PRIMARY CARE DIAGNOSTIC PATHWAY FOR LOWER GI SYMPTOMS

GPNI CLINICAL UPDATE

September 2026

CROHN'S & COLITIS UK

KEY LEARNING OUTCOMES



Rational and local application of the primary care diagnostic pathway for lower GI symptoms



Confidence in investigating IBD and diagnosing other common lower GI presentations



How and when to use a faecal calprotectin

WHY FOCUS ON IBD?



Higher incidence

Approx 0.8% of NI

Approx 17,000 people



Diagnostic conundrums

Up to 10% of contacts gastro related

Overlap: malignant, inflammatory, and self limiting dx



Pre-diagnosis patterns in General Practice

Emergency presentations



Extraintestinal manifestations

‘CLASSICAL PATTERNS’

ULCERATIVE COLITIS:

COLON & RECTUM

Haematochezia, pain, diarrhoea, anaemia, fever, weight loss

CROHN’S DISEASE:

WHOLE GI TRACT

Fatigue, pain, diarrhoea, weight loss, Extra-Intestinal Manifestations

“THINK IBD BEFORE IBS”



ULCERATIVE COLITIS

Prevalence: 0.4%

TOP 5 PRESENTING COMPLAINTS

87% Haematoschezia
87% Loose/watery stools
83% Faecal Urgency
80% ^ Faecal Frequency
74% Fatigue

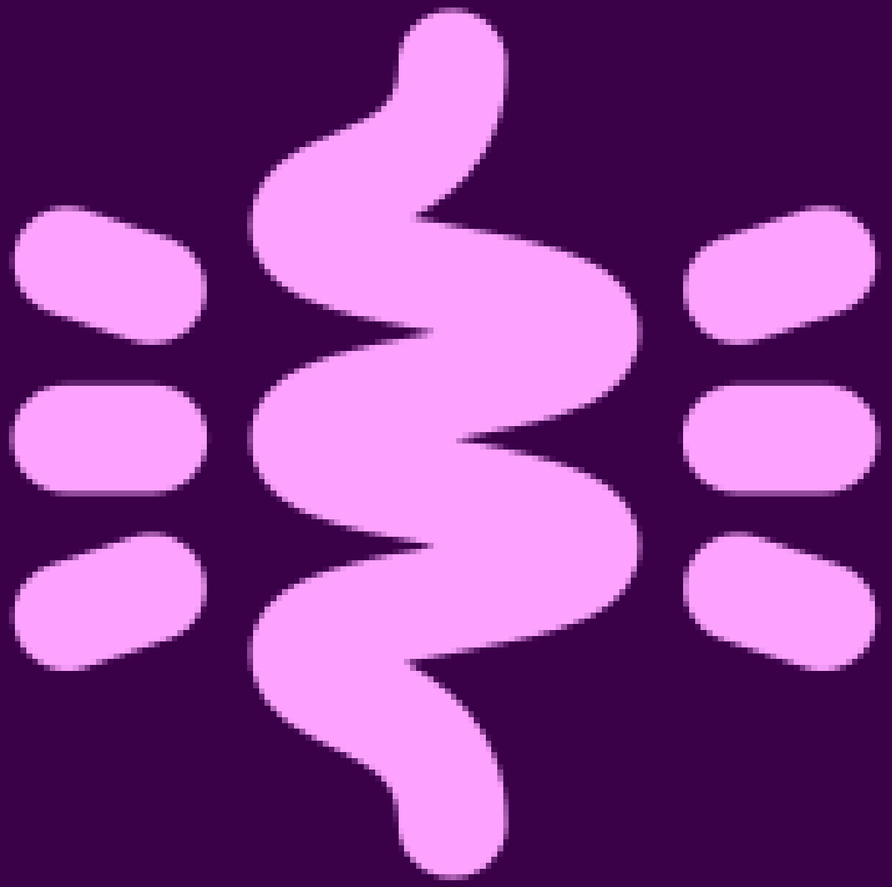
CROHN'S DISEASE

Prevalence: 0.3%

TOP 5 PRESENTING COMPLAINTS

81% Fatigue
80% Abdominal Pain
70% Loose/watery bowel motions
66% Cramping with bowel motions
64% Faecal urgency

IBD SECOND SPIKE @ 60



NOT ONLY A DISEASE OF YOUTH

UP TO 23% OF NEW DIAGNOSES ≥ 60Y

ADULTS >50 & ALARM FEATURES → RF REFERRAL

WHAT HAPPENS IF COLONOSCOPY NORMAL & DISCHARGED?

DIAGNOSING IBS

ABDOMINAL PAIN

- Relieved by defecation

BLOATING

CHANGE IN BOWEL HABIT

- Straining
- Urgency
- Incomplete evacuation

ABSENCE OF ALARM FEATURES

THINK IBD BEFORE IBS



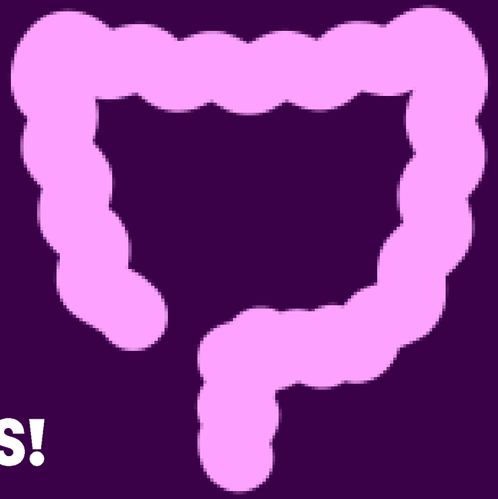
FAECAL CALPROTECTIN

BOWEL NEUTROPHIL ACTIVITY

ANSWERS Q: IBS VS IBD

NOT ALL BOWEL NEUTROPHIL

ACTIVITY IS CROHN'S OR COLITIS!



NEW

SE TRUST LAB UPDATE TODAY

FALSE POSITIVES --> COLONOSCOPIES

Medicines: PPIs + NSAIDs + Aspirin
GI infections
Alcohol

(INTRODUCING?) MICROSCOPIC COLITIS

- Distinct subset of IBD from UC/CD

- Chronic watery diarrhoea
- Faecal urgency
- Faecal incontinence
- Abdominal cramps

- Typically women >50y
- Calprotectin often normal
- Up to 84% remission with treatment

A CHALLENGING DIAGNOSIS

GASTROENTEROLOGY REFERRAL FOR BIOPSY



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.

Based on history and appropriate clinical examination, consider which primary care lower GI investigations are needed to support the clinical assessment of your patient.

POSSIBLE PRIMARY CARE LOWER GI INVESTIGATIONS

BASELINE BLOOD TESTS:

- **Full Blood Count and Ferritin:** looking for anaemia or infection or systemic inflammation.
- **C-reactive protein:** tests for inflammation and autoimmune disease.
- **Coeliac screen:** advise patient not to eliminate or reduce gluten from their diet.
- **Thyroid Function Tests:** to exclude hyperthyroidism as a cause of diarrhoea and hypothyroidism as a cause of constipation.
- **Renal and Liver Function Tests** including albumin and calcium.

STOOL TESTS:

- **Stool sample to test for infection.** If not already excluded, use to eliminate infective causes. Consider also parasites and if specific tests need to be requested e.g. *C. difficile*.
- **Faecal calprotectin** and/or **Faecal Immunochemical Test** (FIT) to support diagnosis or exclusion of IBD, request according to local pathway guidance.

To avoid the patient making multiple trips aim to do all necessary tests at the same time.

A negative bowel cancer screening programme FIT does not mean a patient who presents with symptoms does not have colorectal cancer. Symptomatic thresholds for a positive result are lower than the thresholds used in national bowel cancer screening programmes.

- Coeliac screen positive. REFER to secondary care for diagnosis. If secondary care confirms Coeliac diagnosis, treat with a gluten free diet with dietetic support (as per National/local guidance).
- Coeliac screen negative. See pink dotted border box below and SAFETY NETTING.

Encourage the patient to take gluten in their diet until secondary care confirms diagnosis to avoid false negative.

- Once faecal calprotectin or FIT results are available, refer to local pathway guidance for the appropriate action.
- If faecal calprotectin and FIT are normal for your reference range, see pink dotted border box below and SAFETY NETTING.

Exact thresholds for faecal calprotectin and FIT may vary and should be based on local assays and audit data

- After alternative conditions considered and if baseline tests suggest, make a positive diagnosis of IBS and treat in primary care. SEE SAFETY NETTING.

Woman aged 50 or over with new IBS symptoms in the previous 12 months should be tested for ovarian cancer.

SAFETY NETTING

- **if symptoms persist or symptoms change – reassess (even if tests were negative) and consider referral**
- referrals should be based on clinical need
- if severe symptoms – urgent GI referral may still be needed

IF SYMPTOMS SUGGEST, CONSIDER:

- upper GI cancer e.g. pancreatic or gastric cancer, or cancers of other systems
- non-site specific cancer pathway referral for persistent concerning symptoms
- negative or normal stool tests and ongoing symptoms – could still be IBD or cancer
- false negative Coeliac screen – too little gluten in diet, IgA deficiency (test for total IgA and IgG based serology)
- severe IBS symptoms may need a GI referral to optimise treatment
- conditions of other systems, e.g. gynaecological, liver, renal
- HIV screening for chronic diarrhoea

COULD IT BE ANOTHER LOWER GI CONDITION?

Other conditions may also cause similar symptoms to IBS but not respond to symptomatic, supportive treatment. Multiple lower GI conditions are possible at the same time.

- **microscopic colitis**, if persistent loose watery diarrhoea (exclude by biopsy, faecal calprotectin can be normal)
- **bile acid malabsorption**, common after cholecystectomy
- **diverticulitis**
- **small bowel bacterial overgrowth**
- **pancreatic insufficiency**, often causes weight loss, test for faecal elastase

For more information, visit www.whatsupwithmygut.org.uk

CROHN'S & COLITIS UK · coeliac uk live well gluten free · GUTS UK! · cicra better lives for children with crohns and colitis · The Association of Coloproctology of Great Britain and Ireland · bsg · BSPGHAN · RCGP Royal College of General Practitioners