investigating lower bowel symptoms in general practice

GPs could do more sigmoidoscopies

Gastrointestinal problems account for one in 12 consultations in general practice, with lower bowel symptoms accounting for about half of these.1 Apart from abdominal emergencies these symptoms include chronic, recurrent abdominal pain; changes in bowel habit; and rectal bleeding. Although self limiting minor conditions account for most of these symptoms, colorectal cancer and inflammatory bowel disease will be responsible for a few. A further large group will, of course, be due to the irritable bowel syndrome.

In this issue Rubin reports that nearly three in four practices in the Northern region possess a proctoscope but only 4% undertake rigid sigmoidoscopy (p 1542).2 Almost half of doctors surveyed thought that proctoscopy and sigmoidoscopy were not appropriate procedures for primary care and that standards might be difficult to maintain. Yet timely investigation of patients with lower bowel problems is important. Rectal bleeding is common, occurring in up to one in six of the general population each year,3 and may be the only sign of serious large bowel disease. Colorectal cancer is the second commonest cancer in the United Kingdom, accounting for more than 16 000 deaths annually. Survival depends on the stage of disease at diagnosis, and early detection offers the only opportunity to improve survival.

Recognised risk factors for colorectal cancer include a personal history of colorectal neoplasia and inflammatory bowel disease and a family history of colorectal cancer or of one of various inherited disorders that are associated with colorectal cancer. These include familial adenomatous polyposis, site specific cancer of the colon, and the cancer family syndrome (in which colorectal cancer is associated with adenocarcinoma of the breast and genital tract).4

To evaluate rectal bleeding ano-rectal inspection and digital rectal examination are mandatory, although these are not always performed properly.5 Patients with rectal bleeding are at low risk of colorectal cancer if they are under 40 and do not have significant personal or family histories. A local ano-rectal lesion in these patients is a sufficient cause for their bleeding, which may be treated without further investigation. Older patients, those with personal or family histories, and those with recurrent symptoms should be investigated.

Nearly half of all general practitioners have open access to barium enema examinations, and most radiology departments require sigmoidoscopy before contrast radiology. Only a few general practitioners have access to flexible sigmoidoscopy and colonoscopy.7 About 70% of rectal cancers (15% of colorectal malignancies) can be detected by digital rectal

Cardiac imaging with radionuclides

A useful addition to electrocardiography and echocardiography

Advances in cardiovascular imaging have made accurate diagnosis of cardiac disease easier. Cardiologists, particularly those in teaching centres, now have a wide range of radionuclide techniques to supplement clinical examination, electrocardiography at rest and during exercise, and echocardiography. These include radionuclide ventriculography, perfusion imaging, infarct avid imaging, and, in the most privileged locations, positron emission tomography.

Although echocardiography is already available in most district general hospitals, cardiac radionuclide investigation is not. Only half of the health districts in England and Wales perform cardiac radionuclide investigation; a recent survey found that the rate of such investigation in Britain was one fifth that in the United States.1 This reflects the limited facilities for this technique but also the lack of importance that British physicians place upon these tests.

Determining the optimal use of these techniques is difficult, and American studies suggest a high rate of inappropriate use.14 Good comparative studies are still needed to clarify each technique’s role in diagnosis, but in their absence doctors should at least be aware of cardiac radionuclide investigations and understand their principles, main uses, and limitations.

Ventriculography, with a radionuclide that is retained within the blood pool, can be used to estimate ejection fraction, one of the most important determinants of prognosis, both in chronic ischaemic heart disease and after myocardial infarction.15 Unlike echocardiography, a radionuclide study is not dependent on finding an adequate ultrasonic window. Although anatomical detail is much better with ultrasonography, the isotope technique has the advantage of readily assessing left ventricular function, even in the presence of akinetic or dyskinetic segments. Atrial fibrillation, however, reduces the reliability of both techniques, particularly if the ventricular rate is not well controlled.

Myocardial perfusion imaging depends on the use of agents such as thallium-201, which are taken up by perfused myocardium in proportion to blood flow. Ischaemic or infarcted muscle appears as a “cold spot.” In this test perfusion images obtained immediately after stress (usually exercise) are compared with those at rest. The quality of the image is very important for interpreting the results and has