Case Study

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FIRST CONTACT Dietitian

Initial appointment

Referral

A patient contacted their GP surgery reporting a change in bowel habit. Reception booked the patient in with the First Contact Dietitian (FCD).

Presenting complaint

Increased frequency and loose stools.

Consultation

The FCD obtained a detailed history including medical, family, medication and symptoms. They assessed for any 'red flag' symptoms and completed relevant clinical examinations.

History of presenting complaint

The patient had noticed a change in bowel habits for the past 3 weeks. Their usual bowel pattern would be once every 2 days and they reported usually feeling more constipated. Now, the patient's bowels were opening up to 5 times a day and of a loose consistency. There had been no recent foreign travel, no blood noted in stools, no nocturnal symptoms and no unintentional weight loss. The patient also mentioned how they have suffered for a long time with bloating, abdominal discomfort and feeling lethargic. The patient had not noticed any links with symptoms and diet.

Past medical history

Previous anxiety and depression
Inflammatory arthritis

Medications

Citralopram 20mg OD
Lansoprazole 30mg OD
Zapain 30mg OD-BD
No known drug allergies

Family history

Mother has coeliac disease
Nil history of bowel cancer or inflammatory bowel disease.

Observations

The patient appeared anxious regarding the change in symptoms – fidgety and fast-paced speech.
The patient looked well. They had a normal appearance and gait.

Abdominal examination:
Consent gained, chaperone offered and declined. Abdomen was soft, nontender. No guarding, rigidity, rebound tenderness. Normal bowel sounds observed. No masses or distention.

Previous investigations: raised triglycerides, low folate. Nil else to note.

Social: currently not in work.

The FCD explained to the patient that further tests were required to establish any cause for their symptoms. The following tests were ordered in line with NICE guidance:

FBC
CRP
IgA/tTG
Faecal calprotectin (stool sample)
Ferritin, B12 and folate were also ordered given patient's previous low levels and lethargy.

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The patient was rebooked for 2 weeks to discuss these test results but was advised the FCD would contact them sooner if needed.

Safety netting
If the patient experienced any worsening in symptoms, blood in stools, fever or severe pain, they were advised to get back in touch sooner, or seek urgent medical attention if needed.

Follow up appointment

FBC, ferritin, B12, CRP, IgA/tTG and faecal calprotectin returned within normal range.

Folate was low at 2.6ug/L

The results were explained to patient, and a diagnosis of functional bowel disorder was given. The FCD explained that this is a lifelong condition that can be affected or managed by diet and lifestyle measures.

Changes since initial appointment: the patient reported no changes in their symptoms from the initial appointment.

Assessment
The patient's diet was lacking in fibre, vitamins and minerals which was likely contributing to their symptoms and low folate. The patient had a high intake of caffeine and fizzy drinks. It was discussed how stress may also be impacting on the patient's symptoms.

Plan
Plan agreed with patient after explaining the importance of nutrition and managing stress:

- Gradually reduce caffeine; patient was unaware his fizzy drinks also contributed to this
- Reduce fizzy drinks and increase water or squash
- Introduce vegetables with every evening meal – with particular focus on dark green leafy vegetables
- Snack on fruit (be mindful of portion sizes)
- Introduce an oat-based breakfast
- Referral to the in-house mental health team
- Prescription of folic acid 5mg OD for 3/12*

Follow up
The FCD advised the patient to implement the above plan for 4 weeks and if symptoms continue, to get back in touch for further advice. Safety netting advice was given again

What COULD have happened?

Patient gets back in touch with ongoing symptoms:

- a trial of dietary eliminations or a low FODMAP diet could be undertaken.
- medications for functional bowel disorder could be considered.

Red flags on assessment:

- blood in stools, acute pain, unintentional weight loss, pyrexia, or mass/guarding/rebound tenderness on abdominal examination could have triggered an urgent referral to secondary care or A&E for further investigations or urgent management.
- if the patient was less than 60 years this would have triggered a 2 week wait (2WW).

Please note this is an illustrative case and does not contain information to a specific individual

**The FCD is a supplementary prescriber. They felt the low folate levels were as a result of poor diet quality, however, was unsure if a prescription would also be required. A quick chat with the duty doctor confirmed that a 3-month prescription of folic acid should be issued and they signed the FCD's clinical management plan for this to be actioned.*

BDA The Association of UK Dietitians

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