GUTS Pilot: Advanced Practice Dietitian (APD) Model

What is it?

First APD-led lower GI service in Northern Ireland

Based in Portadown Family Practice (~10,000 patients)

12-month pilot (0.5 WTE)

Applies the Crohn's & Colitis UK lower GI pathway in primary care

Focus on earlier identification of IBD and appropriate management of lower GI symptoms.

PRIMARY CARE DIAGNOSTIC PATHWAY FOR LOWER GASTROINTESTINAL (GI) SYMPTOMS IN ADULTS (NOT FOR ACUTELY UNWELL PATIENTS)

FOR USE BY PRIMARY CARE TEAMS. APRIL 2024.

Click the pointer for hyperlinks

RED FLAG COLORECTAL CANCER SYMPTOMS

A FIT in primary care to support asessment of colorectal cancer may be needed.

Follow country cancer pathway:
England, Scotland, Wales, Northern Ireland

RED FLAG OVARIAN CANCER SYMPTOMS

CA125 blood test in primary care will support need for an ovarian cancer referral.

Follow country cancer pathway:
England, Scotland, Wales, Northern Ireland

COMMON SYMPTOMS OF LOWER GI CONDITIONS

- Change in bowel habit, for example, frequency, urgency, faecal incontinence, tenesmus
- Abdominal pain, cramping, bloating, excessive wind
- Rectal bleeding
- Weight loss
- Mucus in stools/fatty stools

Symptoms may also include:

- Reduced appetite
- Nausea with or without vomiting
- Symptoms made worse with eating
- Persistent mouth ulcers
- Ongoing fatigue

COULD IT BE SELF LIMITING?

Consider duration of symptoms and history.

If less than two weeks duration consider, for example, recent travel, changes in diet, alcohol, medications, infection causing gastroenteritis, menstrual symptoms, possibility of haemorrhoids and fissures.

Consider if stool test necessary to exclude infection. See also INVESTIGATIONS.

If cancer is not being considered

The main forms of IBD are Crohn's Disease and Ulcerative Colitis. More rarely, Microscopic Colitis.

COULD IT BE INFLAMMATORY BOWEL DISEASE (IBD)?

IBD often presents with diarrhoea, abdominal pain, rectal bleeding or weight loss, but may also present with common symptoms in the box above.

Presents at any age but mainly 18-35, with a second peak in 65+. Family history increases risk.

POTENTIAL DISTINGUISHING SYMPTOMS:

Nocturnal defecation, fevers, recurrent/persistent anal abscesses, extra intestinal manifestations in joints, skin, eyes or perianal area. Microscopic colitis, mainly in women 50+, presents as isolated watery diarrhoea.

COULD IT BE COELIAC DISEASE?

Coeliac disease occurs in 1 in 100 people and is undiagnosed in two thirds of cases. It can present in non-specific ways, including the common symptoms in the box above. Family history increases risk (first degree relative 1 in 10 risk).

More likely with Down's/Turner syndromes or history of autoimmune conditions e.g. type 1 diabetes, thyroid disease. Associated with iron deficiency anaemia or B12 or folate deficiency.

POTENTIAL DISTINGUISHING SYMPTOMS:

Dermatitis herpetiformis, tooth enamel problems, reduced bone mineral density, unexplained subfertility or repeated miscarriages, neurological problems such as unexplained ataxia or peripheral neuropathy.

COULD IT BE IRRITABLE BOWEL SYNDROME (IBS)?

IBS is a longstanding illness with frequent abdominal discomfort and bowel symptoms that cannot be explained by any other disease. It is uncommon for people over 50 to present with IBS for the first time. Extraintestinal features are common including: lethargy, nausea, back pain, headache or bladder symptoms.

GI PRESENTATION:

- Abdominal pain or discomfort (present for at least 6 months) and relieved by defecation or associated with altered bowel frequency or stool form.
- Altered stool passage (straining, urgency, incomplete evacuation).
- Abdominal bloating (more common in women than men).
- Passage of mucus.

What Does the APD Role Involve?

Key Activities

Triage and assessment of adults with lower GI symptoms

Telephone (20 minutes) and face-to-face consultations (30 minutes)

Investigation requesting and interpretation (bloods and stool tests)

Communication of results, diagnosis and management plans

Dietary and lifestyle interventions

Referral and liaison with secondary care services and GPs

Daily multidisciplinary working within the practice team.

Impact for General Practice

Supporting Demand Management

The APD role helped:

- Reduce GP workload
- Improve referral appropriateness
- Reduce unnecessary gastroenterology referrals
- Reduce duplicate investigations
- Provide specialist GI support within primary care

Majority of patients reported being satisfied or very satisfied with the APD-led service, showing strong approval.

Case Example: Earlier Identification of IBD

21-year-old male

Previously reviewed by:
- GP
- Emergency Department

Persistent symptoms:
- Abdominal pain
- Altered bowel habit
- PR bleeding
- Urgency/nocturnal symptoms

APD assessment prompted:
- Faecal calprotectin: **3760**
- Urgent secondary care referral

Outcome:

Subsequently diagnosed with Crohn's disease

The APD identified IBD symptoms early and provided nutritional support while awaiting specialist review.

Personal Reflections

1. Understanding the GP perspective
2. Knowing my scope
3. Clinical reasoning beyond Dietetics
4. Working in partnership
5. The right clinician at the right time
6. Future Opportunities.