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GI learning, personalised

Summary

GP perspective: How to diagnose, review lifestyle and diet

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A general practitioner from Croatia describes a pragmatic primary care approach to bloating and abdominal distension, emphasising history-taking, exclusion of red flags, and lifestyle measures including low Fodmap diet, while acknowledging the challenge of patient adherence.

KEY POINTS

- Bloating is among the most frequently reported GI symptoms in primary care, with global prevalence reported between 15 and 30%, more common in women and older patients, and significantly affects quality of life including social, work, and personal relationships.
- The speaker recommends a rule-out diagnostic strategy starting with CBC, CRP, TSH, and glycaemia, with additional workup including coeliac screening, tumour markers, faecal elastase, ultrasound or CT, and endoscopy when indicated.
- Red flags requiring further investigation or referral include unintentional weight loss, GI bleeding, anaemia, nocturnal symptoms, onset above age 50, family history of GI cancer/IBD/coeliac disease, persisting vomiting, progressive severe pain, fever, and abnormal examination findings.
- The speaker identifies key pathophysiological mechanisms as visceral hypersensitivity, abdomino-phrenic dyssynergia, intestinal dysmotility and constipation, microbiome dysbiosis, and psychosocial contributors including stress, anxiety, and depression.
- Treatment centres on reassurance about benign nature, low Fodmap diet, healthy eating and physical activity, with cognitive behavioural therapy and gut-directed hypnotherapy effective for IBS with bloating and considered for refractory cases.
- The speaker acknowledges in discussion that patients often do not adhere to lifestyle recommendations and that low Fodmap diet should be dietician-led but this does not always happen in primary care practice.

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