key points

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The classic symptoms of irritable bowel syndrome (IBS) are abdominal pain, bloating and some form of bowel dysfunction. The pain is typically colicky in nature and can occur at any site although most commonly it is on the left side. The abdomen feels flat in the morning and then gradually becomes more bloated as the day progresses reaching a peak by late afternoon or evening. It then subsides again over night.

Traditionally IBS is divided into diarrhoea, constipation or alternating subtypes. Most patients will also complain of a sensation of incomplete evacuation after defecation as a result of rectal hypersensitivity. Faecal incontinence is not uncommon in the more severe forms of IBS.

IBS patients frequently complain of one or more non-colonic symptoms, these include constant lethargy, low backache, nausea, bladder symptoms suggestive of an irritable bladder, chest pain and dyspareunia in women. The traditional view that IBS is a largely psychological condition is no longer tenable, although psychological factors obviously contribute to the overall clinical picture.

Rectal bleeding, a family history of malignancy and a short history in IBS should always be treated with suspicion. Although IBS rarely causes nocturnal symptoms these may occur in the more severe cases and it is unusual for patients with IBS to be underweight. The diagnosis of IBS is very likely if the patient has had typical symptoms for several years, especially when they are accompanied by non-colonic symptoms and there are no red flags.

Both pain and bowel dysfunction are often made worse by eating. It is recommended that a coeliac screening test is undertaken to rule out this condition. Other routine tests should include inflammatory markers in the form of CRP or ESR. Calprotectin is a marker for leukocytes in the stools and, therefore, detects gastrointestinal inflammation. A negative test almost certainly rules out inflammatory bowel disease, especially in conjunction with a normal CRP.

It is also now recognised that fermentable carbohydrates can have a detrimental effect on IBS and this has led to the introduction of the low FODMAP diet. When advising on an increase in fibre, soluble forms such as that derived from ispaghula are preferable.

Antispasmodics are the drugs of choice for pain, if the pain is intermittent then their use should be on an as necessary basis. Antimuscarinics (e.g. dicycloverine) can be combined with direct acting smooth muscle relaxants (e.g. mebeverine) to obtain a synergistic effect. If the patient fails to respond antidepressants need to be considered, low-dose tricyclics seem to be more effective than SSRIs.