DIVERTICULAR DISEASE WHAT'S NEW?

BACKGROUND: Diverticular disease most commonly occurs in the colon and it is defined as a sac-like protrusion of the mucosa. It is one of the common GI conditions in patients. 20% of patients over the age of 40 and 60% of patients over 60 have diverticulosis. In western countries, diverticulosis occurs mainly o the left side while in Asian it is on the right. **RISK FACTORS:** Low fibre diet, high fats and red meat diets, sedentary lifestyle, obesity are associated with developing diverticular disease. Smoking, along with NSAIDS, opiates, and steroids are associated with increased risk of diverticulitis. Contrary to popular belief, seeds, nuts and corn are not associated with developing diverticular disease or complications. **SYMPTOMS:** Most patients with diverticular disease are asymptomatic. They are often diagnosed on routine screening colonoscopies. 5-15% may experience a lower GI bleed and another 5-15% may develop diverticulitis. Many patients also have concomitant IBS. **DIAGNOSIS & TREATMENT:** Most patients with diverticulitis present with LLQ pain, though some may have RLQ pain (redundant sigmoid). They usually present with acute onset localized LLQ pain AND fever. In healthy patients, an outpatient course of oral antibiotics (ciprofloxacin + metronidazole or amoxicillin/clavulanic acid) for 10-14 days is sufficient. Imaging (CT or U/S) would be ideal to confirm the diagnosis. Those with diverticular bleeding usually do not have abdominal pain, and most will settle with supportive treatment. Outpatient colonoscopy (no earlier than 6 weeks) is advised in patients who have had diverticulitis. The decision to offer surgery to patients is no longer made based on just 2 attacks of diverticulitis, but rather individualized, considering the frequency and severity of attacks.

THORNHILL ENDOSCOPY CENTRE

TEC STAFF SPOTLIGHT OLENA MERENSTOV, R.N.

Olena Merentsov is TEC's head nurse and clinical manager. She has worked at TEC since 2012, exemplifying a consistent commitment to patient care. With over 20 years of clinical experience, Olena strives to ensure that every patient has a positive experience, every time. She combines astute clinical skills with a contagious enthusiasm. Her ability to speak English, Ukrainian and Russian, enables her to connect with many patients at TEC, putting them at ease before their procedures, and ensuring that they leave with all their questions and concerns addressed. When asked why she enjoys working at TEC, she replies, "Seeing what all our nurses do inspire me every day. I love working at TEC as I know the patients are extremely well taken care of by all members of our staff, nurses, and physicians. The most important thing to me is that not only are patients taken care of with compassion, but they always leave our clinic with a smile on their faces".

Thornhill Endoscopy Centre
UNIT 11, 390 STEELES AVENUE WEST,
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Monday to Friday: 7:30 am – 3:30 pm
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THORNHILL ENDOSCOPY CENTRE

TEC Talks

Spring-Summer 2019

A Bulletin for Family Physicians

IBS – Back to Basics!

Diverticular Disease – What's New?

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DR. LUKE BUI, M.D., F.R.C.S.(C.)

MEDICAL DIRECTOR

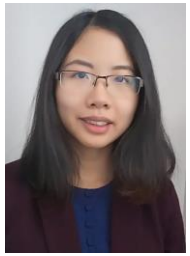
TEC UPDATE

QUALITY CARE – ONE PATIENT AT A TIME

At TEC, our staff and physicians continuously strive to ensure that every patient received the best care possible, every time. I would like to share with you a few of our quality initiatives. **REPEAT COLONOSCOPY REMINDERS**. It is often confusing as to when your patient would need another colonoscopy. Guidelines continue to evolve, particularly now with FIT testing. The number of polyps, size of polyp, type of polyp, cancer risk factors, and quality of the bowel prep, all affect when the next colonoscopy should be. All family physicians who refer patients to TEC will receive a reminder of when their patients are due for a repeat colonoscopy. **EDUCATION MATERIAL FOR PATIENTS.** Often patients may not remember their diagnosis or recommendations once they are discharged. Not only are patients provided with an Interim Report, but they are also given literature and patient education material so that they are fully informed when they leave TEC. **PHYSICIAN REPORT CARDS**. I am please to report that our physicians' performance exceed published standards, based on their monthly quality report cards (colonoscopy completion and polyp detection). These initiatives, amongst others, help ensure that TEC meet the highest standards for our patients.

HIGHEST STANDARDS IN CLEANLINESS AND PROCEDURAL EXCELLENCE

Thornhill Endoscopy Centre



JENNY CHENG, B.SC. (NUTRSC)

DIETICIAN

IBS

BACK TO BASICS

Irritable bowel syndrome (IBS) is a chronic condition that can affect the gastrointestinal (GI) tract with symptoms such as abdominal pain, bloating, cramping, constipation, and diarrhea. To manage symptoms with dietary strategies, it would be helpful to start by determining GI symptoms are caused by current food habits. Keeping a food and symptom diary to track which symptoms improve after eliminating specific foods or changing eating pattern would be a be a great way to start. Patients should also make sure that they have enough fibre (30-50g daily) and plenty of water throughout the day (12-14 glasses of lukewarm water). Soluble fibre from food such as oats, oat bran, and flax seed may help relieve diarrhea and constipation. Avoiding high fat meals and snacks may also help improve cramping and diarrhea. If patients are experiencing bloating, they should reduce the amount of gas producing foods such as onions, garlic, pastas, baked goods, chickpeas, etc.. A low FODMAP diet will reduce symptoms of IBS. Furthermore, caffeine, found in coffee, tea, energy drinks, coke, and other soft drinks, should be avoided as it can cause more bloating and diarrhea. Patients treated at TEC will have access to patient education material and dietary counseling services to help address root causes and manage symptoms.

IBS IS A DIAGNOSIS OF EXCLUSION, OFTEN AFTER A NORMAL COLONOSCOPY

UNIT 11, 390 STEELES AVEUNUE WEST,
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DR. WARREN BEAN, M.D., F.R.C.P.(C.)

ANAESTHESIOLOGIST

SEDATION IN THE HIGH-RISK PATIENT

SAFETY FIRST

With the changing population demographic and the fact that most patients presenting for colonoscopy are middle-aged or older, anesthesiologists are seeing more and more patients with medical comorbidities, including obesity, diabetes, hypertension, coronary artery disease, COPD and sleep apnea to name a few. Each set of comorbidities presents a potential challenge in terms of the risk of administration of anesthesia in an out-of-hospital setting. While these patients clearly are at a higher risk, they are not necessarily classified as high-risk, necessitating a hospital setting for their procedures. At TEC, patients are seen in preoperative consultation by an anesthesiologist, and where necessary, an internist to determine their suitability for outpatient anesthesia. This process has allowed for many patients to be safely taken care of in an out-of-hospital setting. Of course, high risk patients are referred to the hospital for their procedures – fortunately this is the absolute minority of patients. Our mission at TEC continues to be safety and excellent care for all our patients.

PUTTING YOUR MIND AT EASE

WWW.THORNHILLENDOSCOPY.COM