

FAST FACTS

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*Indispensable
Guides to
Clinical
Practice*

Irritable Bowel Syndrome

Second edition

by W Grant Thompson and
Kenneth W Heaton

Foreword by George F Longstreth

What is IBS?	9
Epidemiology	15
Causes and mechanisms	24
Diagnosis	36
Approach to treatment	52
Dietary advice	61
Drug treatment	67
Psychological treatment	78
Future trends	85

HEALTH PRESS

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Irritable Bowel Syndrome

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Foreword	5
Introduction	7
What is IBS?	9
Epidemiology	15
Causes and mechanisms	24
Diagnosis	36
Approach to treatment	52
Dietary advice	61
Drug treatment	67
Psychological treatment	78
Future trends	85
Useful addresses	91
Index	93

Foreword

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In this revision of *Fast Facts – Irritable Bowel Syndrome*, Drs W Grant Thompson and Kenneth W Heaton have updated their comprehensive, concise and useful practice guide on the management of patients with IBS. The additional information will help practitioners care for patients with this common cause of abdominal pain and bowel habit abnormality.

The authors include recent developments in pathophysiology, diagnosis and treatment in a readable style that combines objectivity with the wisdom of experience. Potentially important processes in the central nervous system and the gut are described, including evidence of mucosal inflammation that even challenges the traditional classification of IBS as a ‘functional’ disorder. However, the authors emphasize the difficulty of distinguishing the causality of observed pathophysiological correlates from epiphenomena. On a background of their research on the Manning symptom criteria 25 years ago and their subsequent work on periodic diagnostic criteria revisions, most recently the Rome II criteria, they discuss what is currently known about the comparability of the various diagnostic criteria. Their detailed tips on history taking and interacting with patients, including how to elicit psychological factors and explain them, are especially valuable to both general and specialist practitioners. Economy is served by their advice that a diagnosis in most patients can be based on the presence of typical symptoms, the absence of alarm symptoms, and limited testing. Their assessment of the new, promising serotonergic neuroenteric modulators is accurate and appropriately balanced with skepticism regarding the value of any single drug for a disorder with such a diverse pathophysiological and clinical spectrum. Above all, these respected clinicians emphasize that ‘the doctor is the placebo’, an often neglected concept that has great potential therapeutic value.

When Drs Thompson and Heaton began their professional careers, they likely could have flipped through month after month of

gastroenterology journals before finding an article on IBS. Nowadays, not only is the disorder emerging from such darkness, but the proliferating publication of laboratory research, clinical observations, subject reviews, consensus documents and sophisticated mathematical applications (e.g. meta-analyses) can bewilder a practitioner who primarily wants to know how to diagnose and treat patients. This guide to clinical practice fulfills this need well.

Introduction

This book is the fruit of a transatlantic collaboration spanning 25 years and culminating in a research project based on general practices in the Bristol area of England. When we wrote our first paper together, few people were interested in irritable bowel syndrome (IBS) but, since then, it has become the subject of much scientific inquiry (Figure 1) and also one of great public interest. Much has been learned about its clinical features, its diagnosis and, in particular, its epidemiology.

We now know that IBS is the most common explanation for gut symptoms in the community, the most common reason that people go to their family doctor with a gut complaint and the most common

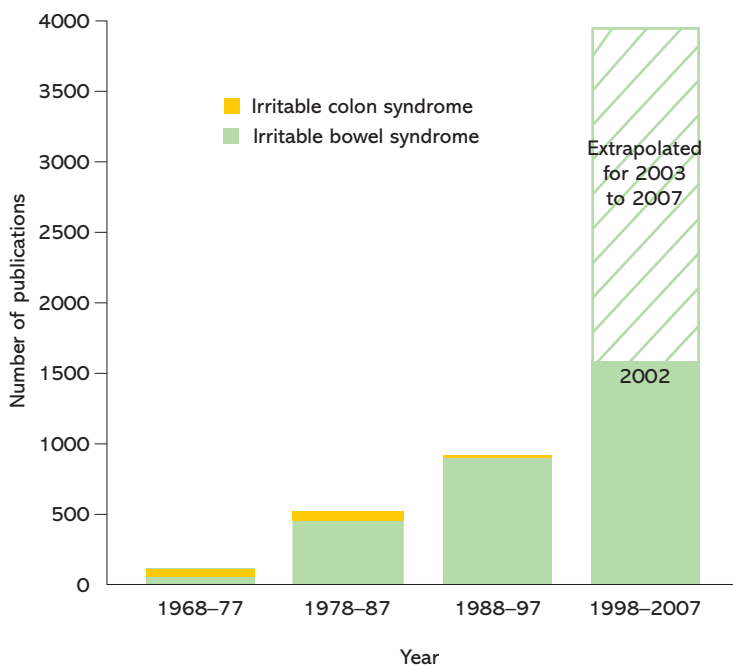


Figure 1 Index Medicus publications about irritable bowel syndrome, or irritable colon syndrome as it used to be called, in the decade before and in the decades after 1978. This was the year in which the authors described the symptoms that enable a positive diagnosis to be made (now known as the 'Manning criteria').

diagnosis in patients who are referred to a gastroenterologist. Despite all this, specialists are still groping to understand the pathogenesis of IBS, and it is a rash doctor who claims to cure it once and for all.

IBS presents itself to the world in many guises. Not only do symptoms vary between patients, but also a single patient's symptoms vary over time. In addition, IBS is perceived differently by patients and non-patients, that is to say people who have the symptoms but do not complain about them. It is seen differently again by each of the many groups of healthcare workers who become involved – family physicians, gastroenterologists, internists, surgeons, gynecologists, psychologists, psychiatrists and healthcare managers. Perhaps because of these varied perspectives, a plethora of belief systems has grown up about the nature of IBS, and we believe that none of them is likely to be wholly true.

In the first edition of *Fast Facts – Irritable Bowel Syndrome*, we attempted to present the scientific facts about IBS clearly and impartially. We also built on our personal experience in proposing a management approach that we believe is a practical and sensible one for family physicians and for other doctors. In the four years since the first edition was published, significant developments have occurred which convinced us of the need to add to and update the book. New epidemiological studies have extended our knowledge of IBS worldwide, and notions that visceral sensitivity or occult inflammation may lie behind the syndrome have been further explored. Experience with diagnostic criteria has grown, and the case for an economical approach to investigations has been strengthened. Patient support groups and pharmaceutical companies have raised the public profile of IBS and promoted new research. For the first time, well-designed trials have shown benefit from drugs and psychological therapy, at least for selected patients. Of course, new data raise new questions, and we discuss these at the end of this book. Unfortunately, management of IBS continues to be handicapped by our ignorance of its pathogenesis and by obstacles in healthcare systems to the nurturing of the all-important doctor–patient relationship, the traditional virtues of which, we steadfastly believe, hold the keys to successful management. Nevertheless there is progress and much to be optimistic about.

Irritable bowel syndrome (IBS) is a constellation of symptoms that doctors recognize when taking a medical history. The symptoms appear to be due to dysfunction of the intestine and are said, therefore, to be ‘functional’. They consist of abdominal pain related to defecation, altered bowel habit and – variably – other symptoms such as abdominal bloating or visible distension, a feeling of incomplete evacuation, and mucus in the stools. Typically the bowel habit is chaotic – sometimes ‘normal’, sometimes constipation, sometimes diarrhea, sometimes both extremes in the same day.

Unlike a structural or ‘organic’ disease, such as peptic ulcer, there is no anatomical lesion that explains the symptoms and that, when found, clinches the diagnosis. There is not even a clear-cut pathophysiological explanation. While the patient’s gut is clearly malfunctioning, current technology cannot precisely measure the abnormality, nor can any test assist the doctor in making the diagnosis.

Hence, we know of the existence of IBS only from patients’ descriptions of their symptoms. The challenge for the doctor is to recognize the pattern of symptoms that identifies IBS. Our ability to do this began with a study carried out by the authors back in 1977–78. We administered questionnaires to patients referred by GPs to medical and surgical clinics in Bristol and found that six symptoms were more prevalent in IBS than in organic abdominal disease. These became known as the ‘Manning criteria’ (Table 1.1). The more that were present, the more likely was it that the patient had IBS (Figure 1.1). These symptom criteria have been validated by others and are used worldwide in epidemiological studies, clinical trials and everyday practice.

In recent years teams of experts, meeting in Rome and using a consensus approach, have developed definitions and symptom criteria for all the recognized functional gastrointestinal disorders (Table 1.2). It is a formidable list and only specialists make many of the diagnoses, but it is important for family doctors and generalists to know that these

TABLE 1.1

Manning criteria for IBS

By convention, a diagnosis of IBS requires abdominal pain and at least two of the following six criteria. The first three are the basis for the Rome II criteria (Table 1.4).

- Abdominal pain eased after bowel movement
- Looser stools at onset of pain
- More frequent bowel movements at onset of pain
- Abdominal distension
- Mucus per rectum
- Feeling of incomplete emptying

Source: Manning et al. 1978

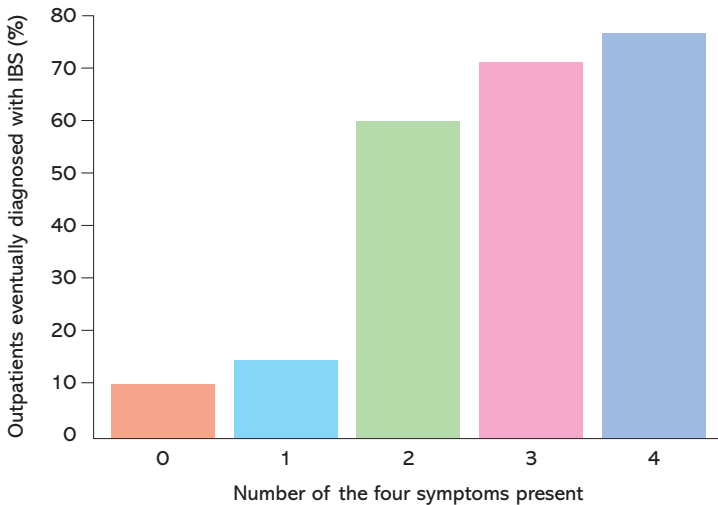


Figure 1.1 Percentage of patients diagnosed as having IBS on referral to hospital clinics with abdominal pain or disturbed bowel habits, according to how many of four symptoms they admitted to at their first clinic visit. The four symptoms were relief of pain with defecation, looser stools since onset of pain, more frequent stools since onset of pain, and abdominal distension (the first three are the Rome II criteria). These symptoms later became incorporated into the Manning criteria, together with feelings of incomplete evacuation and passage of mucus.

5 Approach to treatment

In the previous chapter, we outlined how IBS can be diagnosed promptly and confidently in most cases. This is the bedrock of good management. Only with a confident diagnosis can the doctor reassure the patient effectively, but reassurance is not always effective. In a study of IBS patients attending English general practitioners, we found that more than half the patients waiting to see the doctor harbored fears of serious disease and, unfortunately, most patients still had this fear after seeing the doctor (Table 5.1). We believe this was due to lack of diagnostic confidence in the doctor because when, in a separate study, we asked GPs why they referred patients to specialists, they gave as their principal reason ‘diagnostic uncertainty’. The previous chapter of this book is aimed at helping doctors (and ultimately patients) avoid such uncertainty.

Explaining the diagnosis

Once the doctor is reasonably confident of the diagnosis, the patient should be told what is wrong, and the doctor should state categorically that the symptoms are not those of cancer or other serious disease. It is also important to find out the patient’s beliefs about their symptoms

TABLE 5.1

Disease fears in primary care patients just before seeing the doctor

	Percentage of patients with IBS* (n = 76)	Percentage of patients with organic disease (n = 100)
Fear of cancer	46	30 (vs IBS $p < 0.04$)
Fear of other disease	9	10
Total with fears	55	40 (vs IBS $p < 0.05$)

* Disappointingly but importantly, only 29% of IBS patients had lost their fears after visiting their family doctor

and to correct any misconceptions, stressing that IBS does not increase the risk of developing any other disease. If tests have revealed colon diverticula, their lack of relevance should be explained: half of elderly Westerners have such diverticula and nearly all are asymptomatic; very few develop diverticulitis.

This good news should be tempered with a realistic prognosis: the doctor can point out that IBS symptoms tend to be chronic, or to recur throughout life (Figures 2.4 and 2.5, pages 19, 20). Hopes of permanent cure are unrealistic and likely to be dashed by recurrence. Unless warned of this, patients may consult other doctors and undergo unnecessary and even dangerous tests and treatments. Of course, a diagnosis of IBS confers no immunity to other gut disease, which occurs as often in IBS patients as in the general population. Alert physicians will detect alarm symptoms, risk indicators and physical findings.

Reassurance alone is not enough. Some explanation of IBS must be given too, and it must be tailored to the patient's level of understanding. It may be helpful to describe the gut as 'touchy' or excitable, so that it overreacts to everyday experiences such as stress, eating and defecation, or to gut stimulants such as caffeine, laxatives and drugs. This explanation is in accord with the 'visceral hypersensitivity' hypothesis outlined in Chapter 3 (Causes and mechanisms). Some doctors liken IBS to a headache – a nuisance rather than a disease. It may be a big nuisance, but it causes no physical damage.

Aggravating factors

Patient and doctor together should review the patient's lifestyle in search of aggravating factors. Questions about working hours and family commitments can be revealing. Some patients seem never to relax. Others suspect and eliminate foods, but individual foods are seldom guilty. More likely to disrupt gut function than any specific food are irregular and rushed meals, such as occur with shift work, business lunches, or just in busy households.

Patients with diarrhea as their main symptom should be told about the laxative effects of sorbitol, the artificial sweetener in many sugar-