Primary Care Evaluation and Management of Gastroenterologic Issues in Women

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KEYWORDS

• Colorectal cancer • Irritable bowel syndrome • Peptic ulcer disease
• Gallbladder disorders • Inflammatory bowel disease • Gastroesophageal reflux
• Barrett's esophagus

KEY POINTS

- Colorectal cancer is the third most common malignancy among women and colonoscopy is the screening test of choice.
- Irritable bowel syndrome is a diagnosis of exclusion, for which dietary and lifestyle modifications are first-line therapies.
- *Helicobacter pylori* infection and nonsteroidal anti-inflammatory drugs *are* the primary risk factors for peptic ulcer disease; eradication of *H pylori* and proton pump inhibitors are the cornerstones of therapy.
- Inflammatory bowel diseases, classified as Crohn's disease or ulcerative colitis, are increasing in incidence with increased sophistication of medical therapy.
- Gastroesophageal reflux typically responds to antisecretory therapies; further testing is required when disease complications are suspected, patients fail therapy, or the diagnosis must be confirmed.

INTRODUCTION

Gastrointestinal disorders commonly present to the primary care setting where initial preventive, diagnostic, and treatment strategies are implemented. Both gastrointestinal and liver diseases result in heavy economic and social costs in the United States.[1] Therefore, focusing on the initial presentations and appropriate management of common gastrointestinal disorders has the ability to curtail unnecessary costs in diagnosis

The authors have nothing to disclose.

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Obstet Gynecol Clin N Am 43 (2016) 347–366
http://dx.doi.org/10.1016/j.ogc.2016.01.006 **obgyn.theclinics.com**
0889-8545/16/$ – see front matter

and treatment strategies. In this review, we describe the presentation, diagnosis, and management of common gastrointestinal disorders with a focus on the evaluation and management of gastrointestinal disorders in women.

COLORECTAL CANCER

Colorectal cancer (CRC) is the third most common cancer as well as the third leading cause of cancer-related deaths among women and men. The estimated lifetime risk of developing CRC is 4.7%, although the incidence has been decreasing at a rate of approximately 3% per year from 2002 to 2011, likely as a result of greater adherence to screening recommendations. In the United States, the median age of diagnosis is 68 with a precipitous increase in cases after age 50.[2]

Clinical evaluation of patients in a primary care setting should include a risk assessment for CRC based on a detailed history and physical examination. Family history is integral because patients with first-degree relatives with CRC or advanced adenomas should be screened at an earlier age and potentially at more frequent intervals, depending on the relative's age of diagnosis. Signs and symptoms that should warrant diagnostic endoscopic evaluation include the development of iron deficiency anemia, hematochezia or rectal bleeding, and weight loss or changes in bowel habits, although primary prevention with screening is the key to reducing morbidity and mortality from CRC.

Current Screening Modalities and Guidelines

The evolving landscape of CRC screening tools over the last 2 decades can make the decision of how and when to screen patients daunting for providers. Available screening modalities are stratified into either "cancer detection" or "cancer prevention" tests.[3] Cancer detection tests include stool-based testing such as high sensitivity guaiac-based fecal occult blood test, fecal immunochemical test (FIT), and multitarget fecal DNA testing. These tests have a low sensitivity for polyps and an even lower sensitivity for malignancy as compared with cancer prevention tests, which are able to detect both premalignant as well as malignant lesions, with the preferred modality being colonoscopy. Alternative cancer detection tests include flexible sigmoidoscopy, colonoscopy, computed tomography, colonography, and double contrast barium enema. Physicians should discuss the risks, benefits, and limitations of each test with patients, taking into account their individual clinical picture including age and comorbidities. Screening recommendations are summarized in **Table 1**.

The United States Preventive Services Task Force recommends initiation of CRC screening at age 50 in patients who are average risk for CRC. Recent studies have sought to compare the efficacy of cancer prevention to cancer detection tests in detecting CRC. When the stool-based FIT was compared with colonoscopy, it was found that more advanced adenomas were detected via colonoscopy than with FIT (1.9% vs 0.9%). The difference in the rate of detection of nonadvanced adenomas was more pronounced, at 4.2% via colonoscopy versus 0.4% via FIT testing, whereas the rate of CRC at 10 years was similar in both groups at 0.1%.[4] However, the higher detection rate and diagnostic yield of colonoscopy with respect to premalignant lesions is important to note because advanced adenomas are often considered a surrogate marker for CRC. Therefore, colonoscopy is preferred because it may not only reduce the rate of death from CRC, but also the incidence of disease.