NEW IBS GUIDANCE FOCUSES ON IMPROVING DIAGNOSIS AND CARE

Irritable bowel syndrome is usually diagnosed by excluding other conditions. New NICE guidance offers positive diagnosis criteria, reports Nerys Hairon

NICE has published new guidance on the diagnosis and management of irritable bowel syndrome (IBS) in adults (NICE, 2008). The guidance provides for the first time a clear set of symptoms that must be present for the syndrome to be diagnosed. It also sets out the advice, support and treatment patients should be offered to minimise the effects of this distressing condition.

BACKGROUND
IBS is a long-term, relapsing and often lifelong disorder. It is characterised by abdominal pain or discomfort, which may be associated with defecation and/or accompanied by changes in bowel habit. Symptoms may include disordered defecation (constipation or diarrhoea or both) and abdominal distension. They sometimes overlap with other gastrointestinal disorders such as non-ulcer dyspepsia or coeliac disease.

People with IBS present with varying symptom profiles, most commonly ‘diarrhoea predominant’, ‘constipation predominant’ or alternating symptom profiles. The syndrome most often affects people aged 20–30 and is twice as common in women as in men. Prevalence in the general population is estimated at 10–20%. Recent trends indicate a significant prevalence of IBS in older people. The guidance advises that IBS should be suspected when an older person presents with unexplained abdominal symptoms.

Key aspects in the guidance include: initial assessment; asking about ‘red flag’ indicators and examinations for these; diagnostic criteria; diagnostic tests; dietary and lifestyle advice; and pharmacological treatment.

DIAGNOSIS
The diagnosis and management of IBS can be frustrating for patients and healthcare professionals alike. Both groups need to understand the limitations of current knowledge on the condition and to recognise its long-term nature.

The primary aim should be to establish the person’s symptom profile, with abdominal pain or discomfort being a key symptom. It is also necessary to establish the quantity and quality of pain experienced and to identify its site (which can be anywhere in the abdomen) and whether this varies. This distinguishes IBS from cancer-related pain, which typically has a fixed site.

When establishing bowel habit, showing patients the Bristol Stool Form Scale may be helpful (see guidance appendices at www.nice.org.uk). Faecal incontinence is likely to be a source of embarrassment to those who experience it, and NICE points out that about 20% of patients with this symptom disclose it only if asked. Those presenting with symptoms of IBS should therefore be asked open questions in a sensitive manner. It is also important to be sensitive to the cultural, ethnic and communication needs of people for whom English is not a first language or who may have cognitive and/or behavioural problems or disabilities.

Initial assessment
Healthcare professionals should consider assessing patients for IBS if they report having had any of the following symptoms for at least six months:

- Abdominal pain or discomfort;
- Bloating;
- Change in bowel habit.

All those with symptoms suggesting they
may have IBS should be asked if they have any of the following ‘red flag’ indicators and be referred to acute care for further investigation if any are present:

- Unintentional/unexplained weight loss;
- Rectal bleeding;
- Family history of bowel or ovarian cancer;
- Change in bowel habit to looser and/or more frequent stools persisting for more than six weeks in a person over 60.

They should also be assessed and clinically examined for the following ‘red flag’ indicators and referred to acute care for further investigation if any are present:

- Anaemia;
- Abdominal masses;
- Rectal masses;
- Inflammatory markers for inflammatory bowel disease.

If there is concern that symptoms may suggest ovarian cancer, a pelvic examination must be considered. If any form of cancer is suspected practitioners are advised to consult the relevant NICE guidance for detailed referral criteria (NICE, 2005).

**Diagnostic criteria**

A diagnosis of IBS should be considered only if the person has abdominal pain or discomfort that is either relieved by defecation or associated with altered bowel frequency or stool form. This should be accompanied by at least two of the following four symptoms:

- Altered stool passage (straining, urgency, incomplete evacuation);
- Abdominal bloating (more common in women than men), distension, tension or hardness;
- Symptoms exacerbated by eating;
- Passage of mucus.

Other symptoms such as lethargy, nausea, backache and bladder symptoms are common in people with IBS, and may be used to support the diagnosis.

The guidance lists the specific tests that should be carried out to exclude other diagnoses as well as those that are not necessary to confirm diagnosis in people who meet the IBS diagnostic criteria.

**CLINICAL MANAGEMENT OF IBS**

*Diagnosis and management*

Self-help is important for people with IBS, and patients should be given information on what they can do to effectively manage their condition. This should include information on lifestyle, activity, diet and symptom-targeted medication.

Healthcare professionals should encourage patients with IBS to find time for relaxation, and should also assess their activity levels, ideally using the General Practice Physical Activity Questionnaire (NICE, 2006). Those with low activity levels should be given brief advice and counselling to encourage them to do more. Diet and nutrition should also be assessed and general advice given (see box below).

Patients’ fibre intake should be reviewed and adjusted as necessary (this usually involves reducing fibre) while monitoring the effect on symptoms. Patients should be discouraged from eating insoluble fibre (for example, bran), and if they are advised to increase their intake of fibre, it should be in soluble form such as ispaghula powder or foods high in soluble fibre, such as oats.

Patients who choose to try probiotics should be advised to take them for at least four weeks, at the dose recommended by the manufacturer, while monitoring the effect. The use of aloe vera to treat IBS should be discouraged.

Patients in whom diet continues to be considered a major factor in their symptoms – even though they are following general lifestyle/dietary advice – should be referred to a dietitian for advice and treatment. This may include single food avoidance and exclusion diets. Such advice should only be given by a dietitian.

**Other interventions and follow-up**

A number of pharmacological interventions can be used to treat people with IBS. The guidance recommends that their selection is determined by the patient’s predominant symptoms. It also advises that referral for psychological interventions (CBT, hypnotherapy and/or psychological therapy) should be considered for people who do not respond to pharmacological treatments after 12 months and who develop a continuing symptom profile (described as refractory IBS). However, patients should not be encouraged to use acupuncture or reflexology to treat their condition.

Follow-up should be agreed between practitioners and patients, based on how their symptoms respond to interventions. This should form part of annual patient reviews. If any ‘red flag’ symptoms emerge during management and follow-up, this should prompt further investigation and/or referral to acute care.

**KEYWORDS** GASTROINTESTINAL • IBS • DIETARY ADVICE

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**REFERENCES**
