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Tips for GP trainees working in gastroenterology

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An ST placement on a gastroenterology firm can be a valuable experience for a GP trainee. You will be exposed to patients with many conditions commonly seen in general practice such as inflammatory bowel disease (IBD), peptic ulcer disease, upper GI cancer, and complications of cirrhosis. As in primary care a significant proportion of the work is related to diseases caused by excess alcohol consumption and this is on the rise.

Gastroenterology inpatients are often sick and have complex medical needs. Many patients will have a very poor prognosis or terminal disease so you will work frequently with palliative care services and care for dying patients. Young patients with IBD often need further explanations, information, and a chance to express anxieties following a busy consultant ward round. Your role in this regard can be invaluable.

Gastroenterology jobs tend to be busy but you will learn lots and develop many skills along the way. Here are a few tips to help you get started.

INFLAMMATORY BOWEL DISEASE

1. Ensure the surgical team is aware of all patients admitted with severe colitis. If medical treatment fails they may require a colectomy, so it's best the surgeons are aware of them in advance.
2. Ensure any patient with Crohn's disease has had a proper perianal examination: if you don't look, you won't find.
3. Active IBD is thrombogenic disease. The risk of venous thromboembolism is high. Prescribe deep vein thrombosis prophylaxis, even in those patients with bloody diarrhoea.
4. *Clostridium difficile* infection is common in patients with colitis. Always test for it in any patient admitted with a flare.
5. Remember all patients admitted with a flare of colitis need a plain abdominal X-ray to check for toxic megacolon (transverse colon diameter >6 cm).
6. Prescribe calcium and vitamin D supplements when starting a course of steroids for IBD. If someone thinks of it 2 months later the patient may already have significant loss of bone density.
7. All IBD patients should have a chest X-ray to exclude previous tuberculosis before receiving anti-tumor necrosis factor therapy (for example, infliximab, adalimumab).
8. IBD patients on large doses of steroids are at risk of developing hypokalaemia due to the mineralocorticoid effects, plus diarrhoea.
9. Avoid opiates in patients with severe colitis: they may increase the risk of toxic megacolon.

LIVER

10. Be familiar with your inpatient alcohol detox regimen and the details of the local alcohol support services.
11. Learn to spell caeruloplasmin, and what it is. Ditto for asterixis.
12. Read up acute alcoholic hepatitis, you will see it frequently. Treatments for severe cases include steroids, pentoxifylline, and importantly, nutrition.
13. Read up on the correct technique for paracentesis and the relevant anatomy (what bits to avoid) before you have to do it. Know your hospital protocol for how much albumin to give and when to remove the drain.
14. One of the commonest infections in patients with cirrhosis and ascites admitted to hospital is spontaneous bacterial peritonitis: an ascitic tap for microscopy, culture, and white cell count (WCC) is a mandatory investigation. Ascitic fluid WCC is >500 cells/μL, or neutrophils >250 μL warrants antibiotic treatment.
15. Know your 'liver screen' for investigating patients with unexplained jaundice or

abnormal liver function tests (LFTs). Alcohol and drug history (prescribed and over-the-counter) are crucial. Ask about herbal teas and remedies:

- ultrasound liver plus dopplers;
- hepatitis A/B/C, cytomegalovirus, and Epstein Barr virus serology;
- ferritin;
- copper and caeruloplasmin in those <40 years;
- autoimmune profile and serum immunoglobulins;
- transglutaminase antibody (coeliac disease can present with abnormal LFTs); and
- fasting glucose and cholesterol (possible non-fatty liver disease). (This list is not exhaustive).

16. Prothrombin time is the most sensitive laboratory measure of liver failure. Always request a prothrombin time/international normalised ratio on bloods for any liver patient.
17. If you have a smartphone, download an app. to calculate various gastro prognostic scores (for example, Maddrey's discriminant function, Child-Pugh score, Rockall Score).
18. Patients with a severe paracetamol overdose should be discussed with a liver centre at an early stage.
19. The serum-ascites albumin gradient (SAAG), is not just something that may give you *Campylobacter.* SAAG >11 g/L suggests ascites is due to portal hypertension rather than non-portal hypertensive causes. It is accurate in 97% of cases.
20. Hepatic encephalopathy has four grades:
    1. no effect on consciousness. Impaired higher mental functions;
    2. personality change and disorientation. Asterixis usually present;
    3. increasing drowsiness. Very disorientated. Asterixis usually present; and
    4. coma.

NUTRITION

21. Beware refeeding syndrome. Start feed slowly in malnourished patients, monitor and replace potassium, magnesium, and phosphate. Always involve the nutrition team/dieticians.
22. Malnutrition and weight loss are common in inpatients: remember to prescribe nutritional supplements (for example, fortisips, fresubin).
23. Malnourised or alcoholic patients are at risk of developing Wernicke's encephalopathy, particularly when commencing nutrition or even IV dextrose. Ensure they are prescribed pabrinex/thiamine.

ENDOSCOPY AND GI BLEEDING

24. Management of acute upper GI bleeds is about doing the basics well:
    - two big IV lines and fluid resuscitation;
    - bloods including group and save/crossmatch;
    - think about the cause: nonsteroidal antiinflammatory drugs/liver disease;
    - risk stratification (Rockall/Blatchford score); and
    - communication with the endoscopist early, but remember patients need to be adequately resuscitated before endoscopy is performed.
25. Learn how to write up an omeprazole infusion (8 mg/hour, 40 mg omeprazole in 100 ml saline over 5 hours).
26. Be nice to the blood bank, you may need them in a hurry.
27. Isolated rise in urea, without a change in creatinine is a good marker of significant upper GI bleeding.
28. Antibiotic prophylaxis is no longer recommended for prevention of endocarditis in patients with prosthetic heart valves or valvular heart disease who undergo endoscopy.
29. All patients with suspected or proven variceal haemorrhage should be prescribed IV antibiotics. Approximately 60% have a bacteraemia and infection often precipitates the bleed by increasing portal blood flow (check local guidelines for choice of antibiotic).
30. Ensure all ward patients due for an endoscopy have working IV access.
31. Patients with obstructive jaundice can develop a coagulopathy due to lack of vitamin K absorption. Ensuring that these patients are given IV vitamin K (three doses of 10 mg is sufficient) will avoid postponing an endoscopic retrograde cholangiopancreatography.
32. Learn to love the smell of melaena in the morning.

Provenance

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