PRACTICE OBSERVED

The GP and the Specialist

Gastroenterology

N H DYER

"A gastroenterologist is someone who views life from the wrong end of a dirty sigmoidoscope."

General physicians and general practitioners have long regarded gastroenterology as a simple subject which could be undertaken by anyone and thus not worthy of specialty status. During the 'fifties and 'sixties gastroenterologists enhanced their position by devising an enormous number of new methods to study the alimentary tract. Perhaps this was unfortunate, because they came to be regarded as technicians rather than clinicians, whereas every general practitioner will know that alimentary complaints are dominated by functional and psychological disturbances. Merely performing an investigation in hospital is unlikely to satisfy these patients. Thus the ability to take a full history becomes more important than technical performance. But probing the psychosocial background to a complaint can be both time-consuming and tiring and limits the number of patients who can be seen in any single outpatient clinic.

The x-ray bypass

"Since there is a long wait for a barium meal and, if this is normal, another wait for a cholecystogram, will you please see. . . ."

The use of endoscopy has partially freed the gastroenterologist from dependence on radiology, though a barium enema is still a prerequisite for colonoscopic examination. Unfortunately, the troubles over consultant contracts in the 1970s resulted in severe cutbacks in the number of x-ray examinations performed to put quality before quantity. It may now be quicker to send the patient to the gastroenterology clinic rather than the x-ray department. This has the advantage of obtaining a consultant opinion with the possible reorientation of investigations, but it does increase the waiting times for everyone. If a general practitioner thinks that he can improve his management of a patient by obtaining an x-ray film, then he should stimulate the radiologist before adding to the gastroenterology waiting list.

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Hiatus hernia syndromes

". . . patient has pain, a barium meal shows a hiatus hernia, please advise."

The presence of a small hiatus hernia on an x-ray film of a barium swallow is often irrelevant. Symptoms are usually produced by oesophageal reflux or spasm. If a patient presents with a classic history of heartburn and acid brash he does not require immediate investigation. Treatment should be directed at altering his life-style and giving simple antacids (a useful leaflet entitled "Hints for heartburn" is available from MCP Pharmaceuticals Ltd, Simpson Parkway, Kirkton Campus, Livingston, West Lothian). Expensive drugs should not be prescribed unless the patient is prepared to lose weight and stop smoking. Neither should a patient with uncomplicated heartburn be referred to hospital until simple treatments have failed. Surgical repair of some hiatus hernias is coming back into fashion, however, and patients with intractable symptoms should be sent for an opinion about operation.

Dysphagia

"She complains of a lump in the throat and thinks she has cancer."

Textbooks teach that dysphagia is a medical emergency because the oesophagus may become completely obstructed. There is usually ample warning, however, with progressively worsening symptoms so that a letter to the outpatients department should be sufficient. Nevertheless, a distinction must be made between the globus syndrome (above) and organic obstruction. Patients with globus do not require urgent referral and are more appropriately seen in the ear, nose, and throat clinic. There is a rule that all lesions around the cricopharyngeus should be examined by an ENT surgeon using direct pharyngoscopy and not by a gastroenterologist using a fibre-oesophagoscope. The fibrescope was not designed to examine the throat and may give misleading information.

If carcinoma of the oesophagus is unsuitable for resection or radiotherapy the gastroenterologist may help by inserting a Celestin or equivalent tube using the fibrescope. This is a much less hazardous procedure than open operation, and the patient may often leave hospital after a couple of days. This, however, must not be done too early on before dysphagia is severe. The artificial tube itself represents an obstruction and patients are limited to a liquidised diet. If they try to be too ambitious with their food they merely block the tube and require further admissions to hospital. Conversely, patients who can still swallow liquidised food will not be helped by the procedure.

Dyspepsia

"I think that this patient has an ulcer. Can you see with a view to endoscopy? Meanwhile I have started treatment with an H_2-antagonist."

So powerful are these new drugs that most duodenal and gastric ulcers heal rapidly. Endoscopic findings may then be very difficult to interpret. If the general practitioner really wants to know whether his patient has an ulcer then he should not start treatment. This is particularly true for an older patient with suspected gastric ulcer or carcinoma because small ulcer-cancers may heal temporarily and even patients with large carcinomas may become asymptomatic. In the younger patient with suspected duodenal ulcer the general practitioner may start treatment but should be prepared to manage the disease himself. He may then refer the patient to the clinic if symptoms fail to respond or relapse when treatment is completed. Patients who arrive in the clinic while continuing treatment can have the drug withdrawn and be instructed to telephone the endoscopy unit when symptoms recur. The finding of an ulcer under these circumstances is useful, but the presence of duodenitis (or even a normal mucosa) may mean only that the patient has not been left untreated for long enough. In any event it is likely to add up to more work for the endoscopist.

Irritable bowel syndrome

"She has diarrhoea up to 30 times per day and may be developing colitis."

Patients complaining of a combination of diarrhoea, constipation, and abdominal pain comprise the vast bulk of outpatient referrals. At the moment most clinicians lump them together under the loose term of the irritable bowel syndrome because they have no detectable organic disease—carcinoma, malabsorption syndromes, and inflammatory bowel disease having been excluded. Many of these patients have psychological hang-ups that the general practitioner is in the best position to identify and deal with. Certainly a referral letter containing information on the psychosocial background would be invaluable to the consultant. Ideally a doctor should inspect the stool of someone who complains of diarrhoea. Obtaining a specimen presents difficulties in the hospital ward let alone in general practice, so that this information usually has to await sigmoidoscopy. Nevertheless, a careful history may indicate that the patient is not describing the stools accurately, and a referral may be avoided.

Chronic constipation is usually unrewarding to manage. If the patient continues to complain about the symptom the general practitioner's best move is to order a barium enema. This will exclude organic obstruction and megacolon; a normal study also indicates that routine referral to hospital will be unlikely to help the patient.

Persisting gastroenteritis

". . . caught the local bug while on holiday in Majorca. Diarrhoea has persisted for three months in spite of courses of antibiotics."

This usually turns out to be the postinfective irritable bowel syndrome. The acute episode of diarrhoea and vomiting settles but is replaced by intermittent loose stools and abdominal pain. The GP can help by culturing the stool, treating the irritable bowel, and avoiding antibiotics. Patients who fail to respond may then be referred. Occasionally ulcerative colitis may present in this way, but there will be blood in the motions. Conversely, carriers of *Salmonella* may present with an irritable bowel (or even inflammatory bowel disease); they will need to have investigations performed in hospital to sort out the symptoms.

Recurrent acute abdomen

". . . has been having intermittent attacks of abdominal pain. My partner was called out last night. . . ."

These symptoms are a nuisance to both patient and doctor. Gall stones and relapsing pancreatitis need to be excluded. Examination and investigation in the outpatients department, however, may show nothing abnormal. Thus the patient should be admitted to hospital as an emergency when the next *severe* attack develops. This allows another examination to be made under ideal circumstances, and appropriate investigations may be performed at the time when they are most likely to yield answers. Patients with acute abdominal pain, however, should not be referred for endoscopy because it is rarely helpful. Hospital admission during an attack will also give a strong suggestion of any underlying functional-psychological disturbance.

Jaundice

"This patient had an attack of hepatitis six weeks ago but is still jaundiced."

Old-fashioned teaching used to encourage the general practitioner to leave his jaundiced patients alone to see whether they would improve; those still jaundiced after a certain time limit required laparotomy. With modern techniques this is no longer tenable. The results of liver function tests remain as unreliable as ever but can be supplemented by ultrasound, percutaneous transhepatic cholangiography, endoscopic retrograde cholangiopancreatography (ERCP), computed tomography, and liver biopsy. Investigation may be started immediately. Unfortunately, none of the tests is entirely reliable, and some cynics say that by the time they have all been completed and contradictory results sifted it is time for laparotomy anyway.

Cholecystography may soon be replaced by ultrasound for the diagnosis of gall stones. Similarly, isotope techniques, such as the HIDA scan, may be the best indication of acute cholecystitis. Thus patients with acute gall bladder problems may be best served by hospital admission not only to receive symptomatic treatment but also to expedite diagnosis and surgery.

Haematemesis and melaena

Most patients with haematemesis and melaena will be admitted to hospital in case the bleeding does not stop. The big disappointment is that endoscopy has not improved the crude mortality figures. This is because haematemesis is increasingly becoming a problem of elderly people and that surgical treatment has not been able to overcome associated complicating diseases. Direct attack on bleeding vessels using endoscopy with various forms of cautery is not yet possible at the district general hospital. Bleeding oesophageal varices, however, may now be injected by using techniques similar to those used for sclerosing varicose veins.

Bleeding from the rectum

Most patients who bleed from the rectum have a local lesion at the anorectal margin. They therefore require proctoscopy and sigmoidoscopy. If there are no associated symptoms they are probably best referred to surgical outpatient departments. Referral to a medical clinic invariably results in a longer wait, a longer consultation, and a more comprehensive examination than is really necessary.

Patients with obvious blood loss do not need to have their faeces tested for occult blood. This is an investigation that is well suited to general practice, however. Unfortunately, it is of dubious value for the routine screening for carcinoma of the colon. It comes into its own in patients with iron-deficiency anaemia; a positive test result indicates that a lesion is likely to be found in the gastrointestinal tract.

Conclusion

"She has a low tolerance of minor abdominal symptoms and is demanding a second opinion."

This is a valid reason for referral, and it is helpful to have it stated clearly. There is a vast number of people with gastrointestinal symptoms in the population at large, and most of the symptoms are functional. Gastroenterologists have a wide and growing range of techniques to investigate them, but most techniques will be inappropriate. The potential work load is enormous, but luckily most patients can be managed by commonsense treatment once a careful history has been taken.

New Idea

Recording symptoms and family relationships: a proposal

PETER R WILLIAMS

The value of good medical records has often been stressed,[1] yet in general practice notes are often poor and there is a sense of frustration and guilt about them.[2] The recent series of articles in the *British Medical Journal* on medical records written by general practitioners describes the attempts of a few to improve their records. I would like to add my own attempt to theirs.

In a recent report on the Mental Health Foundation conference on psychological problems[3] wide differences were noted in the way doctors described and reacted to a video recording in which a woman had gone to her general practitioner saying that she was "depressed." The situation was a familiar one and the findings not unexpected. For me it had implications about how we record consultations in the surgery. Although my training in conducting a consultation in general practice has emphasised listening and observing over recording what I hear and see, I am tempted to reconsider the importance of recording during the interview.

In general practice the constraint of time usually means that writing in the notes is relegated to a brief period at the end of the consultation between the departure of one patient and the arrival of the next. Much of what is said is committed to memory and modified in the process. I would like to see recording brought back into the consultation—indeed, made an integral part of the contact between doctor and patient. To make medical records work better for us, and so enhance their value, means not only easier retrieval of information from the patient's folder but a new approach to what we write. Would it not be better for our records to reflect not diagnostic dilemmas of our own making but the problems articulated by patients and some plan of management against which to test our ideas? As Dr Anthony Clare was reported as saying: it is in the "grey" area of patient's psychological problems that diagnosis and management often seem unrelated to each other, doctors often treating without making a formal diagnosis.

It has been my experience, and that of many of my colleagues, that statements made by the patient recorded at the time they were made and unaltered by our memory or interpretation of them can often be helpful on subsequent occasions in dealing with the same problem, which sometimes presents under a different guise. Moreover, to commit to ink a plan of management can both focus the mind on what one is trying to do and be a statement against which it is possible to judge one's achievements—audit in the truest sense.

The family therapy movement encourages therapists to look on patients' symptoms as metaphors for the relationship. The implication for the general practitioner is that he should often look for the communicating function of symptoms in the family of which that patient is a part. If we are to think in these terms we need some device for recording relationships. Dr Luke Zander[4] drew attention to the lack of adequate recording of family and social history in the records of general practitioners and suggested a diagram of a family tree that was easy to construct and could be assimilated at a glance. There is, however, no simple notation to help us record the quality of relationships between family members. As we cannot quantify such things the tendency is to ignore, and yet many symptoms can only be properly understood in the context of the family and the impact that they have on relationships in that household.

In an attempt to introduce into medical recording some

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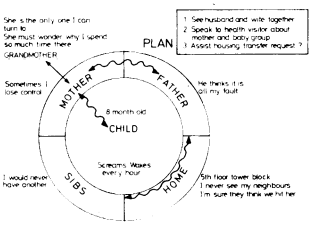
description of the link between symptoms and family relationships I have found the accompanying diagram of value.[5] Within the family circle, which places the child at the centre, are spaces against which the comments of family members can be recorded verbatim during the consultation. Lines are drawn between family members which signify tension (wavy lines) or support (straight lines) within the relationship. The home, as a unifying or disruptive influence on the health of the family, is also described. Different family structures require modification of the basic model, which in the example given shows a family in which there are several disruptive influences at work, the child's sleep problem being the one presented to the doctor. The stamp that is used to record the family circle in the notes includes the word PLAN, which encourages the doctor to think about the aims of treatment and write them down.



I believe that such a device can help general practitioners to think more clearly about problems whose impact is felt throughout the family. It is a form of classification in itself and attempts to bring together a better understanding and management of the patient's problems. The recording is usually done with the patient in the room and the diagram constructed from the patient's own comments to give a dynamic model of the family, which includes some notion of the emotional climate in the home and the part played by symptoms in this.

Our records should serve as a tool in our understanding and management of patients' problems. Records are not immutable, or an end in themselves, but should be a means of revising our notions about people and by which we judge our interventions. For too long what we write has lagged behind our understanding of the problems we encounter in the surgery. I do not believe Lord Taylor's aphorism: "A doctor's practice is only as good as his records,"[6] but I would like to see the day when our records can be used to judge our work.

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ONE HUNDRED YEARS AGO The birth of a baby-elephant and the importation of jumbos have greatly excited popular interest in America. Taking advantage of this, the *Journal of Comparative Medicine* has published an article upon the breeding of elephants, as well as an editorial note upon the diseases of this animal. The subject of elephant-breeding is treated by Mr Arstingstall, Barnum's trainer, who was present at the birth of the only two elephants ever born in the United States. The elephant, he says, rarely breeds in captivity, largely because he is kept on a low diet. If properly fed, the male and female can hardly be prevented from copulating. The evidences of heat are a slight swelling and congestion of the vulva. The period of pregnancy is between twenty and twenty-one months. Within three months, the mammary glands begin to swell, and by the end of pregnancy they are as large as those of a cow. An elephant may conceive when it is only fifteen years old. In that case, it will often grow very rapidly during pregnancy. The elephant, "Queen," which gave birth to a "baby" at Bridgeport in the spring, exhibited no signs of disturbance up to a few hours before the act of parturition. There was then some uneasiness, and the animal was isolated and chained. The infant was delivered rapidly, and without any apparent suffering on the part of the mother, who stood with the posterior extremities somewhat separated. The foetus came out head and feet foremost, enclosed in its membranes. As soon as it was dropped, the mother crossed the hind legs, and by rubbing them together severed the cord. Her subsequent proceeding showed a remarkable instinctive sagacity. The little one lay quietly in its sac—not breathing, and apparently lifeless. The mother, as soon as the cord was broken, turned around, and with one of her fore-feet struck the membranous sac quite forcibly. It broke with a loud report (so says the trainer). After rupturing the membranes, she placed her foot on the thorax and pressed it with the appearance of much force, raised it, and pressed it again, until the baby began to breath and show signs of life. The elephant mother appeared to understand the principles of Sylvester's method as well as if she had taken a course at the First-Aid-to-the-Injured Society. The placenta was delivered in about two hours, the animal suffering considerably meanwhile. Five hours after birth, the baby was able to stand on its feet. It walked to its mother, turned its trunk over its head, and began to nurse. Some facts are given editorially regarding the diseases of elephants. The more prominent affections are meningitis and apoplexy, vomiting, colic, and enteritis, haematuria, tetanus, pneumonia, foot-and-mouth disease, and anthrax. A work on the diseases of elephants is being written. (*British Medical Journal*, 1882.)

Care of weekly boarders

Over the past 20 years there have been considerable changes in the pattern of education, with an appreciable increase in the number of weekly boarders. The boarding schools have continued to expect all boarders to be registered with their school doctor. This concurs absolutely with the National Health Service policy for boarders living *predominantly* at the school—that is, full-time boarders. This is *not* the case with weekly boarders. Weekly boarders spend more than 200 days out of 365 in the care of their own families. Furthermore, they are never far away from their own home for more than three months. For these reasons the correct NHS procedure would be for weekly (not full-time) boarders to remain registered with their home doctor. They would be seen as "temporary residents" at school should this be necessary. The family practitioner services confirmed that the normal NHS rules apply and that there is no special right by which schools can dictate a requirement for pupils to change their doctor.

My concern in this connection is for the long-term care of pupils and their families. Parents bring their children to their family doctor in holidays and weekends, for instance, to deal with emotional and long-term problems. With the best will in the world it would not be possible for the same continuity to be maintained between child, parents, and school doctor. On questioning parents of boarders, the impression from most has been that the schools wanted their children's medical cards for the NHS number and were not aware that their children had become registered with another doctor. I would be interested to know of other doctors' views on this, as I feel that it should be clarified on a national basis. (My own daughter's case has been satisfactorily sorted out.)—R T J HAWKINS, general practitioner, Helston, Cornwall.