

Irritable bowel syndrome in adults

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Yakult **Nursing**
IN PRACTICE

Welcome

In February 2008, NICE published a clinical guideline on the diagnosis and management of IBS in adults within the primary care setting

Nursing
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Irritable bowel syndrome in adults

Irritable bowel syndrome (often called 'IBS') is a disorder that interferes with the normal functioning of the large bowel. The most common symptoms include pain or discomfort in the abdomen, bloating, an urgent need to empty the bowel, and changes in bowel habit (diarrhoea or constipation, or both).

Irritable bowel syndrome will often come and go throughout a person's life and can be a painful and upsetting condition. Its exact cause is unknown. Irritable bowel syndrome affects between 10% and 20% of the general population, but most often occurs in young people between the ages of 20 and 30. It is twice as common in women as in men.

The guideline provides healthcare professionals with a number of recommendations that help to diagnose and manage IBS, and sets out the support, treatment and advice people with the condition should be offered.

DIAGNOSIS

Healthcare professionals should consider assessment for IBS if the person reports having had any of the following symptoms for at least six months:

- Abdominal pain or discomfort
- Bloating
- Change in bowel habit

A diagnosis of IBS should be considered only if the patient has abdominal pain or discomfort that is either relieved by emptying the bowels or associated with altered bowel frequency or stool form. This should be accompanied by at least two of the following four symptoms:

- Altered stool passage (straining, urgency, incomplete evacuation)
- Abdominal bloating (more common in women than men), distension, tension or hardness
- Symptoms made worse by eating
- Passage of mucus.

Other features such as lethargy, nausea, backache and bladder symptoms are common in people with IBS, and may be used to support the diagnosis

In people who meet the IBS diagnostic criteria, the following tests should be undertaken to exclude other diagnoses:

- Full blood count (FBC)
- Erythrocyte sedimentation rate (ESR) or plasma viscosity
- C-reactive protein (CRP)
- Antibody testing for coeliac disease (endomysial antibodies [EMA] or tissue transglutaminase [TTG]).

The following tests are not necessary to confirm diagnosis in people who meet the IBS diagnostic criteria:

- Ultrasound



- Rigid/flexible sigmoidoscopy
- Colonoscopy; barium enema
- Thyroid function test
- Faecal ova and parasite test
- Faecal occult blood
- Hydrogen breath test (for lactose intolerance and bacterial overgrowth).

Red flags

It is important to rule out the possibility that symptoms suggestive of IBS are being caused by other illnesses that need specialist treatment, such as cancer or inflammatory bowel disease (IBD).

All people presenting with possible IBS symptoms should be asked if they have any 'red flag' indicators and should be referred to secondary care for further investigation if

they have unintentional and unexplained weight loss, rectal bleeding, a family history of bowel or ovarian cancer or a change in bowel habit to looser and/or more frequent stools persisting for more than 6 weeks in a person aged over 60 years.

All people presenting with possible IBS symptoms should be assessed and clinically examined for the following 'red flag' indicators and should be referred to secondary care for further investigation if any of the following are present:

- Anaemia
- Abdominal masses
- Rectal masses
- Inflammatory markers for inflammatory bowel disease.

GENERAL DIETARY ADVICE FOR PEOPLE WITH IBS

- Have regular meals and take time to eat
- Avoid missing meals or leaving long gaps between eating
- Drink at least eight cups of fluid per day, especially water or other non-caffeinated drinks such as herbal teas
- Restrict tea and coffee to three cups per day
- Reduce intake of alcohol and fizzy drinks
- Consider limiting intake of high-fibre food (for example, wholemeal or high-fibre flour and breads, cereals high in bran, and whole grains such as brown rice)
- Reduce intake of 'resistant starch' (starch that resists digestion in the small intestine and reaches the colon intact), often found in processed or re-cooked foods
- Limit fresh fruit to three portions (of 80g each) per day
- For diarrhoea, avoid sorbitol, and artificial sweetener found in sugar-free sweets (including chewing gum) and drinks, and in some diabetic and slimming products
- For wind and bloating consider increasing intake of oats (for example, oat-based breakfast cereal or porridge) and linseeds (up to one tablespoon per day)

MANAGEMENT

People with IBS should be given information that explains the importance of self-help in effectively managing their IBS. This should include information on general lifestyle, physical activity, diet and symptom-targeted medication.

Lifestyle and physical activity

- Encourage people to identify and make the most of their leisure time and to create relaxation time
- Assess physical activity levels, ideally using the General Practice Physical Activity Questionnaire (GPPAQ) and give people with low activity levels brief advice and counselling to increase their activity.

Diet

- Assess diet and nutrition and give general advice (see box)
- Review the person's fibre intake and adjust (usually reduce) according to symptoms
- Discourage intake of insoluble fibre (for example, bran)
- If more fibre is needed, recommend soluble fibre such as ispaghula powder, or foods high in soluble fibre (for example, oats)
- If the person wants to try probiotics, advise them to take the product for at least four weeks while monitoring the effect. Probiotics should be taken at the dose recommended by the manufacturer
- Discourage the use of aloe vera for IBS.

Referral to a dietitian

If diet is considered a major factor in symptoms and dietary/lifestyle advice is being followed, refer to a dietitian for single food avoidance and exclusion diets. Only a dietitian should supervise such treatment.

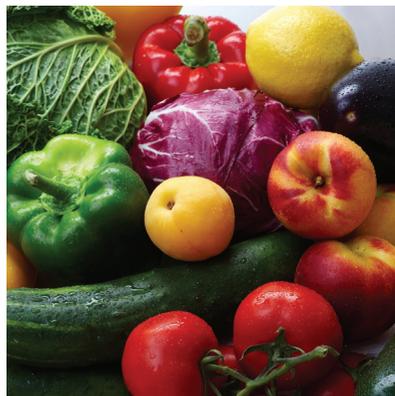
First-line pharmacological treatment

Choose single or combination medication based on the predominant symptom(s).

- Consider offering antispasmodic agents. These should be taken as required alongside dietary and lifestyle advice
- Consider offering laxatives for constipation, but discourage use of lactulose
- Offer loperamide as the first choice of antimotility agent for diarrhoea
- Advise people how to adjust doses of laxative or antimotility agent according to response, shown by stool consistency. The aim is a soft, well-formed stool (Bristol Stool Form Scale type 4).

Second-line pharmacological treatment

- Consider tricyclic antidepressants (TCAs) for their analgesic effect if first-line treatments do not help*.
 - Start at a low dose (5–10 mg equivalent of amitriptyline) taken once at night and review regularly
 - The dose may be increased (but should not usually exceed 30 mg)
- Consider selective serotonin reuptake inhibitors (SSRIs) only if TCAs are ineffective*
- Take into account the possible side effects of TCAs and SSRIs.
 - If prescribing these drugs for the first time, follow up after 4 weeks and then every 6–12 months.

**FOLLOW-UP**

Agree follow-up with the person based on symptom responses to interventions. This should form part of the annual patient review. Investigate or refer to secondary care if 'red flag' symptoms appear during management and follow-up.

Referral for psychological interventions

For people whose symptoms do not respond to pharmacological treatments after 12 months and who develop a continuing symptom profile (refractory IBS), consider referring for:

- Cognitive behavioural therapy (CBT)
- Hypnotherapy
- Psychological therapy.

*At the time of publication, (February 2008) TCAs and SSRIs did not have UK marketing authorisation for the indications described. Informed consent should be obtained and documented.

For more information visit:
<http://guidance.nice.org.uk/CG61>

Find the science behind *Lactobacillus casei* Shirota at yakult.co.uk/hcp

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