GastroIntestinal Endoscopy

newsletter the insider

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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 with seven highly skilled and trained Gastroenterologists.

GIE operates an Open Access Endoscopy Service from four locations:

- **SUNNYBANK** – Brisbane Endoscopy Services
- **CHERMSIDE** – Chermside Day Hospital
- **EVERTON PARK** – North West Private Hospital
- **AUCHENFLOWER** – The Wesley Hospital

Dr William Robinson

Pregnancy and IBD

The highest rates of inflammatory bowel disease (IBD) in Australia overlap the peak reproductive years. New therapies are resulting in healthier patients, longer disease free periods and improved likelihood of conception.

Fertility

Women: It is considered to be similar to that of the general population. Prior pelvic surgical intervention can however, reduce fertility by up to 80%.

Men: Sulphasalazine has been shown to reduce sperm count and motility and alter sperm morphology. These effects are reversible within two months of ceasing therapy and are not seen with 5ASA drugs.

Disease activity

Women should be in remission prior to contemplating conception. The chance of an exacerbation of IBD during pregnancy is the same as for non-pregnant women (33% per annum).

Pregnancy outcome

Women with IBD have an increased rate of adverse pregnancy outcomes, including spontaneous abortion, premature birth and complications of labour and delivery. The magnitude of risk is related to disease severity before and during pregnancy. Adverse events during one pregnancy do not correlate with the course of subsequent pregnancies. The majority of infants are normal and healthy but there is a minor increase in risk of low birth weight and pre-term infants. There is no apparent increase in congenital malformations.

Assessment of patient in pregnancy

Flexible sigmoidoscopy is safe. Colonoscopy and radiographic studies should be considered only to obtain information critical to management decisions.

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www.gastros.com.au

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Mode of delivery

Normal spontaneous vaginal delivery is appropriate unless there is an obstetric indication for Caesarean section. It is usually advised that the patient with active perianal Crohn's Disease have Caesarean section. Women with an ileoanal pouch can deliver vaginally, although there is concern regarding the effect on anal sphincter function, which is critical in these patients.

Medications

The choice of drugs used during pregnancy and breast feeding should be based on their relative safety and indications. There have been many, usually small, studies related to safety of the medications used for treating IBD and the conclusions are at times, conflicting. A concensus view is outlined below.

Sulphasalazine:

There is extensive experience with this drug which is safe during pregnancy and can be continued during breast feeding. It is not reported to cause kernicterus.

5ASA drugs:

Oral and topical 5ASA agents such as mesalazine appear to be safe during pregnancy.

Continued use of 5ASA drugs and sulphalazine should be encouraged in pregnancy to maintain remission.

Use is compatible with breastfeeding although there is a potential for diarrhoea.

Antibiotics:

Metronidazole

- Long term use in pregnancy should be avoided as metronidazole is carcinogenic in rodents and mutagenic in bacteria. Short (up to 10 days) courses are reasonable in second and third trimesters.

Ciprofloxacin

- Not recommended as this drug affects growing cartilage in humans and can cause arthropathy. Although excreted in breast milk, short courses are probably safe with breast feeding.

Glucocorticoids

- Extensively used in pregnancy for treatment of various inflammatory disorders and should not be withheld if clinically indicated.
- Use in the first trimester is associated with low risk of cleft palate.
- Theoretical risk of adrenal insufficiency in the neonate with long-term high dose steroid therapy.
- Glucocorticoids have the potential to exacerbate pregnancy induced hypertension and gestational diabetes.
- Use appears to be safe during pregnancy. However, prednisolone can be measured in breast milk and it is recommended that breast feeding be deferred for several hours after oral administration.

6 Mercaptopurine and Azathioprine

- These drugs cross the placenta and are detected in cord blood. Evidence however, suggests that it is reasonable to continue these medications during pregnancy.
- Breastfeeding should be avoided for four hours post administration to minimise exposure to the neonate.

Methotrexate

- Contraindicated in pregnancy as this is a potent cause of abortion and use during pregnancy is associated with multiple skeletal abnormalities.
- Women and men taking methotrexate for IBD should discontinue this drug for at least three months prior to conception.

Anti TNF agents

- Infliximab/Adalimumab are considered low risk and can be used in pregnancy and breast feeding.
- These drugs cross the placenta readily and can be detected in the infant for up to six months after birth. If the mother is in remission it is recommended that the last dose be given at 32 weeks in order to minimise exposure to the infant.
- Live virus vaccines should not be given to the infant in the first six months of life.

Summary

Patients with IBD, in general, do not have reduced fertility compared to the general population. Provided the mother is in remission at the time of conception the risk of pregnancy is considered acceptable. With respect to use of any medication, the potential risk to the mother of a disease flare-up needs to be balanced against the theoretical risk to the foetus. In general, the most important determinant of a good outcome in pregnancy is a healthy mother.

AGW 2012

www.agw.org.au

The genetic basis for colorectal cancer (CRC) continues to become clearer. This disease is our best target for cancer prevention through polyp removal. Pathways include:

- Adenomatous polyposis gene (APC) important in sporadic CRC and the basis of Familial Adenomatous Polyposis
- BRAS mutations as the basis of the sporadic serrated adenoma path to CRC
- Lynch syndrome (micro-satellite instability as the result of DNA mismatch repair enzyme mutations)
- MYH mutations (homozygotes develop 10–500 adenomas while heterozygotes have a 1.5–3 x increased risk of CRC)
- The genetics of Peutz Jeghers, Juvenile Polyposis and Hereditary Mixed Polyposis are also being clarified.

At the primary care level it is vital that those with symptoms or more than the average risk for CRC are identified and referred for colonoscopic assessment.

Endoscopic management of large polyps is associated with lower complication rates compared to surgery. As a result, techniques are being used to determine if a particular large polyp has a malignant component. Sometimes malignant pedunculated polyps can be

A Report from the Australian Gastroenterology Week, Adelaide 16–19 October 2012

Dr Andrew Bryant

adequately removed endoscopically without the need for surgery. There is often an adequate tumour margin if the stalk is clear of neoplasia and there is no lymphatic or vascular invasion.

There have been significant advances in drug management for Hepatitis C which currently infects 1% of the Australian population and has the potential to cause increasingly large burdens of liver disease. It is already the major indication for liver transplantation. We already have access to Boceprevir and Telaprevir which inhibit the viral protease NS3/4a. These specific anti-HCV drugs are used in combination with Pegylated Interferon alpha and Ribavirin to significantly increase sustained virological response rates in genotype 1 infections. Boceprevir side effects include anaemia, neutropenia and a poor taste in the mouth. Telaprevir can cause a rash and perianal discomfort.

We are on the verge of a wave of newer antiviral medications that will replace Interferon containing regimens altogether. It is likely this will involve the combination of two new antivirals with Ribavirin. Watch this space for some significant changes to HCV therapy. It is likely that simpler regimens with fewer side effects will mean most HCV treatment will occur in the primary care setting and less visits to specialist clinics will be needed.

Some trials of lambda Interferon suggest it is as effective as alpha Interferon but with fewer side effects.

The role of genetics is being clarified. It has been found that Interleukin 28B gene variants can influence treatment response in HCV. Those with the CC variant have significantly better treatment responses than the TT variant. The mixed CT variant has intermediate response rates.

Treatment of cirrhotic patients continues to present challenges with some data suggesting high complication and mortality rates in the treatment of Childs B and C cirrhosis (poorer functional groups) with the antiviral agents.

A session on the management of obesity continues to throw up challenges. The poor responses seen in the morbidly obese to attempts to lose weight with diet and exercise interventions feeds the current enthusiasm for surgical options. Banding seems to be reducing in popularity due to complications (eg band slipping or erosion into the upper stomach). The two other operations are sleeve gastrectomy and intestinal bypass. Some other interventions include gastric balloons. A US presenter even showed some data about the use of a venting percutaneous endoscopic gastrostomy such that obese individuals could eat a meal and then empty themselves out afterwards. It just shows the extreme desperation to find an answer to this worsening problem across the western world. The multiplicity of operative and endoscopic options show there is no best solution. All options have pros and cons. I would suggest that government needs to address this issue aggressively with banning of fast-food advertising and better education programs starting early in schools promoting healthy food and a more physically active lifestyle. It looks like it is going to get worse before it gets better. On the endoscopic side, there have been some advances in the management of surgical complications such as fistulae seen with the sleeve gastrectomies.

Adelaide put on some excellent weather for us despite a storm with snow in the Adelaide Hills. The Adelaide Oval is being renovated and they are building a new public hospital just to the west of the CBD. The South Australian wines continue to make life worthwhile.

Frequently Asked Questions Dr Roderick Roberts

Q Why do patients treated with Inflammatory Bowel Disease (IBD) still get symptoms?

A There are a number of reasons for this. It is obviously important to be sure that the IBD is completely controlled by the medications administered. That can be a little difficult in the case of Crohn's Disease, particularly where it affects the small bowel, but there are ways to do that. One useful test that is currently appearing is a faecal calprotectin. Royal Brisbane performs this for us at the present time, but there is an application to MSAC for funding of this test in the long term.

However, the issue is more often that the disease does seem to have settled yet symptoms persist. Professor Peter Gibson at Monash has had a great interest this area, together with a dietician attached to his unit, Sue Shepherd, and has investigated this phenomenon for some years now. It was out of that question that the concept of FODMAPS arose. These, as you may be aware, are Fermentable Oligo-, Di-, Mono-saccharides and Polyols. These are constituents of many foodstuffs, especially fruits and vegetables, and probably account for the symptoms of looseness, distension and gas that persist in some patients after adequate treatment of IBD. They are a potential cause of such symptoms in a proportion of patients with irritable bowel symptoms (IBS) as well. Other triggers for IBS are no less likely to affect those with treated IBD either, so there is a third potential explanation. A low FODMAP diet booklet can be obtained from the Monash University Department of Medicine website.

Q What is the rate of false positive FOBT (Faecal Occult Blood Tests) and how is this best approached?

A The positive predictive value of the FOBT is 26.3%. This means that cancers and adenomas (including small adenomas) are detected 26% of the time that a positive FOBT is identified in average risk patients in a population. That value falls to 20% if you take out diminutive adenomas. This does mean that a large proportion of the FOBTs are falsely positive. Having said that, there is strong evidence that colon cancer mortality is reduced by up to one third with a FOBT screening program. A positive test should be followed up by a colonoscopy if the patient has not had a screening colonoscopy in the immediate past (about two years). If an FOBT is positive and the most recent colonoscopy was two years prior, then I think that a positive FOBT should trigger a further colonoscopy.

It is instructive to look at the outcomes of the National Bowel Cancer Screening Program (NBCSP) in Queensland. Between 8 June and 12 October, 552,400 kits were posted. The number returned was 183,000, of which 14,000 were positive. All patients with positive FOBT were offered screening at a Queensland Health facility and 4,800 accepted the offer. Amongst these 4,800 individuals there were 210 colon cancers, and 3,070 polyps of which about half were advanced (>1cm in diameter), i.e. a positive FOBT identified a significant polyp or cancer in 36% and any polyp or cancer in 68%. The false positive rate then for significant lesions was 64% and for any lesion, 32%. The figure of 26.3% mentioned above is a national figure and reflects the outcome in the screened population as a whole, including the majority who either did not return the test or did not attend for colonoscopy when indicated.

If you require an electronic referral template or A5 referral pads, please contact one of our four practice locations below or download from our website www.gastros.com.au

GIE practice locations and contact details For all appointments, call 1300 4 GASTRO (1300 4 427876)

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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

The Wesley Hospital

3rd Floor, East Wing
451 Coronation Drive
Auchenflower
QLD 4066

Phone: 07 3870 3799
Fax: 07 3870 5069

North West Private Hospital

Endoscopy Unit
137 Flockton Street
Everton Park
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