

People with this debilitating condition need individualised treatment that takes into account their perception of symptoms and the effect on their quality of life

Individual treatment for irritable bowel syndrome

In this article...

- › Prevalence and causes of irritable bowel syndrome
- › How IBS is diagnosed
- › Treatment and management options

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Abstract Ness W (2012) Individual treatment for irritable bowel syndrome. *Nursing Times*; 108: 30/31, 20-22. Irritable bowel syndrome is a debilitating and distressing condition. This article explores the prevalence, causes, investigation and treatment of it.

The most common condition seen in gastrointestinal outpatient clinics is irritable bowel syndrome (IBS), which has a prevalence rate of 14-24% in women and 5-19% in men (Spanier et al, 2003). The frequency of IBS symptoms peaks in the third and fourth decades and, in most surveys, there is a female predominance of approximately 2:1 in the 20s and 30s, although this bias is less apparent in older patients (Kumano et al, 2004).

Although it is not as common in older patients, IBS should be considered in the group if patients have unexplained abdominal symptoms (National Institute for Health and Clinical Excellence, 2008).

Causes

Ford et al (2008) suggested that, although IBS is a common complaint, there is no known structural or anatomical explanation that accounts for the pathophysiology and the exact cause remains unknown. Altered gastrointestinal motility may contribute to the change in bowel habit that some patients report.

A combination of smooth muscle spasm, visceral hypersensitivity and abnormalities of central pain processing may explain the abdominal pain that patients often experience.

Camilleri (2008) argued that the condition is a biopsychosocial disorder with three major mechanisms: psychosocial factors; altered motility; and/or heightened sensory function of the intestine.

Psychological disturbance, especially in referred patients, includes psychiatric disorders (such as panic, generalised anxiety, mood and post-traumatic stress), sleep disturbance and dysfunctional coping. As in many bowel dysfunction complaints, a history of childhood abuse is common (Longstreth et al, 2006).

Depending on the setting, 6-17% of patients with IBS report that their symptoms began with an episode of gut inflammation related to gastroenteritis (Longstreth et al, 2001). When assessing these patients, it is important to establish whether they have travelled abroad recently.

Symptomology and diagnosis

NICE (2008) defines IBS as a chronic, relapsing and often lifelong disorder, characterised by abdominal pain or discomfort, which may be associated with defecation and/or accompanied by a change in bowel habit. Symptoms may include disordered defecation (constipation, diarrhoea or both) and abdominal distension.

Although IBS significantly reduces quality of life and social functioning in many patients, it is not known to be associated with the development of serious disease or excess mortality. However, the condition generates significant healthcare costs, both direct because of IBS symptoms and associated disorders, and indirect because of time off work (Spiller et al, 2007). Patients often describe their symptoms as embarrassing and fear going out,

5 key points

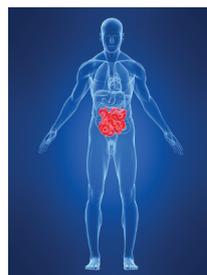
1 The exact cause of irritable bowel syndrome (IBS) remains unknown

2 IBS is a chronic, relapsing and often lifelong disorder

3 Diagnosis is based mainly on patient symptoms; there is no specific test to diagnose IBS

4 Each patient needs an individualised plan of treatment based on symptoms, their perception of the problem and how this affects their quality of life

5 Decisions about pharmacological management should be based on the nature and severity of symptoms



A number of factors cause pain in IBS

which leads to isolation and interferes with relationships.

Diagnosis is based mainly on patients' symptoms; there is no specific test to diagnose IBS. Patients often undergo unnecessary tests that may be harmful to them and costly to the NHS. Diagnostic testing should be based on age, duration and severity of symptoms, psychosocial factors, alarm symptoms and family history of gastrointestinal disease (Longstreth et al, 2006).

The ABC diagnosis

NICE (2008) said health professionals should consider assessment for IBS if patients report having had any of the following symptoms for at least six months:

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

A diagnosis of IBS should be considered only if patients have 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 made worse by eating;
- » Passage of mucus.

QUICK FACT

5-24% Prevalence of IBS; it is more common in women than in men

Other features such as lethargy, nausea, backache and bladder symptoms are common in people with IBS, and may be used to support the diagnosis. Apart from the above guidance from NICE (2008), the most common diagnostic tool used for IBS is the Rome III Criteria (Box 1).

IBS can be broken down into sub-classifications based solely on stool consistency. Patients who have hard stools more than 25% of the time and loose stools less than 25% of the time are defined as "IBS with constipation" (IBS-C). In "IBS with diarrhoea" (IBS-D), patients have loose stools more than 25% of the time and hard stools less than 25% of the time. About one-third to half of IBS patients are "IBS mixed" (IBS-M) – these describe having both hard and soft stools more than 25% of the time. A small (4%) unclassified group is IBS-U, with neither loose

nor hard stools for more than 25% of the time (Spiller et al, 2007).

It is important to be aware of any "red flag" indicators (Box 2), to rule out bowel or ovarian cancer. Practitioners should also ask about family history of inflammatory bowel disease, particularly in people under the age of 50 (Spiller et al, 2007).

History taking is important to establish the symptom profile and should include:

- » How long symptoms have lasted;
- » Recent foreign travel;
- » Medical, surgical and obstetric history;
- » Medications taken (both prescribed and over the counter);
- » Diet and fluid intake (using a food and fluid diary);
- » Stool type (using the Bristol Stool Form Scale and diary);
- » The most bothersome symptoms.

IBS is also common in the following syndromes: fibromyalgia (77% also have IBS); chronic fatigue syndrome (92%); and temporomandibular joint disorder (64%) (Spiller et al, 2007). As a result of this, family and medical history must be included in the assessment.

Patients with IBS-D tend to need more in terms of investigation than those with IBS-C because of the overlap with other diarrhoeal diseases, including coeliac and inflammatory bowel disease.

Investigations

Invasive investigations should be limited as there is no gold standard investigation that diagnoses IBS. NICE (2008) said patients who meet the IBS diagnostic criteria should have the following tests to exclude other diagnoses:

- » Full blood count;
 - » Erythrocyte sedimentation rate or plasma viscosity;
 - » C-reactive protein;
 - » Antibody testing for coeliac disease.
- The following tests are not necessary to confirm a diagnosis:
- » Ultrasound;
 - » Rigid/flexible sigmoidoscopy;
 - » Colonoscopy;
 - » Barium enema;
 - » Thyroid function test;
 - » Faecal ova and parasite test;
 - » Faecal occult blood;
 - » Hydrogen breath test (NICE, 2008).

Treatment

Health professionals may have a different perception of the problem than patients. Spiller et al (2007) asked members of the IBS network to complete the following: "When I visit my health professional about my IBS, I would like them to give me...".

BOX 1. ROME III IBS DIAGNOSTIC CRITERIA*

Recurrent abdominal pain or discomfort** for at least three days a month in the past three months, associated with two or more of the following:

- Improvement with defecation
- Onset associated with a change in frequency of stool
- Onset associated with a change in form (appearance) of stool.

*Criteria fulfilled for the last three months with symptom onset at least six months before diagnosis.

** "Discomfort" means an uncomfortable sensation not described as pain. Source: Spiller et al (2007)

BOX 2. RED FLAG INDICATORS

- Rectal bleeding – often blood mixed in with stool
 - Unexplained, unintentional weight loss
 - Change of bowel habit to looser and/or more frequent stools lasting for more than six weeks in people aged over 60
 - Family history of bowel or ovarian cancer
 - Anaemia
 - Abdominal masses
 - Rectal masses
 - Inflammatory markers for inflammatory bowel disease
- Source: NICE (2008)

The general consensus was that patients want to be treated as individuals who have an illness that has no miracle cure, and would like to know the treatment options available.

As there is no single specific treatment for IBS, it is essential that each patient has an individualised plan based on their symptoms, their perception of the problem and how this affects their quality of life. Treatments could include nutritional changes, pharmacological therapy, psychological interventions and complementary and alternative therapies.

People with IBS should be given information that explains the importance of self-help in managing their condition effectively. This should include information on general lifestyle, physical activity, diet and symptom-targeted medication (NICE, 2008).



Dietary advice

Although scientific evidence on the role of diet in treating IBS is poor (Smith, 2010), changing diet can often be effective, is simple to achieve and worth trying before using medication or other types of management. Before making any changes, patients should record what they eat and drink in a nutritional diary to ascertain whether there are any trigger foods or fluids that make the problem worse; they should also record the time of day this happens. Ideally, this should include days when they work and days when they do not, recorded for about four days. Once patients have done this, practitioners should give the advice in Box 3.

Apart from this advice, it is worth trying a daily probiotic, which is a live microbial strain thought to have a beneficial effect on health through its influence on gut microflora (Miles, 2007). This can often improve IBS symptoms although the evidence is limited. Patients who choose to try probiotics should be advised to take the product for at least four weeks while monitoring the effect. Probiotics should be taken at the dose recommended by the manufacturer (NICE, 2008).

Aloe vera used to be recommended for people with IBS but this is now discouraged due to limited evidence that it is effective. Also patients should avoid nutritionally depleted diets and should have regular unhurried meals (Longstreth et al, 2006).

Pharmacological therapy

Decisions about pharmacological management should be based on the nature and severity of symptoms (NICE, 2008). The most prominent symptom, such as bloating, constipation, diarrhoea or cramping pain, should be treated.

Medications may be used on their own or in combination. For bloating and cramping pain, antispasmodics and peppermint oil have been found to be effective (Ford et al, 2008). They can be taken as needed alongside dietary and lifestyle changes.

Laxatives should be considered for constipation (avoid lactulose), and an anti-motility agent should be used for diarrhoea (loperamide) (NICE, 2008). Doses should be adjusted depending on symptoms. If these are not effective, tricyclic antidepressants should be considered as a second-line treatment. It is important that these are started at a low dose and patients are monitored closely; the dose should be reviewed four weeks after starting treatment (NICE, 2008).

BOX 3. DIETARY ADVICE FOR PATIENTS

- Have regular meals and take time to eat
 - Avoid missing meals or leaving long gaps between eating
 - Drink at least eight cups of fluid per day, especially water or other non-caffeinated drinks such as herbal teas
 - Restrict tea and coffee to three cups per day
 - Reduce intake of alcohol and fizzy drinks
 - It may be helpful to limit intake of high-fibre food
 - Reduce intake of “resistant starch” (starch that resists digestion in the small intestine and reaches the colon intact), which is often found in processed or re-cooked foods
 - Limit fresh fruit to three portions per day (a portion should be about 80g)
 - People with diarrhoea should avoid sorbitol, an artificial sweetener found in sugar-free sweets and drinks, and in some diabetic and slimming products
 - People with wind and bloating may find it helpful to eat oats (such as an oat-based breakfast cereal or porridge) and linseeds (up to one tablespoon per day)
- Source: NICE (2008)

Psychological therapies

The limited success of physically oriented pharmacological approaches has given strength to the argument that IBS has a strong psychological component. When selecting the most appropriate treatment for a patient, it is important to place emphasis on the perception and impact of symptoms, rather than on specific symptoms themselves. For example, anxiety may be the cause of pain or the pain may cause anxiety (Smith, 2010). NICE (2008) said that if patients do not respond to other treatments after 12 months, practitioners should consider a referral for psychological interventions.

The role of psychological interventions is unclear. Smith (2011) suggested that one such therapy – gut-directed hypnotherapy – could be effective in managing IBS by affecting parts of the brain that experience abdominal pain or influence bowel movements. Conventional (face-to-face) cognitive behavioural therapy (CBT) has also been shown to be effective in treating IBS and NICE (2008) suggests CBT as a treatment. Ljotsson et al (2011) compared

face-to-face CBT with CBT delivered by an online psychologist, and found online treatment was more effective and soothed some patients for up to six months.

Mindfulness training has also had substantial therapeutic effects on bowel symptom severity, improving health-related quality of life and reducing distress (Gaylord et al, 2011).

Although these therapies are effective for many patients, not all will respond to this kind of treatment. It is important that nurses are aware of the limited scientific evidence and potential safety issues when recommending these therapies.

Conclusion

Although IBS is a common and potentially debilitating illness, patients are often labelled as “neurotic” and told that symptoms are all in their mind. This attitude needs to change to ensure patients are diagnosed correctly and that they receive the treatment they need. Treatment needs to be specific to patient symptoms and their perception of them. **NT**

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