Irritable bowel syndrome

Professor Ingvar Bjarnason, consultant gastroenterologist, offers his quick guide to diagnosing and managing IBS

Features:
Recurrent abdominal pain or discomfort at least three days a month in the past three months plus two of the following:
- Improvement with defaecation
- Change in frequency of bowel openings
- Change in form or appearance of stool (diarrhoea-constipation)

There are various sub-categories of IBS associated with hypermobility syndromes (Ehlers Danlos), IBS developing following food infection syndromes (post-infectious IBS) etc. Some patients, especially those on statins and retrovirals, associate their IBS-like symptoms with treatment. At present, treatment for the symptoms experienced according to the 'cause' of IBS do not differ and are tailored, apart from withdrawing medication that may contribute to symptoms.

Differential diagnosis
- Short history: food infections, diverticulitis, appendicitis, salpingitis
- Longer history: inflammatory bowel disease, diverticular disease, colorectal cancer, diabetic diarrhoea (including diarrhoea due to metformin), side-effects of medication, pancreatic insufficiency, coeliac diseae, endometriosis, period pains etc.
- Beware of any patient with 'red flag symptoms' (pr bleeding, weight loss, abnormal screening tests etc.). IBS can mimic any gastrointestinal disease

Associated symptoms – these may be continuous or intermittent

Intestinal
- Abdominal bloating or distension
- Feeling of incomplete evacuation of stools
- Mucus in stool
- Specific food intolerances

Extra-intestinal
- Headaches
- Muscular complaints, including fibromyalgia
- Non-inflammatory joint and back pain
- Menstrual irregularities
- Urinary tract symptoms, pain on voiding, increased frequency of voiding
- Sexual dysfunction
- Tiredness

Investigations
- Invasive investigations are usually unnecessary before starting treatment in primary care, provided that:
  - Full blood count is normal
  - Basic biochemistry, including CRP and ESR, is normal
  - Faecal calprotectin is normal
- Stool microbiology microscopy and cultures may be indicated
- Serum transglutaminase should be undertaken for all patients

NB
These tests should be normal in IBS, but there are many reasons why test results are somewhat abnormal:
1 ESR and CRP are not GI specific.
2 A calprotectin value less than 200 (normal less than 60) does not automatically require invasive investigation – 15% of patients with IBS have slightly raised calprotectins

Treatment
- A holistic approach is important
- The various forms of IBS – conventional IBS, post-infective IBS, IBS associated with hypermobility syndromes – are all treated in the same way
- A realistic expectation is to anticipate a 70% improvement in 70% of patients. There is absolutely no cure.
- Tailor the treatment to the symptoms
- Patients with IBS and multiple unexplained symptoms frequently think that they have the 'leaky gut' syndrome, whereby increased intestinal permeability is postulated to allow absorption of bacterial toxins. This is a myth and intestinal permeability testing can confirm this

Conventional
Laxatives (fibre, osmotic agents, stimulants, etc.), constipants (loperamide, codeine phosphate, etc.), antispasmotics (mebeverine, buscopan), peppermint, amitriptyline or other antidepressants, anxiolytics

Modern day – multifactorial approach
Dietary advice – consider lactose free diet, gluten free diet, low FODMAP, elimination diet with re-introduction of foods.
- Low FODMAPS and a wheat free diet help mostly in patients with bloating and diarrhoea
- Dairy free diet is not indicated for IBS patients with constipation, but might help diarrhoea and bloating

Probiotics – Symprove, Align, VSL-3 (unproven efficacy in IBS).
- Probiotics help with abdominal pain and diarrhoea/constipation
- Different types of probiotics have different benefits and need to be tailored to symptoms

Psychiatric anxiety/stress – reduction, lifestyle management by CBT
- Recommended (NHS) number of CBT sessions is 10, although most IBS patients with moderately severe anxiety will achieve maximum benefit from 20-40 sessions

Common sense – eat regularly, eat slowly, take exercise, maintain high fluid intake, cut down on alcohol, coffee and tea.

Referral to specialist gastroenterology centers
- Bear in mind that most gastroenterologists consider that management of IBS should be GP-led within primary care
- Gastroenterologists are happy to investigate patients with IBS but only a few hospitals have dedicated IBS treatment clinics.
- The most severely affected patients with IBS may benefit from referral to these dedicated clinics

Follow up
- Review yearly to assess:
  - Lifestyle issues – stress, anxiety, etc.
  - Encourage moderation of caffeine and alcohol intake, smoking, etc.
  - Consider repeating calprotectin test for reassurance in the very anxious patients concerned about new symptoms – do not get overexcited about mildly elevated levels of 50-200mcg/g
- Supplementary treatment for extra-intestinal complaints
- Direct patients to IBS support groups that are accessible via the internet

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