

Mastering IBS Management: Tips for General Practice

Irritable bowel syndrome (IBS) is the most commonly diagnosed gastrointestinal condition affecting up to 25% of the population, most of whom never seek medical attention. It is a chronic condition that can substantially reduce quality of life. In the absence of an organic cause and a biological marker, diagnosing IBS continues to be a challenge. Nonetheless a positive, symptom-based approach to diagnosis is the first crucial step in mastering IBS management.

IBS is almost certainly not a single disease but rather a symptom cluster resulting from diverse pathologies. Recent important developments in IBS patients include alterations in the gut microbiome (dysbiosis), intestinal permeability, gut immune function, motility, visceral sensation, brain-gut interactions, and psychosocial status. However additional environmental factors such as early life stressors, food intolerances, antibiotic exposure and enteric infections also contribute to the onset of IBS symptoms¹.

Typical IBS symptoms include:

- Loose/frequent stools, constipation, bloating
- Cramping, pain aggravated or relieved with defaecation
- Food intake triggering complaints
- Fluctuating stool pattern over time

According to the recently released ROME IV criteria, suspected IBS symptoms need to be present for at least 3 months with symptom onset 6 months before making a diagnosis². The ROME criteria are *helpful in making a diagnosis of IBS but less helpful in understanding the causes of IBS*.

Concerning alarm features supporting a diagnosis of organic disease:

- Symptom onset after age 50y
- Severe or progressively worsening symptoms
- Unexplained weight loss
- Nocturnal diarrhoea
- Family history of bowel cancer, coeliac disease or inflammatory bowel disease (IBD)
- Rectal bleeding, melaena or unexplained iron deficiency with or without anaemia
- Recent antibiotic use

In 2016, the diagnosis of IBS remains a symptom-based diagnosis, with absence of alarm features and exclusion of organic diseases that can mimic IBS by performing selected tests (FBE, C-reactive protein, faecal calprotectin, coeliac serology, and age-appropriate colorectal cancer screening including FOBT and colonoscopy). Currently many patients are either over or under investigated, both in primary care and by specialists.

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A coeliac screen has a 5% chance of being positive in "IBS patients"³. This is a 5-fold increased probability of having coeliac disease compared with the general population. Negative coeliac serology has a very high negative predictive value for gluten enteropathy if the patient is following a gluten-containing diet.

Faecal calprotectin is useful in differentiating IBS and IBD, or other organic GI disorders. Calprotectin is a calcium-binding protein found in neutrophils, shed in the stool of patients with an inflamed bowel. Calprotectin has high sensitivity (96%) and specificity (93%) for the detection of IBD⁴. Calprotectin is very useful in ruling out IBD, potentially eliminating the need for a colonoscopy. However, an increased calprotectin level has also been reported in colorectal cancer and diverticular disease.

It is often difficult to decide when to refer a suspected IBS patient for an endoscopy. A referral for gastroscopy or colonoscopy is advisable in patients with alarm symptoms, an abnormal screening test (such as calprotectin or coeliac serology), or if the patient is refractory to symptom-based therapy. We would also advise endoscopic investigation in the patient where there is diagnostic uncertainty.

General practitioners and specialists need to make a definitive diagnosis of IBS after performing the appropriate tests, as without a diagnosis, IBS patients continue to search for an alternative diagnosis despite numerous negative investigations, fearful that something remains undetected. Once reasonable investigations are negative, effective management strategies can be implemented.

Many patients identify food as a trigger for their IBS symptoms. In IBS, true food allergies are uncommon; however food intolerances, especially to fermentable oligo-, di- and mono-saccharides and

polyols (FODMAPs), are increasingly recognised. FODMAPs are rapidly fermentable carbohydrates that are poorly absorbed leading to increased fermentation in the small bowel or colon. Hydrogen/methane breath testing enables detection of carbohydrate malabsorption and facilitates the development of a targeted and evidence-based exclusion diet to manage IBS symptoms. A low FODMAP diet supervised by a suitably qualified dietitian/nutritionist relieves IBS symptoms in up to 75% of IBS sufferers, and patients typically respond within 1-2 weeks of initiation of the diet⁵. Diarrhoea- and bloating-predominant IBS are the most likely subtypes to respond. A low FODMAP diet is not intended to be a long-term strategy and gentle FODMAP re-introduction is encouraged, as a reduction in the microbiome load and diversity have been noted following long-term FODMAP exclusion.

Various other medical and behavioural interventions, including cognitive behavioural therapy, have also proven effective in randomised clinical trials. Unfortunately, the majority of treatments which are able to modify symptoms do not alter the course of the condition. While a subgroup of patients shows benefit from pharmacological therapy, the effect is disappointing, and at best is only 15% better than placebo¹.

A paradigm shift may be required for those health care professionals who view IBS as a diagnosis of exclusion and are uncomfortable relying solely on symptoms for diagnosis. Evidence suggests that a diagnosis of IBS can be confidently made for patients who fulfil the symptom-based criteria and have no concerning features because the yield of extensive diagnostic testing is low.



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