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'I've been bleeding from the bowel'

Background

Much undifferentiated illness is seen in general practice. Patients with a vague feeling of general unwellness may have multiple unrelated problems, serious underlying pathology, definite but indefinable pathology, and/or illness of psychological origin.

Objective

This article looks at an approach to a patient who complains of tiredness but also has the 'red flag' symptom of 'bleeding from the bowel'.

Discussion

Awareness of individual emotional and contextual issues is crucial to achieving a successful outcome. Careful history, examination and investigation are essential. Spreading assessment and management over several consultations can help achieve this. Organising principles such as Murtagh's safe diagnostic strategy and the BATHE framework can help guide clinical thinking.

Case study

Serge, 57 years of age, is a corporate manager in a major bank. He lives in suburban Sydney with his wife June and three daughters. You often see the rest of the family but Serge himself attends rarely. The first thing you notice is that Serge is quite overweight. The chair creaks as he eases his bulky frame into it.

Serge begins with the following statement: 'I wanted to see you because I just feel exhausted all the time. I have no energy at work and feel completely bugged by the end of the day. Then when I try to sleep I just keep waking up all the time and the next day have to drag myself to work again. And I'm having some trouble with my bowels. I think I'm a bit constipated'.

As an afterthought he adds: 'Oh, and June told me to mention... I've had some bleeding from the bowel'.

■ **Serge presents with tiredness, constipation and rectal bleeding. All of these symptoms may be indicators of very serious disease. However, as the cluster of symptoms described provides very little specificity, the list of possible diagnoses is extensive. Significant rectal bleeding or malignancy can cause tiredness. Some causes of tiredness (eg. hypercalcaemia) can cause constipation leading to rectal bleeding. Stress and psychological distress can cause tiredness and poor fluid and fibre intake leading to constipation and rectal bleeding. And at this stage we don't know whether the symptoms are causally related at all.**

Tiredness is common in general practice, and has an estimated prevalence of 10–40%, with about 6% of patients presenting initially for that reason.^{1–3} Around 70% of patients complaining of tiredness have a concurrent psychological disorder and a diagnosis of depression is common.⁴ However, only about half of the time do patients attribute their tiredness to psychological causes.^{2,5,6} In Serge, obstructive sleep apnoea needs to be considered. It has a prevalence of 2–4% in middle aged men.⁷

Approach to vague presentations

Vague presentations are challenging. A balance must be maintained between using all the available information and maintaining clarity and perspective. Patient body and verbal language provide important initial clues to what is important to the patient.

- How did this patient look as he walked through my door?
- Did I listen actively and hear the symptoms in the patient's own words?

Further history

Lists of causes of tiredness and constipation are shown in *Table 1* and *2*.⁸ Notably, there is some overlap between the two lists. The following priorities in history taking will help narrow Serge's presentation down.



History of presenting complaints

- Open questions to allow Serge to raise any bizarre symptoms which may be pathognomonic of unusual causes. What does Serge actually mean by tiredness?
- An assessment of duration and progression of symptoms
- Historical features of the rectal bleeding including colour and amount of blood, associated anal symptoms and relationship of blood to faeces.

Some studies estimate that one in 50 patients presenting to general practice with rectal bleeding have bowel cancer.⁹ This rises to about one in 10 if the patient has a change in bowel habit or does not have anal symptoms suggesting haemorrhoids or fissure.¹⁰

Lifestyle factors

An assessment of Serge's alcohol intake, diet, physical activity and smoking status is necessary. Any major stressors in home and work life need exploration. What is his sexual function?

Psychological

Moving the patient into the emotional and psychological domain in a way that is acceptable can be challenging. My personal strategy is to say: 'You know the commonest cause of tiredness in general practice patients is depression. Do you think you could be depressed?'

Some other tools for moving into this area are the BATHE framework¹¹ (Table 3). Asking the patient what they think is causing the problem or whether they are afraid of anything in particular can also be revealing. Other models have been proposed.^{12,13}

Time management

Time management requires consideration. The time needed to fully assess Serge will be longer than a standard 15 minute consultation. The waiting room may be starting to fill up before you even get to the investigation and management phases of the consultation. It may be necessary to explain this to Serge and spread assessment and management over several consultations in order to cover all aspects.

Physical examination

An appropriate physical examination of Serge would include: pulse, blood pressure (BP), temperature, weight/height, urinalysis, cardiovascular respiratory, and abdominal and digital rectal examination.

Case study continued

Serge's tiredness has been present for about 3 months. He feels lethargic and lacks energy. There are no cardiac symptoms. Serge is short of breath going up stairs consistent with a lack of fitness. He complains of increased day time somnolence and he is a loud snorer at night. Serge works long hours and frequently eats out for work. He regularly wakes in the middle of the night worrying and wakes early feeling very low. He has lost

enjoyment in work over the past year.

Serge has always had a tendency toward constipation but this has been worse over the past couple of years. He opens his bowels every 1–2 days and tends to produce a hard, pelleted stool. Last Wednesday, there was blood on the toilet paper and quite a bit in the pan, but not on the stool and not mixed in. A similar thing happened last year. It is now painful to pass stools. There is no cold intolerance.

Serge admits he could be depressed. He complains of a low mood and is under a lot of pressure at work with the recent downturn in the financial services industry. He feels stymied in his career, is not getting on with the boss and now realises his long hours have put him out of touch with his teenage daughters. He consumes 3–4 standard drinks per night and does very little exercise.

When you ask him what he thinks is wrong he tells you he's frightened he has bowel cancer like his older brother.

System review reveals normal erections with low libido and no other significant findings.

Examination reveals:

- pulse 84 BP 155/90 afebrile, urinalysis negative
- body mass index, 31
- cardiovascular system otherwise normal
- respiratory system otherwise normal
- abdomen obese
- rectal examination: anal fissure seen with sentinel tag; cannot tolerate further rectal examination due to fissure.

Table 1. Causes of tiredness⁸

- Psychogenic
 - psychiatric
 - lifestyle
- Organic
 - cardiac, eg. heart failure
 - haematological, eg. anaemia
 - malignancy
 - infections, eg. human immune deficiency (HIV), chronic infections
 - endocrine, eg. thyroid, adrenal, hyperparathyroidism, diabetes
 - nutritional
 - kidney failure
 - hepatic, eg. chronic liver failure, chronic active hepatitis
 - respiratory, eg. asthma, chronic obstructive pulmonary disease (COPD)
 - neuromuscular, eg. multiple sclerosis, myasthenia gravis, parkinson disease
 - metabolic, eg. hypokalaemia, hypomagnesaemia
 - drug related, eg. toxicity, addiction, side effects
 - autoimmune disorders
 - sleep disorders
 - postinfectious, eg. mononucleosis, influenza
- Unknown
 - fibromyalgia
 - chronic fatigue syndrome (CFS)

Table 2. Causes of constipation⁸

- Psychogenic, eg. depression, anorexia nervosa
- Neurological disease, eg. cerebrovascular accident (CVA), autonomic neuropathy
- Drugs
- Endocrine/metabolic, eg. hypothyroidism, hypercalcaemia
- Idiopathic, eg. simple constipation (low fibre, low exercise), slow transit, irritable bowel syndrome (IBS)
- Organic disease of large bowel, eg:
 - carcinoma of the colon
 - inflammatory bowel disease
 - impaction
 - anorectal disorders (eg. carcinoma, fissure, haemorrhoids)
 - others (eg. a dynamic bowel, connective tissue disorders)

What next?

Serge has presented in part through fear of bowel cancer. His tiredness is likely to be due to psychological distress, perhaps related to his work and loss of life meaning. Many of the psychological disorders found in fatigued general practice patients do not neatly fit into disease classifications.⁴ His symptoms also relate to his generally unhealthy lifestyle. When faced with a vague and complicated set of facts diagnostic strategies can help.⁸ Murtagh's safe diagnostic strategy (*Table 4*)⁸ is particularly helpful as a way to pull things together and focus into a plan for investigation and management.

What are the probability diagnoses?

- Psychological distress
- Sleep disorder
- Simple constipation with anal fissure.

What serious disorders should I look out for?

- Major depression
- Serious causes of constipation and rectal bleeding such as cancer.

Table 3. The BATHE framework¹¹

Background: 'What is going on in your life?' ascertains the context of the visit. If the patient has already discussed this, go directly to 'affect'

Affect: 'How do you feel about that?' elicits the patient's emotional response. It is therapeutic for the patient to label feeling(s)

Trouble: 'What troubles you the most about this?' gets at the symbolic meaning of the situation for the patient

Handling: 'How are you handling that?' helps to assess the patient's resources and responses to the situation

Empathy: 'That must be very difficult for you' reflects an understanding that the patient's response is reasonable under the circumstances

Table 4. Murtagh's safe diagnostic strategy⁸

1. What is the probability diagnosis?
2. What serious disorders must not be missed?
3. What conditions are often missed (the pitfalls)?
4. Could this patient have one of the masquerades of medical practice (depression, diabetes, drugs, anaemia, thyroid and other endocrine, spinal dysfunction, UTI)?
5. Is this patient trying to tell me something else?

What conditions are often missed?

- Other causes of depression and constipation such as endocrine disorders (hypothyroidism, hyperparathyroidism, diabetes, Addison disease)
- Metabolic and nutritional disorders
- Substance abuse.

Could it be a masquerade?

- All of the masquerades are possible and must be excluded, although spinal dysfunction and urinary tract infection (UTI) seem less likely.

Is the patient trying to tell me something?

- Almost certainly this patient is telling me something about his happiness and lifestyle.

Investigations and initial management

You explain to Serge that you suspect his tiredness is due to a mixture of lifestyle factors, which are making him depressed and unwell. However, you emphasise that it is essential to exclude a number of potentially serious conditions and you would like to organise some tests.

Serge agrees to provide some blood for tests including full blood count (FBC), electrolytes and creatine (UEC), liver function tests (LFTs), fasting lipids and blood sugar level (BSL), thyroid function tests (TFTs), iron studies, B12 and red cell folate, calcium and phosphate. You also refer him for colonoscopy in view of the family history, rectal bleeding and constipation.

In the meantime you suggest some changes to his diet and that he start walking for half an hour a day. You suggest a fibre supplement, more fresh fruit and vegetables and more water to keep his stools soft. You recommend topical glyceryl trinitrate cream to treat the anal fissure.

Next you explain that you would like to defer discussion of alcohol intake, BP, specific approaches to his psychological distress and referral for sleep study until you have more time and the results necessary to calculate his absolute cardiovascular risk. You organise a double appointment the following week.

Case study continued

Investigation results reveal: cholesterol 6.3, HDL 0.9, and all other blood tests normal. At colonoscopy two polyps are removed and examination is otherwise normal.



Further management

Now that the feared diagnosis of cancer has been excluded there is space and possibility to motivate Serge to address his lifestyle. Since seeing you he has started walking at lunch time and is including more fresh fruit and vegetables in his diet. His anal pain is improving with the glyceryl trinitrate cream. You congratulate him and use this presentation to motivate him to institute behaviour change. There are a number of issues that can usefully be addressed with Serge.

- Constipation – this will initially be addressed through diet and exercise
- Cardiovascular risk – assessment and management according to the Heart Foundation's 2008 hypertension guideline¹⁴
- Lifestyle changes will help with his lipid disorder
- Depression/anxiety – Serge is already feeling a bit better since seeing you last week and making some changes in his life. You will need to follow up with him over the next few weeks to assess whether his psychological distress is persisting and significant
- He may benefit from referral to a psychologist under the Medicare Better Access to Mental Health scheme for a brief intervention to help him with problem solving with regard to his work and life direction. He may benefit from cognitive behavioural therapy
- Sleep apnoea – Serge requires referral for a sleep study
- Engagement – you are seeing a middle aged working man: a group that tends to see doctors less often. This is an opportunity to build a relationship that will accommodate ongoing preventive care. Use of the recall system in the medical software can help with this.

Case study continued

Serge does prove to have significant obstructive sleep apnoea. Treatment with continuous positive airway pressure results in significant improvement in his energy levels, hypertension and depression.

Serge initially makes large changes in his lifestyle: losing 7 kg, increasing his exercise, decreasing his alcohol intake and improving his diet. He stops attending after a few months but returns 12 months later when you send him a recall to repeat his lipids. They are much the same as he has been unable to maintain the lifestyle changes you recommended. You see him regularly for a few weeks and discuss his continued sense of loss of enjoyment of life and inability to make changes. Eventually you agree that some sessions with a psychologist may help him and refer him under the Medicare Better Access to Mental Health scheme.

Discussion

Serge's vague presentation turned out to be due to multiple common lifestyle related problems. Any one of his symptoms could have been caused by serious disease. Cognisance of the emotional and contextual issues is crucial to achieving a successful outcome. Careful history, examination and investigation remain the essential foundations to satisfactory management. Spreading assessment

and management over several consultations can help achieve this. Organising principles such as Murtagh's safe diagnostic strategy⁹ and the BATHE framework¹¹ can help guide our thinking.

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