main Rooms:**<br>66 Bryants Rd, Loganholme QLD 4129 | **T: 3801 5200**<br>F: 3801 5212 | **SI:** Barrett's oesophagus, gastric intestinal metaplasia, polyp surveillance, capsule endoscopy<br>**C:** Loganholme (Limited consulting – endoluminal gastroenterology only)<br>**P:** Sunnybank |
| **Dr Roderick Roberts** MB BS FRACP AGAF<br>**Main Rooms:**<br>Level 2, Suite 62, Ballow Chambers<br>121 Wickham Terrace, Brisbane QLD 4000 | **T: 3831 2704**<br>F: 3835 1069 | **SI:** IBD, coeliac disease, drug induced liver disease and polyp surveillance<br>**C:** Wickham Terrace, Sunnybank, North West Ramsay Place, Chermside Day Hospital<br>**P:** Sunnybank, Chermside Day Hospital, North West Private Hospital, The Wesley Hospital |
| **Dr William Robinson** MB BS FRACP<br>**Main Rooms:**<br>Level 4, Suite 85, Sandford Jackson Building<br>30 Chasley St, Auchenflower QLD 4066 | **T: 3870 7433**<br>F: 3870 7466 | **SI:** Gastroenterology and parental nutrition<br>**C:** The Wesley Hospital and Strathpine Specialist Centre<br>**P:** Sunnybank, Chermside Day Hospital, North West Private Hospital, The Wesley Hospital |
| **Dr Neville Sandford** BSc (Med) MB BS (1st Class Hons) FRACP AGAF<br>**Main Rooms:**<br>Brisbane Clinic, 79 Wickham Tce, Brisbane QLD 4000 | **T: 3270 4593**<br>F: 3270 4588 | **SI:** Gastroenterology and hepatitis treatment<br>**C:** Wickham Terrace, North West Specialist Centre<br>**P:** Sunnybank, Chermside Day Hospital, North West Private Hospital, The Wesley Hospital |
| **Dr Patrick Walsh** BSc MB ChB FRACP<br>**Main Rooms:**<br>Holy Spirit Northside Hospital<br>Level 1, Medical Centre, 627 Rode Rd, Chermside QLD 4032 | **T: 3861 4866**<br>F: 3861 4897 | **SI:** Gastrointestinal malignancy, endoscopic ultrasounds, advanced polypectomy, polyp surveillance<br>**C:** Holy Spirit Northside, St Andrew's Hospital<br>**P:** Sunnybank, Chermside Day Hospital, The Wesley Hospital |

*SI: Special Interests C: Consults P: Procedures*