

key points

SELECTED BY

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IBS is not just a motility disorder of the colon, but a condition that affects the whole length of the GI tract. Other factors, such as visceral hypersensitivity; inflammation; heredity; disturbed CNS processing of noxious stimuli from the intestine; diet and psychological influences also contribute to the overall clinical picture. In the past, the psychological aspects of the condition have probably been overemphasised. Stress does not cause IBS, although it affects consultation behaviour and exacerbates the condition.

The principal symptoms of IBS are abdominal pain, which can occur at any site; abdominal bloating, which may be accompanied by an actual increase in girth; and a disturbed bowel habit: about one-third of patients have constipation, one-third diarrhoea and one-third alternate between the two. Many patients also complain of non-colonic symptoms. Symptoms are often worse during menstruation and women may also experience pain during or after intercourse, sometimes the following day.

Diarrhoea may indicate coeliac disease or inflammatory bowel disease, although the latter is often accompanied by blood in the stools, systemic upset, extraintestinal manifestations and a raised ESR or plasma viscosity.

All patients with suspected IBS should have an FBC, ESR or plasma viscosity, CRP and serological screening for coeliac disease.

Carcinoma of the colon should always be ruled out in patients over 50 years or in younger patients with a family history of colon cancer, especially if this occurred at a young age. It is also important to enquire about red flags, such as rectal bleeding, anaemia, weight loss and recent onset of symptoms.

Patients often find that eating makes their symptoms worse. The most common component of the diet that can exacerbate the condition is fibre. Patients should therefore be advised to avoid breakfast cereals, brown bread and anything containing brown flour for 8-12 weeks.

Antispasmodics can be effective for treating pain and should preferably be used on an as necessary basis. It is well worth trying a variety, as some have an anticholinergic effect, such as hyoscine or dicycloverine, and others act on smooth muscle, for example mebeverine or alverine. Loperamide is probably the most useful antidiarrhoeal that is safe for long-term treatment.

Laxatives such as macrogols should be prescribed at a low dose on a regular basis rather than intermittently. Lactulose should be avoided as it tends to cause gas and bloating, which can exacerbate IBS.

If these measures fail the next step is to try antidepressants. Tricyclics, such as amitriptyline, are to be especially effective even at low doses, such as 10-20mg.