Canterbury
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Te Poari Hauora ō Waitaha

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9(2)(a) [redacted]

RE Official information request CDHB 10787

We refer to your email dated 23 November 2021 to the Ministry of Health which they subsequently transferred to us today requesting the following information under the Official Information Act from Canterbury DHB. Specifically:

1. "What are the official Guidelines/procedures for urgent X-rays (24 hour)"

Urgent x-rays are triaged on clinical assessment for an individual patient. 'Immediate' and within '4 hours' are the highest priority for acutely unwell inpatient and outpatient cases, then Urgent (within 24 hours).

2. "What are the Guidelines/procedures for patients repeatedly admitted to Emergency Department with severe epigastric pain/ and upper right and left quadrant pain"

Repeated presentations for a similar clinical condition are assessed at each presentation. Community HealthPathways and Hospital HealthPathways are used to guide clinical staff with investigation and diagnosis along with guidance on referral pathways to specialist clinical services when required. The relevant pathways are shown in **Appendix 1**.

3. "Guidelines/procedure for investigating possible Colonic Motility Dysfunction/Defecatory Disorders/Anorectal Dysfunction"

Patients with lower colonic disorders will initially be managed by their primary care provider using Community HealthPathways. These are part of a series of clinical and referral guidelines that is outlined electronically and is available to clinicians on the Canterbury DHB HealthPathways system. Access to this system is limited to health professionals working within the Canterbury DHB Health System. The information in these pathways supports clinicians to prescribe, refer and monitor health requests and treatment according to agreed ways of working in the Canterbury DHB.

I trust that this satisfies your interest in this matter.

Please note that this response, or an edited version of this response, may be published on the Canterbury DHB website.

Yours sincerely

Ralph La Salle
Senior Manager, OIAs
Canterbury DHB and West Coast DHB

Community HealthPathways

Appendix 1

Haemorrhoids

Assessment

1. History – Ask about:
    - perianal discomfort, pruritus, and a mucous discharge.
    - an intermittent or persistent palpable lump after defecation.
    - the nature and extent of any outlet rectal bleeding.
    - pain. If present, consider a strangulated internal haemorrhoid or acute external anal haematoma.
    - constipation or frequent defecation.
    - spending a long time on the toilet.
    - heavy lifting.
    - chronic cough.
2. Examination:
    - Visually inspect the anal area, looking for lumps, skin tags, or fissures.
    - Perform:
        - digital rectal examination, checking for palpable internal lumps or evidence of bleeding.
        - proctoscopy, which provides much more information than a digital rectal examination alone.
3. Record the location (3, 7, or 11 o'clock), and type of haemorrhoid.
4. Differentiate haemorrhoids from an external anal haematoma.
5. If bleeding is suggestive of a sinister cause, see Colorectal Symptoms.

Management

1. If bleeding is suggestive of a sinister cause, see Colorectal Symptoms for referral options.
2. Advise simple measures to help relieve symptoms and prevent recurrence.
3. If constipated, consider stool softeners or bulk-forming laxatives.
4. Treat discomfort with local preparations for haemorrhoids:
    - Soothing haemorrhoidal preparations
    - Compound haemorrhoidal preparations
5. If the above treatments fail to settle the symptoms, consider referral for procedural or surgical management:
    - If small bleeding internal haemorrhoids (grade 1), injection sclerotherapy may be used.
    - If large internal haemorrhoids that are prolapsing but able to be returned either spontaneously or digitally (grade 2 or 3), rubber band ligation may be used.
    - If large prolapsing internal haemorrhoids (grade 4), especially if strangulated or associated with large external haemorrhoids and skin tags, haemorrhoidectomy (surgical excision) is usually required.
    - If severely tender and thrombosed external anal haematoma, consider incising in general practice with a scalpel blade without local anaesthetic. Otherwise, reassure the patient and recommend they use ice packs, local anaesthetic gel, analgesia, or stool softeners, and advise against heavy lifting, or straining while passing stools.

Request

- If gastrointestinal bleeding is severe, consider acute general surgery assessment.

- The Department of General Surgery does not usually accept requests for non-acute surgical assessment for haemorrhoids.
- Other options for assessment may include:
  - Canterbury Charity Hospital
  - Private referral.

Constipation in Adults

Red flags

- Unintentional weight loss
- Abdominal mass
- Iron deficient anaemia
- Blood in or with stool
- Palpable or visible rectal mass

Background

About constipation

Assessment

1. Take a history:
    - Whether the patient has constipation
    - Frequency and consistency of motions, presence of alternating diarrhoea
    - Blood, lumps, pain, soiling of underwear
    - Whether the patient is taking any:
        - medications that can cause constipation
        - medications to treat constipation
        - complementary treatments for constipation
2. Assess for red flags and consider secondary causes, e.g. hypothyroidism, diabetes.
3. Ask about social and psychological well-being, exercise, and activity levels.
4. Measure height and weight, calculate body mass index (BMI), and check for unintentional weight loss.
5. Examine abdomen and rectum. Consider bimanual pelvic examination. Listen for bowel sounds.
6. Investigations:
    - Plain abdominal X-rays are generally not useful in the diagnosis of chronic constipation.
    - Blood tests are only required if looking for a secondary cause, e.g. hypothyroidism.
    - Further investigations, including colonoscopy or CT colonography, may also be indicated depending on likely differential diagnosis.

Management

1. If red flags are present, consider referral according to the Colorectal Symptoms pathway.
2. Patient education is important to prevent laxative dependence.
    - Avoid medications that can cause constipation.
    - Advise about simple measures to relieve and prevent recurrence of constipation.
3. Medications:
    - Provide the patient with information on medicines for constipation (adults).
    - A stepped approach is recommended:
        - Begin treatment with a single oral laxative, e.g. an osmotic or bulk-forming laxative if appropriate – a trial period is recommended to assess effectiveness and tolerability.

        - Increase the dose of the laxative if the patient has not responded sufficiently to treatment.
        - Consider switching laxatives if the patient is experiencing adverse effects or if treatment is ineffective.
        - A combination of laxatives may be necessary if monotherapy is insufficient.
        - Withdraw gradually.
    - Osmotic laxatives
    - Bulk-forming laxatives
    - If constipation is due to opiates, see the management of constipation associated with opioid use.
    - Other options include:
        - Stimulant laxatives
        - Stool-softening agents
4. If faecal impaction:
    - Consider faecal disimpaction with a warm water enema and lignocaine gel 2% for the rectum and anus, or consider suppositories or enemas:
        - glycerol suppositories
        - bisacodyl suppositories
        - sodium citrate (Micolette or Microlax) enema
        - phosphate enema – should usually be avoided in the elderly or those with chronic kidney disease as there have been cases of phosphate nephropathy and acute kidney injury, some of which have been fatal. However, if non-phosphate enema products are not available, phosphate enema may be used with precautions, including ensuring adequate hydration and minimising the number of doses used.
    - Consider oral macrogol 3350, two to three sachets per day, followed by bisacodyl or docusate sodium with senna.
5. Pregnancy
6. Acupuncture has been shown to be as effective as medical treatment in increasing bowel movements. [1]

Community HealthPathways

Appendix 1

Irritable Bowel Syndrome (IBS)

Red flags

- Older than 50 years at first presentation
- Family history of colon cancer or inflammatory bowel disease
- Rectal bleeding
- Unexplained iron deficiency anaemia
- Unintended weight loss

Background

About irritable bowel syndrome (IBS)

Assessment

1. Take a history of symptoms – a diagnosis of IBS is made on the variability of the symptoms, an absence of red flags, and the absence of nocturnal symptoms.
    - Look for any red flags.
    - Ask about a family history of coeliac disease or inflammatory bowel disease.
2. Assess the patient's diet and lifestyle:
    - Ask about the patient's usual diet and eating habits, or ask the patient to keep a seven-day food and symptom diary.
    - Ask about foods avoided.
    - Consider foods that could be causing symptoms (bearing in mind symptoms are usually delayed and relate to the amount eaten).
    - Identify lifestyle factors.
    - Consider psychological factors, e.g. anxiety, depression, and life stressors such as divorce, family illness, or financial difficulties.
3. Examine abdomen and rectum, and perform gynaecological examination (if appropriate).
4. Arrange investigations to exclude pathology: [1]
    - CBC, CRP, ferritin, tissue transglutaminase (tTG), thyroid function tests (TFT), electrolytes.
    - Arrange faeces testing only if diarrhoea and specific indications are present. [1] When testing, obtain a single faeces sample requesting tests as detailed in the infectious gastroenteritis testing guide.
    - Second-line: Faecal calprotectin if CRP negative and there is concern about possible inflammatory bowel disease (IBD). Consider first-line if family history of IBD.
5. Consider other possible diagnoses.
6. If IBS the most likely diagnosis, determine the IBS sub-type.

	Sub-type
	Diarrhoea predominant (IBS-D)
Loose stools	More than 25%
Hard/lumpy stools	Less than 25%
	Constipation predominant (IBS-C)
Loose stools	Less than 25%
Hard/lumpy stools	More than 25%
	IBS mixed bowel pattern (IBS-M)

Loose stools	More than 25%
Hard/lumpy stools	More than 25%

Sub-type	Loose stools	Hard/lumpy stools
Diarrhoea predominant (IBS-D)	More than 25%	Less than 25%
Constipation predominant (IBS-C)	Less than 25%	More than 25%
IBS mixed bowel pattern (IBS-M)	More than 25%	More than 25%

Management

1. If any red flags or concerns that the patient may have inflammatory bowel disease or colorectal cancer, request non-acute gastroenterology assessment. In the absence of any red flags, patients with IBS are unlikely to be seen in the public system.
2. Provide explanation and reassurance information on lifestyle, exercise, and diet.
3. Suggest healthy eating and lifestyle options:
    - First-line – Provide healthy eating and lifestyle education. Provide education tailored for the specific sub-type or symptoms:
        - Bloating and wind
        - Constipation
        - Diarrhoea
    - Second-line – if the patient meets the criteria for low FODMAP diet education, request dietitian services for adults, and give patients in Christchurch Group Education on the Low FODMAP Diet.
4. Consider complementary treatments for IBS:
    - Probiotics
    - Fermented foods
    - Peppermint oil
    - STW 5 (Iberogast)
    - Aloe vera juice – there is not enough evidence [4] to support the use of aloe vera to treat IBS symptoms.
5. If the patient regularly uses supplements, protein powders, and sports drinks that may contribute to IBS symptoms, suggest they avoid or limit these supplements and drinks for 4 weeks.
6. If the patient is physically inactive, consider a Green Prescription.
7. Address any psychosocial issues and manage stress. If stress or anxiety appear to be a major driver of symptoms, consider:
    - requesting brief intervention talking therapies.
    - private referral to a:
        - clinical psychologist for cognitive behaviour therapy (CBT), or
        - clinical hypnotherapist for gut-directed hypnotherapy (see New Zealand Association of Professional Hypnotherapists – Hypnotherapists in Your Area).
8. Prescribe medications if needed. Most patients do not need medication, but some require symptom-targeted medication.
    - Treat the most troublesome symptom:
        - Diarrhoea
        - Constipation
        - Abdominal pain and bloating
    - Consider antidepressants.
9. Regularly review to encourage self-management, look for red flags, and assess diet.