If you only have a few minutes with a drug addict

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CPD/CME

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I was going through a particularly bad time some years ago when I went to my general practitioner to try and get a prescription for diazepam (Valium). I had been buying it illicitly for some time so knew that I had a problem and genuinely wanted help. I also knew that most GPs were reluctant to prescribe this type of drug because it is so open to misuse.

I had a pre-prepared script ready to use that I hoped would come across as sincere. This dialogue was the result of much trial and error in trying to obtain prescriptions and the trading of information between myself and other drug users about which doctors would prescribe and what had been successful in the past.

I began by telling the doctor how I'd been depressed and started using tablets off the internet or the street and telling her that I could no longer cope. While I was in mid flow she asked: "How's your mum these days? How's your family? Is there anyone else who can support you at the moment?"

I was not expecting this line of questioning and it threw me; I found myself being honest with a doctor for the first time in a long while.

Judged by my addiction

I have had a lot of experience with GPs because I have spent most of my adult life (more than two decades) in opiate addiction. The GPs I came across fell into one of three broad categories. The first type judged me by my addiction and straight away presumed that my motives were nefarious and my sole intention was to exhort as many drugs as possible from them. (I don't deny that in many instances this was true.)

The second kind made the same judgments but tried to get me out of their surgery as soon as possible by prescribing whatever I asked for with little or no preamble or questioning.

The third type didn't judge me and asked pertinent questions about how I felt psychologically as well as physically, listening to what I had to say. They then made a professional diagnosis and prescribed what would cause the least harm, both short term and long term, and would ease my emotional suffering most effectively.

At the time I knew I looked like the stereotype of a drug addict and it was often difficult to walk into a GP's surgery. I felt self conscious about the way I looked and my past experiences with doctors also dictated how I felt.

I realise that doctors have to be aware of patients' motives in coming to see them, especially those who ask for specific drugs, but this needs to be offset by what is best at that time for that particular patient.

For example, I had a longstanding problem with benzodiazepines, mainly diazepam, and more than once asked for help to become stable and then reduce my intake. My GP at the time was reluctant to do this, but through a prolonged conversation where we discussed my needs and my hopes, and also what

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responsibilities I had to myself and my own recovery, we came to a compromise. This doctor's questions about what I hoped to achieve were a lot less formal than usual—questions such as what I would like for my future, what my job aspirations were, and whether I saw myself with a partner or having more children. This allowed me to let down my guard and answer his questions truthfully. The more it felt like a conversation the harder it was to keep up any pretence.

Autonomy in my recovery

Although that surgery had a general policy against using benzodiazepines, he was able to use his discretion to come up with a solution that ultimately benefited me enormously: he agreed to prescribe a short maintenance course until I became stable and then to oversee a reduction in my dose. At first I was put on a daily pick-up (coming back each day for a small prescription) to ensure I didn't misuse the tablets. It was made clear that if I didn't behave responsibly towards my prescription I would lose it. This covered the doctor while also giving me some autonomy in my recovery.

I understand that GPs are under pressure and have time constraints that make it difficult to get a full picture of a situation in a 10 or 15 minute consultation, but it can make all the difference to someone in addiction just to be treated as a human being and an individual. Being asked to come back for return visits to the doctor, to talk about my progress, and to consider what action to take next also helped me feel like the doctor was really interested in giving me the best help that he could.

THE BOTTOM LINE

- Not all drug users are the same—they are all individuals with individual needs. Ask what their hopes and plans are for the future and how they see their own responsibility for their recovery; listen without judging
- Don't dismiss patients who ask for a specific drug out of hand. If they seem to have a prepared dialogue ask some questions that they might not be expecting—ones that will test their sincerity, such as questions about their family and how they are emotionally
- Whenever possible try to give the patient some autonomy and responsibility. I found that I responded better when I had a modicum of control over the direction my treatment was taking. I also found it beneficial to know exactly where the boundaries were, such as when I was told that my prescription was my responsibility and that if I lost it I would not get a replacement

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EASILY MISSED

Inflammatory bowel disease

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This is one of a series of occasional articles highlighting conditions that may be more common than many doctors realise or may be missed at first presentation. The series advisers are Anthony Harnden, professor of primary care, Department of Primary Care Health Sciences, University of Oxford, and Richard Lehman, general practitioner, Banbury. To suggest a topic for this series, please email us at practice@bmj.com.

A 21 year old woman presented to her general practitioner with tiredness and abdominal discomfort for the past year. She is treated for iron deficiency anaemia (attributed to menorrhagia) and for presumed irritable bowel syndrome. After hospital admission a few months later with suspected appendicitis, tests reveal vitamin B_{12} deficiency and raised inflammatory markers, prompting gastroenterology referral. Colonoscopy with terminal ileal biopsy confirms a diagnosis of Crohn's disease.

What is inflammatory bowel disease?

Inflammatory bowel disease encompasses ulcerative colitis and Crohn's disease, both idiopathic chronic diseases of the gastrointestinal tract. Ulcerative colitis is characterised by diffuse inflammation affecting the mucosa of the colon only. Crohn's disease involves patchy transmural ulceration that can affect any part of the gastrointestinal tract. Around 5% of patients have features of both subtypes and are labelled inflammatory bowel disease "unclassified."[1]

Why is it missed?

Recent data on the incidence of delayed diagnosis are limited. A recent Swiss cohort study found the median diagnostic delay among patients with Crohn's disease was 9 months and was 4 months among patients with ulcerative colitis. Age <40 years and ileal disease were independently associated with a long diagnostic delay in Crohn's disease.[4]

Lower gastrointestinal symptoms are common in general practice, and symptoms typical of irritable bowel syndrome are often described in patients with inflammatory bowel disease.[5] A large UK based case-control study found that patients with inflammatory bowel disease were three times more likely to have a prior diagnosis of irritable bowel syndrome.[6] A prospective cohort study found patients with probable and possible pre-existing irritable bowel syndrome were likely to experience longer symptom duration before diagnosis of inflammatory bowel disease.[7] Onset of both diseases is often insidious, and there are no pathognomonic signs or symptoms of either. Many patients have vague, non-specific symptoms for some time, consistent with chronic low level inflammation which can mimic irritable bowel syndrome. In addition the relapsing and remitting nature of inflammatory bowel disease compounds the diagnostic difficulty.

THE BOTTOM LINE

- Inflammatory bowel disease can present with symptoms similar to irritable bowel syndrome
- Diarrhoea of >6 weeks' duration, especially with weight loss and where cancer is not suspected, warrants testing (such as full blood count, C reactive protein or erythrocyte sedimentation rate, coeliac antibodies, and thyroid function)
- NICE guidelines recommend measuring faecal calprotectin in all patients with suspected inflammatory bowel disease, as it is useful in excluding the disease
- Delayed diagnosis of inflammatory bowel disease is associated with reduced response to medical therapy and higher incidence of surgical intervention

HOW COMMON IS INFLAMMATORY BOWEL DISEASE?

- A large systematic review showed the incidence and prevalence of inflammatory bowel disease are increasing with time,[2] in particular among second generation Asian migrants in the UK
- The incidence of ulcerative colitis is about 10-20/100 000/year, with a reported prevalence of 100-200/100 000 people[3]
- The incidence of Crohn's disease is around 5-10/100 000/year, with a prevalence of 50-100/100 000 people[3]
- There is little gender difference in the prevalence of inflammatory bowel disease, but it is more common in white people

Why does this matter?

Delay in the diagnosis of inflammatory bowel disease has been suggested to reduce patient quality of life but also to reduce response to medical therapy.[8] A retrospective cohort study showed that longer diagnostic delay in Crohn's disease was associated with greater risk of bowel stenosis and of intestinal surgery for Crohn's disease.[8]

Current statistics suggest up to 50% of patients with Crohn's disease will require surgery within 10 years of diagnosis,[3] but evidence suggests a reduction in surgery over the past decade owing to treatment advances.[8] Improved remission rates and short term treatment efficacy have been observed in those treated aggressively at an early stage.[9] In addition, early biological therapy with mucosal healing may modify the course of the disease.[9]

Gastrointestinal malignancy is more common in patients with inflammatory bowel disease, and surveillance colonoscopy is recommended for patients with colitis from 10 years after the onset of symptoms. Therefore, timing of diagnosis is crucial.

How is inflammatory bowel disease diagnosed?

Clinical features

Both Crohn's disease and ulcerative colitis most commonly present in late adolescence and early adulthood, with a small second peak in the fifth decade in the case of ulcerative colitis.[10] Non-bloody diarrhoea lasting more than six weeks makes infective causes less likely and warrants further investigation.[10] Fever and anorexia are not seen in irritable bowel syndrome and nocturnal symptoms are unusual, whereas they are not uncommon in inflammatory bowel disease.[1]

Some 90% of patients with ulcerative colitis report bloody diarrhoea,[10] usually triggering prompt investigations;

in addition, abdominal pain and urgency of defecation are commonly seen. Crohn's disease tends to have a more varied presentation—chronic diarrhoea is the most common symptom, but abdominal pain and weight loss are seen in 70% and 60% of patients, respectively.[11] Other patients can present more acutely with intestinal obstruction due to stricturing disease or perianal complications including abscesses and fistulas.

Between 25% and 40% of patients with inflammatory bowel disease have extraintestinal manifestations, more often affecting those with Crohn's disease. The musculoskeletal system (arthritis, ankylosing spondylitis) and skin (erythema nodosum, psoriasis, pyoderma gangrenosum) are most commonly affected and may be the presenting feature.[12]

Investigations

There is no single diagnostic test for inflammatory bowel disease: a combination of clinical, radiological, endoscopic, and histological investigations are used in secondary care. In primary care, check full blood count for anaemia or microcytosis (suggesting iron deficiency or anaemia of chronic disease) and for thrombocytosis (indicating inflammation). Check C reactive protein or erythrocyte sedimentation rate: these inflammatory markers can indicate disease activity but lack sensitivity and specificity. Exclude coeliac disease (with antibody testing), thyroid dysfunction (with serum thyroid stimulating hormone level), and infective diarrhoea (stool microscopy). As malabsorption may occur in inflammatory bowel disease, check serum B_{12}, folate and ferritin levels, and transferrin saturation.

Faecal calprotectin is released into the colon in excess in the presence of inflammation. The National Institute for Health and Care Excellence (NICE) recommends testing for this to help distinguish inflammatory bowel disease from other non-inflammatory bowel conditions such as irritable bowel syndrome in those with lower gastrointestinal symptoms of recent onset and where cancer is not suspected[3]—that is, those without referral criteria for malignancy.[13]

A recent systematic review has shown a cut-off of 50 µg/g of faecal calprotectin to be sensitive and specific for inflammatory bowel disease,[14] but more data are needed to determine optimal threshold values in primary care. Values >50 µg/g are not diagnostic but warrant specialist assessment within four weeks. The test's utility lies in its high negative predictive value.[14] Thus, a normal result means inflammatory bowel disease is unlikely.

Lower gastrointestinal endoscopy with histological confirmation on biopsy is considered the first line diagnostic test after referral. Plain abdominal x ray is essential if acute colonic inflammation or bowel obstruction is suspected, but is not diagnostic and not recommended for routine use.[10 11]

How is inflammatory bowel disease managed?

Refer patients who have bloody diarrhoea, diarrhoea of >6 weeks' duration, abdominal pain with weight loss, raised faecal calprotectin, or unexplained vitamin B_{12} or folate deficiency in an adult <40 years old. Management is based in secondary care and made on an individual basis, dependent on disease extent, location, and behaviour with the aim to induce and maintain remission via a multidisciplinary approach. Diet and lifestyle advice (such as eating a balanced diet and staying well hydrated, exercising, and avoiding stress) is important, with smoking cessation crucial in Crohn's disease. Medical management is individualised and includes glucocorticosteroids, immunomodulators, biological therapy, and mesalazine (5-aminosalicylic acid) in ulcerative colitis. Nutritional deficiencies should be corrected. The need for surgery is declining, but currently 10% of ulcerative colitis patients will need a colectomy and up to 50% of patients with Crohn's disease will require surgical management in the first 10 years after diagnosis owing to stricturing or fistulating disease.[3]

ANSWERS TO ENDGAMES, p 35 For long answers go to the Education channel on thebmj.com

CASE REVIEW

Skin lesion in a critically ill man

1 Tsutsugamushi disease (severe type), typhoid fever, relapsing fever, and epidemic haemorrhagic fever.
2 Weil-Felix test, immunofluorescent antibody test, polymerase chain reaction (PCR).
3 Once confirmed as tsutsugamushi disease, treatment with tetracycline and doxycycline is highly effective.
4 Older age; absence of an eschar; shock; multiple organ dysfunction; underlying chronic disease; decreased albumin and haemoglobin; leucocytosis; increased concentrations of aspartate aminotransferase, serum creatinine, urine albumin, and C reactive protein; and an APACHE II score of 50 or more all contribute to a poor prognosis.
5 Take a detailed medical history (especially travel history), repeat the physical examination, and characterise the eschar.

STATISTICAL QUESTION

Understanding the ecological fallacy

Statements *a*, *b*, *c*, and *d* are all true.

SPOT DIAGNOSIS

An uncomfortable hip exacerbated by exercise

This plain radiograph shows several radiographic signs that are characteristic of developmental dysplasia of the left hip.