



# Practical implementation tips: irritable bowel syndrome

Dr Mike Cohen shares some key points for diagnosing and managing irritable bowel syndrome in adults in primary care

## 1 Listen to the patient and explore their concerns

Take the patient's symptoms seriously and explore their worries and concerns. A careful review of previous symptoms is worthwhile. Is this a new presentation or an ongoing condition? Consider asking patients presenting with symptoms of irritable bowel syndrome (IBS): *'How is life at the moment?'*

Stress and life events play a large part in functional bowel problems and it is worthwhile getting a sense of these from the outset. Many patients with IBS say they were told there was 'nothing wrong' or that 'nothing serious was found'. This leaves the patient baffled and confused; they still have symptoms so something must be wrong.

## 2 Initial assessment and follow up

There is insufficient time during the traditional 10-minute GP consultation to perform a realistic and holistic initial assessment. Investment in a longer initial consultation at the outset is often worthwhile. Be prepared to bring the patient back for at least one and probably two follow-up consultations to review progress.

It is often not easy to make a diagnosis of IBS; some patients may have atypical symptoms. Irritable bowel syndrome is quite common with a prevalence estimated to be around 10–20% and some patients with IBS may well also have coexisting gastrointestinal (GI) pathology.<sup>1,2</sup> The GP, as ever, is in a tricky position.

### Read this article to learn more about:

- ▶ how classification of IBS can help patients manage their symptoms
- ▶ dietary advice and pharmacological therapies
- ▶ when to refer patients for further investigation.

## 3 Diagnosing IBS

Over recent years there has been a move to encourage clinicians to make a positive clinical diagnosis of IBS without resorting to invasive or more complex investigations. In February 2015, NICE released the updated Clinical Guideline (CG) 61 on: *Irritable bowel syndrome in adults—diagnosis and management of irritable bowel syndrome in primary care*.<sup>1</sup> It is important to remember that guidelines are just guidelines; clinicians should exercise clinical judgment and manage patients according to their individual symptoms. If you have concerns regarding underlying pathology or if a patient's IBS is becoming difficult

to manage then onward referral is always appropriate.

An assessment for IBS should be considered if the patient reports having had any of the following symptoms for at least 6 months:<sup>1</sup>

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

Positive answers to the following additional questions are suggestive of IBS:

- ▶ are you experiencing cramps?
- ▶ is the pain in your lower left side (iliac fossa)?
- ▶ do you have to undo your trousers or loosen your belt at the end of the day?
- ▶ do you feel less bloated in the morning?
- ▶ do you often feel you have not emptied your bowels properly?
- ▶ do you sometimes pass loose and then sometimes pellet-like stools?

Consider performing some simple initial investigations in most patients. These could include:

- ▶ full blood count
- ▶ C-reactive protein (CRP)
- ▶ thyroid function tests
- ▶ coeliac screen
- ▶ stool microscopy culture and sensitivity test if patient has true diarrhoea.

▲

---

**It is often not easy to make a diagnosis of IBS; some patients may have atypical symptoms**

---

▼

## 4 When to refer—the red flags

Red flags could indicate presence of a more serious condition. Nocturnal diarrhoea is highly suggestive of organic disease.<sup>3</sup> Patients experiencing one or more of the following should be referred for further investigation:<sup>1</sup>

- ▶ unintentional and unexplained weight loss
- ▶ rectal bleeding
- ▶ a family history of bowel or ovarian cancer
- ▶ change in bowel habit to looser stools in an older patient
- ▶ iron deficiency anaemia
- ▶ a change in bowel habit to looser and/or more frequent stools persisting for more than 6 weeks in a person aged over 60 years
- ▶ abdominal masses
- ▶ rectal masses
- ▶ inflammatory markers for inflammatory bowel disease.

A rectal examination is not usually necessary but should always be performed if there has been rectal bleeding or a change in bowel habit.

## 5 Faecal calprotectin testing

Calprotectin is a heat stable intracellular protein shed by neutrophils into the intestinal lumen in response to inflammation. Some have described faecal calprotectin (FCP) as the CRP of the gut. A normal FCP is suggestive of functional intestinal disease.

NICE recommends FCP testing as an option to support clinicians with the differential diagnosis of inflammatory bowel disease (IBD) or IBS.<sup>4</sup> I would recommend carrying out FCP testing in those patients with ongoing, non-red-flag symptoms who are not responding to treatment.

It is vital that patients do not take non-steroidal anti-inflammatory drugs for 4 weeks or proton pump inhibitors for at least 2 weeks prior to having the FCP test

as presence of these agents can cause false positives.<sup>5,6</sup>

Currently there is much discussion regarding the level above which one would consider colonoscopy. A FCP level of >100 µg/g merits referral but intermediate levels require repeating and reassessing.<sup>7</sup>

## Diet and nutrition should be assessed for people with IBS and appropriate advice should be offered

## 6 Classifying IBS helps patients manage symptoms

Irritable bowel syndrome can be classified as:<sup>8</sup>

- ▶ IBS-C—constipation predominant
- ▶ IBS-D—diarrhoea predominant or
- ▶ IBS-M—mixed.

Ask patients which of their symptoms is most troubling and try to target treatment accordingly (see Table 1, p.48). Mixed IBS is difficult to treat as many patients have fluctuating symptoms. In this instance, concentrate on treating the predominant symptoms at the time of presentation.

## 7 Offer dietary advice

Diet and nutrition should be assessed for people with IBS and appropriate advice should be offered.<sup>1</sup> Patients often refer to the internet and many may try unusual diets that may not help with managing their symptoms. Ask the patient to keep a food diary for a month or so and to bring it along at the follow-up appointment. The food diary should include information about food and drink intake as well as bowel movements and exercise.

The following dietary advice may help patients to manage their IBS:

- ▶ eating more bran can make bloating and pain worse so avoid high-fibre cereals
- ▶ increasing intake of soluble fibre, such as that found in ispaghula husk and oats, can be beneficial
- ▶ drink 8–10 cups of liquid per day and avoid fizzy drinks
- ▶ wheat-free or dairy-free diets may help. Patients need to prepare for this and avoid eating out for that week. It takes some commitment
- ▶ fermentable oligosaccharides, disaccharides, monosaccharides, and polyols (FODMAPs) are found in many foods and can cause bloating and diarrhoea.

## 8 Pharmacological therapy

The decision to initiate pharmacological therapy depends on the severity of the patient's symptoms. Many patients will respond to a good explanation and dietary modification; however, drug treatment will be indicated in those who have persistent symptoms. Choice of treatment is dependent on the predominant symptoms of IBS (see Table 1, p.48).

### First-line treatment

Antimotility agents and laxatives should be used appropriately depending on the patient's predominant symptoms. People with IBS should be advised on adjusting the dose of such agents according to the clinical response.<sup>1</sup>

NICE recommends that antispasmodics should be considered for first-line use.<sup>1</sup> In my opinion, these agents can help ease pain and bloating but they have also been noted to have a high a placebo effect.<sup>9</sup>

### Second-line treatment

Low-dose tricyclic antidepressants (TCAs), such as amitriptyline 5–10 mg, are effective for easing abdominal pain and diarrhoea, and often help settle associated anxiety symptoms. Emphasise to the patient that they are not being used as an antidepressant but rather as a tricyclic analgesic.

Table 1: Dietary and pharmacological management by IBS classification

IBS type	Dietary management	Pharmacological therapy options
IBS-C	Increase intake of soluble fibre (e.g. ispaghula powder, oats)	<ul style="list-style-type: none"> <li>▶ Laxatives (avoid lactulose)</li> <li>▶ Linaclotide or TCAs if laxatives are ineffective</li> <li>▶ SSRIs if TCAs are ineffective</li> </ul>
IBS-D	Consider trialling a: <ul style="list-style-type: none"> <li>▶ wheat-free diet <b>or</b></li> <li>▶ dairy-free diet <b>or</b></li> <li>▶ low-FODMAP diet</li> </ul>	<ul style="list-style-type: none"> <li>▶ Antimotility agents (e.g. loperamide)</li> <li>▶ TCAs if the patient is not responding to loperamide</li> </ul>

IBS=irritable bowel syndrome; TCA=tricyclic antidepressant; SSRI=serotonin reuptake inhibitors; FODMAP= fermentable oligosaccharides, disaccharides, monosaccharides, and polyols

Linaclotide is a first-in-class guanylate cyclase-C receptor agonist, which promotes fluid movement into the gut lumen and helps ease constipation and abdominal pain in patients with IBS-C.<sup>10</sup> The dose is 290 µg per day. The initial side-effect, unsurprisingly, is diarrhoea so patients should be warned of this.

## 9 Role of imaging and endoscopy

There will always be patients who will need referring for an opinion. Young patients with IBS often find colonoscopy very painful. The alternative is computed tomographic colonography, but the drawback here is that there is a significant dose of radiation.<sup>11</sup> A typical history and normal initial non-invasive investigations in a younger patient should obviate the need for more invasive tests.

## 10 Explaining IBS to the patient

The precise cause of IBS symptoms are not wholly understood. Nonetheless, patients often value some explanation so that they can gain an understanding of their condition. Assure the patients that their symptoms are very real. Explain peristalsis and inform them that their peristaltic movements are probably not

well synchronised, recognising that this is a simplistic explanation. A description of the brain–gut neuronal axis allows them to accept that the brain interacts with the gut during times of stress and worry. Explain that IBS is a life-long condition and that living with it rather than reacting to it will be more beneficial in the long term. Use of information leaflets, such as those found at Patient UK are very helpful in reinforcing this information.<sup>12–14</sup>

Over the course of two to three consultations the majority of patients with IBS should show signs of improvement. There are of course some patients with difficult symptoms who will remain a challenge, and for whom referral will be necessary.

**Note:** Prime Endoscopy Bristol is a community gastroenterology service providing endoscopy and community clinics to NHS patients in South Gloucestershire, Bristol and North Somerset.

**Dr Mike Cohen**  
**Clinical Director, Prime Endoscopy Bristol**  
**Member of the Steering Committee for the Primary Care Society for Gastroenterology**

## References

- NICE. *Irritable bowel syndrome in adults: diagnosis and management of irritable bowel syndrome in primary care*. Clinical Guideline 61. NICE, 2015. Available at: [www.nice.org.uk/guidance/cg61](http://www.nice.org.uk/guidance/cg61)
- Jones R, Lydeard S. Irritable bowel syndrome in the general population. *BMJ* 1992; **304**: 87.
- Thomas P, Forbes A, Green J et al. Guidelines for the investigation of chronic diarrhoea, 2nd edition. *Gut* 2003; **52** (Suppl V): v1–v15.
- NICE. *Faecal calprotectin diagnostic tests for inflammatory diseases of the bowel*. Diagnostics Guidance 11. NICE, 2013. Available at: [www.nice.org.uk/guidance/dg11](http://www.nice.org.uk/guidance/dg11) (accessed 1 September 2015).
- Tibble J, Sighthorsson G, Foster R et al. High prevalence of NSAID enteropathy as shown by a simple faecal test. *Gut* 1999; **45**: 362–366.
- Poullis A, Foster R, Mendall M. Proton pump inhibitors are associated with elevation of faecal calprotectin and may affect specificity. *Eur J Gastroenterol Hepatol* 2003; **15** (5): 573–574.
- Seenan J, Thomson F, Rankin K et al. Are we exposing patients with a mildly elevated faecal calprotectin to unnecessary investigations? *Frontline Gastroenterol* 2015; **6** (3): 156–160.
- Longstreth G, Thompson W, Chey W et al. Functional bowel disorders. *Gastroenterology* 2006; **130** (5): 1480–1491.
- Darvish-Damavandi M, Nikfar S, Abdollahi M. A systematic review of efficacy and tolerability of mebeverine in irritable bowel syndrome. *World J Gastroenterol* 2010; **16** (5): 547–553.
- NICE. *Irritable bowel syndrome with constipation in adults: linaclotide*. Evidence Summary New Medicine 16. NICE, 2013. Available at: [www.nice.org.uk/advice/ESNM16](http://www.nice.org.uk/advice/ESNM16) (accessed 1 September 2015).
- Berrington de Gonzales A, Kim K, Yee J. CT colonography: perforation rates and potential radiation risks. *Gastrointest Endosc Clin N Am* 2010; **20** (2): 279–291.
- Patient UK. *Irritable bowel syndrome leaflet*. Available at: [patient.info/health/irritable-bowel-syndrome-leaflet](http://patient.info/health/irritable-bowel-syndrome-leaflet) (accessed 1 September 2015).
- Patient UK. *Irritable bowel syndrome diet sheet*. Available at: [patient.info/health/irritable-bowel-syndrome-diet-sheet](http://patient.info/health/irritable-bowel-syndrome-diet-sheet) (accessed 1 September 2015).
- The Association of UK Dietitians. *Food fact sheet: irritable bowel syndrome and diet*. Available at: [www.bda.uk.com/foodfacts/IBSfoodfacts.pdf](http://www.bda.uk.com/foodfacts/IBSfoodfacts.pdf)