Guideline Updated: 12 December 2005 Specialty: Gastroenterology

Hemoccult Positive Stool Referral Guideline

Diagnosis/Definition

- Occult bleeding is not obvious to the naked eye(that is, no melena or hematochezia) detected by the use of fecal occult blood testing cards (Hemoccult, Fecult).
- FOBT - Fecal occult blood test.

Initial Diagnosis and Management

- Used in the screening of appropriate patients (> age 50) for colorectal cancer. A positive stool card on any one of 3 spontaneously passed, consecutive bowel movements with patient on a dietary protocol.
- Should not be done in course of a routine rectal (digital) examination if assessing truly for occult bleeding.
- Patients with iron deficiency anemia do not require FOBT as they automatically require both an upper endoscopy and a total colonic evaluation REGARDLESS of the result of an FOBT.

Ongoing Management and Objectives

- A positive result requires a total colonic evaluation.
- Colonoscopy is the preferred test

Indications for Referral to Gastroenterology:

- Patients with a positive FOBT who have never had a total colonic evaluation via a colonoscopy previously.
- Colonoscopy is desired as first-line w/u for heme + stool.

Criteria for Return to Primary Care

- Completion of colonoscopy with recommendations to the primary care provider.

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Irritable Bowel Syndrome Referral Guideline

Diagnosis/Definition

Continuous or recurrent symptoms for at least 3 months of:

- Abdominal pain or discomfort relieved with defecation, or associated with a change in the frequency or consistency of stool, and
- An irregular pattern of defecation at least 25% of the time and consisting of two or more of the following:

    a. Altered stool frequency.
    b. Altered stool form (hard or loose, watery stool).
    c. Altered stool passage (straining or urgency, feeling of incomplete evacuation).
    d. Passage of mucus.
    e. Bloating or feeling of abdominal distention

Initial Diagnosis and Management

- Evaluation: only a history, physical exam are needed if a positive diagnosis had been made by above criteria. Lactose intolerance should be sought in the history, but an exclusion diet may be needed to rule this out.
- Extra evaluations should be reserved for a history suggestive of specific problems (e.g., U/S for gallstones, UGI for PUD, ACBE for severe constipation.).
- Emphasize it is a "real" disease, but not associated with serious morbidity.
- Explain it is a motility disorder, and "spasm" may cause the pain and stress may make it worse. Educational handouts are recommended.
- A high fiber diet, usually including psyllium (e.g., Metamucil) should be used first. Gradually increase psyllium to as much as 1 tsp. tid, advising that excess gas is usually transitory.
- If psyllium alone doesn't help, anticholinergic (e.g., dicyclomine) for pain and loperamide for intermittent bouts of diarrhea can be used.
- When patient's fail to respond to the above; the provider should consider psychiatric screening for depression.

Ongoing Management and Objectives

- Major objective should be symptom alleviation, as this is a chronic disorder with intermittent exacerbations, and a cure is not possible.
- Needed diagnostic tests should be done early and NOT repeated.
- The patient should be reassured that serious pathology has been excluded.

Indications for Referral to Gastroenterology:

- When the diagnosis is uncertain.
- When specific organic pathology is suspected. Examples: gross blood in stool, diarrhea waking the patient from sleep or associated with weight loss, iron deficiency anemia, or significantly elevated ESR.
- Referral should not be given to merely confirm the diagnosis.