PRIMARY CARE DIAGNOSTIC PATHWAY FOR LOWER GASTROINTESTINAL (GI) SYMPTOMS IN CHILDREN AND YOUNG PEOPLE (NOT FOR ACUTELY UNWELL PATIENTS).

FOR USE BY PRIMARY CARE TEAMS. APRIL 2024.

Click the pointer for hyperlinks

COMMON SYMPTOMS OF LOWER GI CONDITIONS

- Change in bowel habit; diarrhoea, constipation, frequent bowel movements, straining, urgency, incomplete evacuation
- Abdominal pain, cramping or bloating, excessive wind
- Poor growth, delayed puberty
- History of weight loss
- Mucus in stools/fatty stools

Symptoms may also include:

- Rectal bleeding
- 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, infection causing gastroenteritis, diet, menstrual history, medication history (e.g. antibiotics).

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

The main forms of IBD are Crohn's Disease and Ulcerative Colitis.

COULD IT BE INFLAMMATORY BOWEL DISEASE (IBD)?

IBD in children often presents with one or more of diarrhoea, abdominal pain, rectal bleeding or weight loss but may also present with other common symptoms in the box above. Uncommon in pre-school children. Incidence rises with age. Family history increases the risk.

POTENTIAL DISTINGUISHING SYMPTOMS:

Pallor, perianal disease/ano-rectal pain, nocturnal defaecation, fevers, extra intestinal manifestations in joints, skin or eyes.

COULD IT BE COELIAC DISEASE?

Coeliac disease can present in non specific ways, including the common symptoms in the box above. More likely if family history (first degree relative 1 in 10 risk), with Down's/ Turner syndromes or if a history of autoimmune conditions e.g. type 1 diabetes, thyroid disease. Associated with iron deficiency anaemia or B12 or folate deficiency.

POTENTIAL DISTINGUISHING SYMPTOMS:

Pallor, tooth enamel problems. Neurological problems such as ataxia or peripheral neuropathy.

COULD IT BE ANOTHER GI CONDITION?

Consider functional GI symptoms (e.g. functional abdominal pain/diarrhoea/ Irritable Bowel Syndrome), food intolerances/ allergies or constipation/overflow diarrhoea.

Based on history and clinical examination, consider which of the primary care lower GI investigations to request for the child/young person.

POSSIBLE PRIMARY CARE LOWER GI INVESTIGATIONS

BASELINE BLOOD TESTS:

- **Full Blood Count and Ferritin:** looking for signs of anaemia or infection or systemic inflammation.
- **C-reactive protein:** tests for inflammation and autoimmune disease.
- **Coeliac screen:** the child/young person should not eliminate or reduce gluten from diet.
- **Thyroid Function Tests:** to identify thyroid dysfunction.
- **Renal and Liver Function Tests** including albumin.

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:** to support diagnosis or exclusion of IBD, request according to local pathway guidance.

To avoid the child/young person making multiple trips aim to do all necessary tests at the same time.

Faecal calprotectin levels vary depending on age. Avoid use in children under 4 years unless strongly indicated.

- Coeliac screen positive. REFER to secondary care/paediatric gastroenterology. If secondary care/paediatric gastroenterology 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 child/young person to take gluten in their diet until secondary care/paediatric gastroenterology confirms diagnosis to avoid false negative.

- Faecal calprotectin result abnormal for your reference range and significant clinical concern. REFER to secondary care/paediatric gastroenterology. If no significant clinical concern consider repeating to exclude a false positive result.
- Faecal calprotectin in the normal range, see pink dotted border box below and SAFETY NETTING.

Thresholds for faecal calprotectin tests may vary and should be based on local assays and audit data.

- If Coeliac disease and IBD have been considered, think, *could it be another GI condition?* (see box on page 1). If appropriate, treat in primary care with SAFETY NETTING.

SAFETY NETTING

Referrals should be based on clinical need. Do not delay referral unnecessarily.

- Consider severity of the child/young person's symptoms - urgent referral to secondary care may still be needed
- If symptoms persist or symptoms change – reassess (even if negative tests) and consider referral
- Consider the possibility of:
  - another uncommon lower GI condition – if concerned refer
  - false negative Coeliac serology – too little gluten in child's/young person's diet, IgA deficiency (test for total IgA and IgG based serology)

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

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