

CLINICAL UPDATE

Irritable Bowel Syndrome

IBS

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Table of Contents

1	Digestive Health Foundation
2	What Is Irritable Bowel Syndrome?
2	How Big is the Problem?
3	What Causes Irritable Bowel Syndrome?
3	Diagnosis of Irritable Bowel Syndrome
3	Other Gut Symptoms in Irritable Bowel Syndrome
3	Non Gut Symptoms in Irritable Bowel Syndrome
4	Differential Diagnosis of Irritable Bowel Syndrome
4	How To Manage Irritable Bowel Syndrome
5	Investigations
5	Diet and the Role of Fibre
6	Medications
6	Psychosocial Approaches
7	If No Improvement
8	Application Statement

Digestive Health Foundation

The Digestive Health Foundation (DHF) is an educational body committed to promoting better health for all Australians by promoting education and community health programs related to the digestive system.

The DHF is the educational arm of the Gastroenterological Society of Australia, the professional body representing the specialty of gastrointestinal and liver disease in Australia. Members of the Society are drawn from physicians, surgeons, scientists and other medical specialties with an interest in GI disorders.

Since its establishment in 1990 the DHF has been involved in the development of programs to improve community awareness and the understanding of digestive diseases.

Research and education into gastrointestinal disease are essential to contain the effects of these disorders on all Australians.

Guidelines for General Practitioners and patient leaflets are available on a range of topics related to GI disorders. Copies are available by contacting the Secretariat at the address below.

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What is Irritable Bowel Syndrome?

IBS (Irritable Bowel Syndrome) is a chronic relapsing disorder of gastrointestinal function, the main features of which are abdominal pain associated with an altered bowel habit, in the absence of any structural pathology.

Subgroups of IBS are recognised:

- Constipation predominant.
- Diarrhoea predominant.
- A syndrome of alternating diarrhoea and constipation.

IBS is one of the functional disorders of the gut, others include functional dyspepsia, functional diarrhoea or constipation without abdominal pain, abdominal bloating without a disordered bowel habit.

The diagnostic criteria for IBS have recently been revised and are known as The Rome II Criteria. They are useful for both research purposes and clinical assessment.

How big is the problem?

IBS is very common and affects approximately 15% of people in Australia. However not everyone with symptoms seeks medical advice.

IBS is a very common reason for people to see their GP and is responsible for up to 50% of consultations with specialist gastroenterologists.

It is very costly to the community in terms of money spent on medical consultations, investigations and days missed from work as well as medications and alternative treatments. It also has an enormous indirect cost to the community in terms of its effect on quality of life.

**IRRITABLE BOWEL SYNDROME
IS TWICE AS COMMON IN
FEMALES AS MALES**

Rome II Diagnostic Criteria for IBS

The patient has had at least twelve not necessarily consecutive weeks in the last year of abdominal discomfort or pain with at least two of the following three features:

- Pain is relieved by defecation and/or
- Onset is associated with a change in stool frequency and/or
- Onset is associated with a change in stool form or appearance.

Symptoms that cumulatively support the diagnosis of IBS are:

- Abnormal frequency (more than three motions per day or less than three motions per week).
- Abnormal form (pellets, pencil-like or unformed motions).
- Abnormal stool passage (straining, urgency or a feeling of incomplete evacuation).
- Passage of mucus.
- A sensation of bloating or distension.

What causes IBS?

IBS has a complex multifactorial aetiology. The following factors, which may interact, have been found to be important in this condition:

- **Visceral hypersensitivity:** Normally most gastrointestinal processes are not perceived by the individual. However in IBS these processes are consciously experienced and may be perceived as painful. Abdominal pain may also be referred to various unusual anatomical sites. The reason for this alteration in gastrointestinal sensation is not known.
- **Intestinal dysmotility:** There are abnormalities of contractions in the small and large bowel in some patients.
- **Autonomic dysfunction:** There appears to be an abnormality of autonomic function and feedback loops in some individuals.
- **Post infective IBS (intestinal inflammation):** Approximately 25% of people report their symptoms commenced after an episode of infective diarrhoea. Mild persisting chronic inflammation of colonic mucosa has been identified in some patients with IBS.
- **Psychological factors:** There are strong associations with psychological distress and psychiatric illness. There is also evidence that stressful life events increase the risk of IBS developing de novo or after an episode of gastrointestinal infection. Some studies have reported an association between chronic stressful life events, sexual or physical abuse in the present or past and IBS symptoms in some individuals. There is an interaction between personality-type and stress that may be involved in pathogenesis. Psychological factors may also determine whether or not people seek health care. Both anxiety and depression can impact on the perception of symptoms.
- **Familial tendency:** There is epidemiological evidence that IBS has a slight familial component.

Diagnosis of IBS

A careful medical history and physical examination allows for a positive diagnosis in most cases.

This should include a medication history, history of any coexistent illness and a family history. Physical examination is essentially normal.

Other gut symptoms in IBS

Other functional gut symptoms are more common in IBS sufferers than the general population. These include heartburn, dyspepsia, globus, nausea and excessive belching.

These features require further consideration or investigation:

- Rectal bleeding.
- Steatorrhoea.
- Significant weight loss.
- Nocturnal diarrhoea.
- Fever.
- Family history of bowel cancer.
- Family history of coeliac disease.
- Family history of inflammatory bowel disease.
- Abnormality on examination of the abdomen.

Non gut symptoms in IBS

Other somatic complaints that are more common include:

- Fatigue.
- Dysmenorrhoea.
- Dyspareunia.
- Headache.
- Bladder irritability.
- Fibromyalgia.
- Sleep dysfunction.

Differential diagnosis of IBS

Abdominal pain associated with a disorder of bowel habit can occur in a number of illnesses. These need to be considered.

The differential diagnosis includes:

- Inflammatory bowel disease.
- Coeliac disease.
- Lactose intolerance.
- Side effect of medication.
- Carcinoma of the colon.
- Chronic giardiasis.
- Thyroid disease.
- Eating disorder.
- Microscopic colitis.
- Laxative abuse.
- Somatisation disorder.

How to manage IBS

It is appropriate to find out what goals the patient has for the consultation. Do they want bowel cancer excluded or significant symptoms controlled, or are they presenting for some other reason? It is also important to address why the patient is presenting at this time - is it related to severity of symptoms and the effect of IBS on quality of life or is some other reason for distress driving the consultation?

A mutually satisfying doctor/patient relationship is the key to successful management of IBS.

A number of factors aid this, including:

- Taking a detailed history and actively listening to the patient's concerns.
- Performing a thorough physical examination.
- Communicating the diagnosis of IBS clearly to the patient and explaining that it is a legitimate diagnosis of a well defined medical condition and not just a 'label' attached to people with normal investigations and symptoms.
- Explaining the concepts of visceral hypersensitivity and disordered motility.
- Reassuring the patient that IBS is the correct diagnosis and that more serious conditions are not present, whilst acknowledging how seriously IBS can impair quality of life.
- Explaining that IBS is a chronic condition with exacerbations and remissions. Reassuring the patient that IBS does not lead to serious bowel disorders.

Many patients will be quite happy to accept reassurance given in this manner. Investigations may not be required. It is also appropriate, however, to discuss the lifetime risk of bowel cancer and appropriate screening now or in the future.

Investigations

It is important to explain that investigations will be normal in IBS. Excessive investigations can be counterproductive as it can raise the spectre of doubt as to the true diagnosis. However, appropriate tests, depending on symptoms, done as part of an initial assessment may include the following:

Investigation of diarrhoea predominant IBS:

- Full blood count and C-reactive protein
- Stool microscopy and culture
- Testing for coeliac disease
- Thyroid function tests
- Colonoscopy and biopsy

Investigation of constipation predominant IBS:

- Full blood count
- Thyroid function tests
- Serum calcium level
- Colonoscopy

Some females with abdominal pain may require gynaecological assessment.

Colonoscopy should be considered in patients over 40 years of age presenting for the first time, particularly if there has been a recent onset of symptoms, a change in pre-existing symptoms, or a family history of colorectal neoplasia.

The lifetime risk of bowel cancer should be discussed as a separate issue from IBS.

Faecal occult blood testing (FOBT) is not an appropriate test in people with symptoms – it is only appropriate as a screening test in people with no symptoms at all.

Diet and the role of fibre

Some people find their symptoms are triggered by particular foods such as high fat meals, alcohol, coffee or spicy foods. It is also important to assess the patient's fibre and fluid intake. Is there a high consumption of foods that produce flatulence such as cabbage, lentils or beans? Does the patient chew gum or drink cordials containing indigestible sugars such as sorbitol or fructose that could exacerbate IBS symptoms? Does the patient take any exercise? On occasion a food diary can be helpful in obtaining a more accurate record of what is being eaten.

Dietary fibre supplement

Patients with constipation predominant IBS may respond to an increased amount of fibre, preferably through high fibre foods, aiming at an intake of up to 25-30 gm/day. The fibre should be gradually increased to avoid abdominal bloating. Stool bulking agents may be better tolerated than dietary fibre. The increased amount of fibre needs to be given for at least a month before the effect can be assessed.

Stool bulking fibre supplements may firm the consistency of the bowel motion in diarrhoea predominant IBS.

In some cases exclusion of a particular food or food group may be helpful. Examples include caffeine, alcohol, spicy foods, high fat foods or foods that cause excessive bloating such as beans, lentils or certain vegetables. A small proportion of people may have lactose intolerance and find that symptoms are better when they have a limited amount of dairy products. However this needs to be carefully assessed as a low calcium diet taken over time increases the risk of osteoporosis and bowel cancer and alternative dietary measures or a calcium supplement may be necessary. Some individuals report that limiting wheat based foods such as pasta or bread improves discomfort and their bowel habit. Very occasionally people with severe symptoms benefit from a formal exclusion diet supervised by a dietician.

It is appropriate to discuss with the patient their responsibility for addressing lifestyle factors such as diet, exercise, fluid intake, chronic stress and sleeping patterns, which may significantly affect IBS.

Medications

The decision to use medications for IBS depends on the severity and frequency of symptoms. The medication needs to be tailored to the pattern of symptoms. Because IBS tends to fluctuate over time medication should be used when needed and not necessarily long term.

Abdominal pain

Antispasmodics (mebeverine) or anticholinergics (eg dicyclomine) may help individual patients, although trials have not shown consistent benefit. A small dose of a tricyclic antidepressant such as amitriptyline 10mg per day has been shown to be of use in some individuals. Anecdotal reports have suggested SSRIs at a low dose may also be beneficial in some patients.

Diarrhoea predominant IBS

Antidiarrhoeal drugs such as loperamide can be very effective for control of diarrhoea but on occasion may exacerbate abdominal pain. Cholestyramine may help some patients. New pharmacological agents are at present being trialled.

Constipation predominant IBS

A trial of stool bulking agents, an increase in fluid intake, judicious use of osmotic laxatives and regular exercise may be helpful for the treatment of constipation. The 5HT₄ partial agonist tegaserod has been shown to decrease pain, improve stool frequency and consistency and reduce bloating in a percentage of females with constipation predominant IBS.

Psychosocial Approaches

Good communication between the doctor and the patient is essential. Explanation and education may be very therapeutic.

In moderate to severe IBS it is important to identify disorders of mood (anxiety disorders or depression), sleep or coexistent psychiatric illness, as these problems need to be treated in their own right. Individual patients may benefit from cognitive behaviour therapy, relaxation therapy or hypnotherapy. Patients may need help to develop coping skills to tolerate their symptoms.

A combination of multi-component behaviour therapy with medical treatment may be better than behaviour therapy alone.

If No Improvement

Reconsider the diagnosis.

If, however, IBS is the correct diagnosis, discuss the continuing symptoms with the patient and reemphasise that current therapies can help control symptoms but don't offer a cure.

Successful management of IBS

This requires a comprehensive approach including:

- Appropriate communication of the diagnosis of IBS.
- Identification and avoidance of trigger factors.
- Manipulation of diet and lifestyle.
- Treatment of any coexistent psychiatric illness.
- Psychological interventions aimed at providing improved coping skills.
- Medications tailored to an individual's symptoms.

Helpful counselling techniques in IBS

- Explain it is a legitimate diagnosis of a well defined condition.
- Explain the concept of visceral hypersensitivity and disordered motility.
- Explain the usual pattern of remissions and exacerbations.
- Explain that these symptoms do not lead to other bowel disorders.

Strategies to help patients take responsibility for treatment of IBS

- Breakfast cereal each morning.
- 25-30 gm of fibre per day, unless symptoms are exacerbated by fibre.
- 3 to 5 serves of vegetables per day.
- 3 pieces of fruit per day.
- 6 to 8 glasses of water or juice or herbal teas per day.
- Regular exercise.
- Avoidance of dietary trigger factors.
- Avoidance of excessive alcohol.
- Avoid smoking.
- No more than 30gm amount of fat per day.
- Attention to psychological trigger factors.

Application Statement

The documents in this section have been prepared by the Digestive Health Foundation of the Gastroenterological Society of Australia and every care has been taken in their development. The documents are intended to be used as a guide only and not as authoritative statement of every conceivable step or circumstance which may or could relate to the management of the relevant diseases.

Practitioners should use this document as an aid in relation to the early diagnosis of gastrointestinal disease and not as a complete or authoritative statement.

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