Community HealthPathways North Cumbria

Irritable Bowel Syndrome (IBS)

Red flags

- Aged over 50 years at first presentation
- Blood in stool
- Unexplained iron deficiency anaemia
- Unintentional weight loss

Background

About irritable bowel syndrome (IBS)

About irritable bowel syndrome (IBS)

Irritable bowel syndrome is a relapsing functional bowel disorder that is characterised by abdominal pain, distension, and altered bowel habits.

- Prevalence is 10 to 15% of the population.
- The pathophysiology is poorly understood. Contributory factors include:
  - environmental exposures and factors, including childhood stresses and learned illness behaviour
  - post-infection, e.g. *Campylobacter*
  - visceral afferent hypersensitivity, i.e. for a given gastrointestinal stimulus, IBS patients experience more pain and related symptoms than people without IBS
  - altered intestinal transit
  - psychological distress and ongoing stress
- Definition (Rome IV criteria):
  - Recurrent abdominal pain or discomfort at least 1 day per month in the last 3 months, plus at least 2 of the following:
    - Pain related to defecation
    - Change in frequency of stool
    - Change in form (appearance) of stool
    - Symptom duration at least 6 months

- This definition is useful for younger patients, i.e. aged under 50 years, and those with long-standing symptoms and no red flags for colorectal cancer. [1]

Assessment

A diagnosis of IBS is made on the presence of symptoms and exclusion of other diagnoses.

1. Ask about:
   - symptoms .

     Symptoms

     - Abdominal symptoms including pain, bloating, triggers, and pattern.
     - Bowel symptoms:
       - Abnormal stool form, i.e. hard or loose
       - Abnormal stool frequency
       - Incomplete evacuation
       - Faecal urgency
       - Faecal incontinence
       - Passing mucus per rectum
       - Recent gastroenteritis (can be a precipitating factor)
     - Anxiety and depression

     Check the patient's main concern about their symptoms – often people are worried they have cancer.

   - family history of colorectal cancer in patients younger than 50 years
   - family history of coeliac disease, or inflammatory bowel disease.
   - previous cholecystectomy, or terminal ileal disease or resection – risk factors for bile salt malabsorption.
   - medications, e.g. metformin, proton pump inhibitors, supplements.
   - lifestyle:
     - diet, alcohol, caffeine, artificial sweeteners
     - eating habits
     - physical activity
     - travel
2. Look for any red flags .

Red flags

- Aged over 50 years at first presentation
- Blood in stools
- Unexplained iron deficiency anaemia
- Unintentional weight loss

3. Consider other possible diagnoses .

Other possible diagnoses

- Coeliac disease especially if positive family history
- Lactose intolerance
- Bile salt malabsorption – consider if previous cholecystectomy, or terminal ileal disease or resection
- Inflammatory bowel disease especially if positive family history
- Colorectal carcinoma
- Microscopic colitis
- Acute diarrhoea due to infection
- Diverticulitis
- Endometriosis
- Pelvic inflammatory disease
- Pelvic radiation disease
- Ovarian cancer

4. Examine abdomen and rectum and, if appropriate, perform a gynaecological examination to rule out other conditions.
5. Arrange tests to exclude pathology:
   - Include FBC, CRP, ferritin, B12, folate, coeliac screen, thyroid function tests (TFTs), urea and electrolytes .

Urea and electrolytes

When requesting urea and electrolytes, the laboratory will automatically test:

- Sodium
- Potassium – blood sample must be spun down or analysed within 6 hours of collecting, or the lab will omit potassium analysis
- Urea
- Creatinine

> - eGFR

- Consider CA125 for women, particularly if aged 50 years or older. See NICE – Ovarian Cancer: Detection in Primary Care .
- If diarrhoea, check faecal culture and sensitivity and ova and parasites, especially if foreign travel, spring water ingestion, farm exposure.
- If risk factors for Clostridium difficile , check stool PCR.

> **Risk factors for *Clostridium difficile***
>
> - Previous *C. difficile* infection
> - Antibiotic use
> - Proton-pump inhibitor use

- Consider faecal calprotectin if:
  - family history of inflammatory bowel disease (IBD).
  - patients younger than 50 years with chronic diarrhoea and there is suspicion of possible inflammatory bowel disease (IBD).

  To avoid a false positive results, the patient must stop any NSAIDs for at least 4 weeks before the test.

Management

In the absence of any red flags and normal investigations, referral is rarely required.

1. If abdominal, or rectal mass, request 2 week wait gastroenterology assessment.
2. If pelvic mass, request 2 week wait gynaecology assessment.
3. If any red flags , or concern that the patient may have colorectal cancer, request 2 week wait gastroenterology assessment.
4. If positive anti-tissue transglutaminase antibodies, arrange upper GI endoscopy. Advise the patient to continue to include sufficient gluten in their diet before endoscopy. Once the GI endoscopy has been completed the:
   - patient can start a gluten-free diet
   - gastroenterology team will organise a non-acute assessment, if appropriate
5. Request urgent non-acute gastroenterology assessment if faecal calprotectin greater than 250 microgram/g.
   - If faecal calprotectin is between 100 and 250 microgram/g, repeat the test two weeks later.
   - Ensure that the patient has stopped NSAIDs (including otc ibuprofen, aspirin) 4 weeks before the test.
6. Provide education and reassurance .

Education and reassurance

- Stress the importance of learning to self-manage IBS.
- Reassure the patient but take care not to minimise the significance of the symptoms.
- Inform patients of the chronic relapsing-remitting of symptoms and benign nature of IBS.

7. Advise on lifestyle options:
   - Advise on diet

Diet

- Advise patient to:
  - practice good eating habits – regular meals, eating slowly, chewing food thoroughly, sitting down to eat, not eating late at night.
  - eat a variety of foods.
  - watch portion sizes.
  - avoid or reduce fatty food, spicy food, caffeine, fizzy drinks, fruit juice, artificial sweeteners, and alcohol.
  - increase or decrease fibre depending on current bowel habit.
  - limit fresh fruit to 3 portions per day.
  - consider eating more oats (e.g. porridge) to help with wind and bloating.
  - have adequate fluid – at least 8 cups of water or other non-caffeinated drink per day.
- Consider asking the patient to keep a food and symptom diary to identify trigger foods.

Food and symptom diary

Because IBS is unlikely to be IgE-mediated, there are no reliable tests to identify trigger foods. Therefore, accurate diary-keeping is an essential diagnostic tool.

Bupa Food Diary

- Consider food intolerance, e.g. FODMAPs, lactose intolerance, wheat intolerance.

Wheat intolerance

- Wheat intolerance differs from coeliac disease.
- Coeliac disease is a lifelong intolerance to gluten, whereas those with wheat intolerance still experience adverse symptoms from gluten-free products, due to the remaining part of the wheat affecting them.

- A food diary, with elimination and re-introduction of wheat into the diet can help establish a case for wheat intolerance.

Lactose intolerance

- About 5% of people in the United Kingdom are lactose intolerant. The level of intolerance varies. Some patients are able to digest small amounts of lactose if consumed in small quantities at different times of the day.
- If lactose intolerance is suspected, try simple dietary exclusion for 4 weeks, then re-challenge with lactose. Dietitian advice on elimination and challenging may be useful.
- Lactose intolerance can sometimes be overcome with slow incremental increases in dietary lactose intake.
- If lactose intolerant, very small amounts of lactose in the diet usually do not cause any symptoms.
- Consider lactase enzyme tablets (e.g. Lacteeze), especially if eating out. These are available over-the-counter from some pharmacies (and health food shops). Take 1 to 3 tablets with a high-lactose meal.
- Advise patients how to read food labels correctly.

FODMAPs

- FODMAP means:
  - Fermentable – rapidly broken down by bacteria in the gut
  - Oligosaccharides – fructans and galacto-oligosaccharides (GOS)
  - Disaccharides – lactose
  - Monosaccharides – fructose
  - And
  - Polyols – sorbitol, mannitol, maltitol, xylitol, and isomalt
- Clinical studies have shown that a low FODMAP diet can lead to marked improvement in abdominal symptoms for up to 75% of people with IBS. [2]
- The low FODMAP diet is complex and can be confusing. Referral to a FODMAP-trained dietitian is recommended, although this is not currently provided locally.
- The low FODMAP diet is not a life-long diet. It includes a 4 to 6 week exclusion phase followed by FODMAP reintroduction, using a systematic food challenge process to determine personal tolerance thresholds to individual foods, and enabling long-term self-management.
- For more information about FODMAPs, see:
  - Information sheet by Australian dietitian Dr Sue Shepherd, author of the low FODMAP diet.

- Food Intolerance Management Plan , a website to support the food intolerance management plan book written by Sue Shepherd. It is a good resource for patients who want to trial a low FODMAP diet.
- Monash University Low FODMAP smartphone app (there is a cost) – provides accurate information about foods that trigger IBS reactions to help sufferers to manage their symptoms.

- If the patient has tried all of the advice above, consider requesting dietetics assessment.

- Recommend increased physical activity to improve symptoms [3]
- Address any psychosocial issues and stress management

Psychosocial issues and stress management

- Specific interventions may help some patients, e.g. relaxation techniques such as breathing techniques, meditation, or T'ai Chi.
- Gut-directed hypnotherapy has also been shown to be effective. [4]
- If stress and anxiety appear to be a major driver of symptoms. [4], consider requesting cognitive-behaviour therapy from First Steps or Quell .

- Do not recommend probiotics.

8. Prescribe medications if needed. Most patients do not need medication, but some require symptom-targeted medication. Treat the most troublesome symptom:

- Diarrhoea

Diarrhoea

- Loperamide is the first-choice anti-motility agent, and is preferred over codeine phosphate which has the significant issues of dependence, tolerance, and drug interactions.
  - Only use loperamide if an infective cause has been excluded and there is no clinical suspicion of IBD. Use 2 to 4 mg as required, and titrate to a maximum of 16 mg.
  - Encourage patients to learn how to adjust their doses of anti-diarrhoeal agent according to stool frequency and consistency.
- Trial a stool bulking agent – 3.5 g ispaghula husk, e.g. Fybogel 1 sachet twice a day.
- If previous cholecystectomy, trial colestyramine once or twice a day (unlicensed indication). Start at half a sachet and increase gradually to 4 gram twice a day until symptoms are controlled. Stop if no benefit after 2 weeks.

- Constipation

Constipation

1. Encourage patients to learn how to adjust their doses of laxative according to stool frequency and consistency (aim for 1 soft well-formed stool daily).
2. Start with bulk-forming laxatives, although soluble fibre bulking agents may initially worsen the bloating and wind. Bulk-forming laxatives:
   - increase faecal mass which stimulates peristalsis.
   - need adequate fluid intake to avoid intestinal obstruction.
   - are contraindicated in pre-existing intestinal obstruction.

   Common preparations include:

   - ispaghula husk
   - sterculia
3. Consider osmotic laxatives, e.g.:
   - lactulose
   - macrogols
4. Consider stimulant laxatives, e.g.:
   - bisacodyl
   - ducosate sodium

Note that osmotic and stimulant laxatives are commonly used to treat constipation but there are few randomised controlled trials to support their use in IBS.

- Abdominal pain, bloating, and distension

Abdominal pain, bloating, and distension

Consider:

- first-line – antispasmodics, e.g. peppermint oil , mebeverine.

  Peppermint oil

  - There is some evidence this may be useful for bloating, wind, and bowel cramps.
  - Has antispasmodic and antiflatulent effects with mild analgesic effects.
  - May cause or worsen reflux.
  - Peppermint oil capsules, e.g. Colpermin or Mintec, are enteric coated so designed to be released in the colon.
  - Trial 1 to 2 capsules, 3 times a day until symptoms resolve. Can be continued up to 3 months. If helpful, continue but reduce to the lowest effective dose.

- second-line – hyoscine butylbromide.
- third-line – antidepressants .

Antidepressants

- Effective for the treatment of discomfort and pain in IBS.
- Mechanism of action is likely to be through analgesic and motility effects rather than the treatment of psychological symptoms.
- Tricyclic antidepressants:
  - Inform the patient that this is an unlicensed indication and document that they consent to unlicensed use.
  - Start with low dose, e.g. amitriptyline (unlicensed indicating) 10 mg at night, increasing to a usual maximum dose of 30 mg.
  - Slowly increase if needed only after 3 to 4 weeks due to delayed onset of action.
  - Avoid with constipation.
  - Review after 4 weeks, then every 6 to 12 months.
- SSRIs (unlicensed indications):
  - Consider if tricyclic antidepressants are ineffective.
  - Use where there is constipation or where psychological symptoms predominate.
  - Inform the patient that this is an unlicensed indication and document that they consent to unlicensed use.
  - Consider sertraline 50 to 100 mg (first line), or citalopram or fluoxetine 10 to 20 mg (second line).
  - Review after 4 weeks, then every 6 to 12 months.

9. Review intermittently to encourage self-management, look for red flags , and assess diet.

Request

- Request 2 week wait gastroenterology assessment if:
  - abdominal, or rectal mass.
  - concern that the patient may have colorectal cancer, even in the absence of overt red flags
  - aged over 50 years at first presentation.
  - blood in the stools.
  - unexplained iron deficiency anaemia.
  - unintentional weight loss.
- If pelvic mass, request 2 week wait gynaecology assessment.
- If faecal calprotectin greater than 250 microgram/g, request urgent non-acute gastroenterology assessment.

- If no improvement despite trying all of the above management, consider requesting dietetics assessment.
- If stress and anxiety appear to be a major driver of symptoms. [4] , consider requesting cognitive-behaviour therapy from First Steps or Quell .

Information

For health professionals

Education

- BMJ Learning:
  - Irritable Bowel Syndrome
  - Irritable Bowel Syndrome: New and Emerging Treatments
- North Cumbria HealthPathways – Continuing Professional Development

Further information

- NICE Clinical Knowledge Summaries (CKS) – Irritable Bowel Syndrome
- World Gastroenterology Organisation – Irritable Bowel Syndrome: a Global Perspective

For patients

- Bupa – Irritable Bowel Syndrome Symptom Diary
- ibsnetwork – FODMAPS
- Patient:
  - IBS Diet Sheet
  - Irritable Bowel Syndrome

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SOURCES

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