

IBS

4th year MBCHB , UON 2021

E O Ogutu

What is IBS

- It is a functional gastrointestinal disorder characterized by abdominal pain
- & altered bowel habits in the absence of a specific & unique organic pathology
- Global prevalence is 10-20%
- Incidence of 1-2%

Manifestations

- Altered bowel habits
- Abdominal pain
- Abdominal bloating/distension

Altered bowel habits in IBS

- ❖ Constipation: Stool are narrow/pellety

- ❖ Infrequent defecation

- ❖ Diarrhea: Small volume of loose stools

- Urgency/frequent defecation

Post prandial urgency is common as is alteration of diarrhea & constipation

- ❖ Abdominal pain;

- pain is often diffuse without radiation

- Common site of pain is lower abdomen especially LLQ

- Meal may precipitate pain

- Defecation improves pain

Rome 1V criterion for diagnosing IBS

It requires patient to have recurrent abdominal pain on average at least 1 day / week during the previous 3 **months**

That is associated with 2 or more of the following:-

- ❖ Related to defecation (may be ↑ or unchanged by defecation)
- ❖ Associated with a change in stool frequency
- ❖ Associated with a change in stool form or appearance

Supporting symptoms include:

- ❖ Altered stool frequency
- ❖ Altered stool form
- ❖ Altered stool passage(straining &/or urgency)
- ❖ Mucor rhea
- ❖ Abdominal bloating or subjective distension

Bowel Patterns noted

In Rome 1V classification as in Rome 3

IBS –D. (Diarrhea predominant)

IBS –C (constipation predominant)

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IBS – M (mixed diarrhea & constipation)

IBS- U (Unclassified, the symptoms cannot be categorized into any one of the above 3)

Diagnostic consideration

Manning & associates established 6 criteria to distinguish IBS from organic disease: (Insensitive 58%, nonspecific 74% & less reliable in men)

- 1) Onset of pain associated with more frequent bowel movements
- 2) Onset of pain associated with looser movements
- 3) Pain relieved with defecation
- 4) Visible abdominal bloating
- 5) Subjective sensation of incomplete evacuation in > 25% of time
- 6) Mucorrhea

Work up

- ❖ Good History
- ❖ Physical exam
- ❖ Tailored laboratory
- ❖ Tailored imaging

Work Up

Laboratory:

Blood

- ❖ TBC: & CRP: Is there anaemia, Inflammation, infection
- ❖ Metabolic panel
- ❖ UEs
- ❖ Screen for coeliac in IBS-D

Work Up

IBD-D

Stool:

- ❖ Ova & parasite, also take specimen for giardia antigen
- ❖ Enteric pathogen
- ❖ Leucocytes
- ❖ Clostridium difficile toxin

Hydrogen breath test:

- ❖ to exclude bacterial overgrowth, lactose/& or fructose intolerance

Work up

❖ IBS-D

Tissue transglutaminase antibody testing & small bowel Bx to exclude coeliac disease

❖ TSH, FT3, FT4 : to exclude hyperthyroidism (IBS-D)
hypothyroidism (IBS-C)

❖ Serum Calcium to screen for hyperparathyroidism : IBS-C

Work up

❖ Imaging:

- U/S: Recurrent upper abdominal pain to exclude Gall bladder pathology
- CT abdomen /MRI: Exclude pancreatic disease
- CT abdomen exclude exclude tumors, obstruction,

❖ Capsule endoscopy in suspected small bowel disease

❖ Colonoscopy if alarm symptoms present

Treatment approach

Dietary measures:

- Identify & restrict offending items

- Consider diets low in FODMAPs(fermentable oligosaccharide,disaccharide,monosaccharide & polyols)

- Psychological support

- Pharmacological Rx : is adjunctive & symptom directed

 - e.g.:

 - Antidepressants: TCA e.g. amitriptyline, SSRIs e.g. Fluoxetine

- Fiber/psyllium in IBS-C

- ↑ Water intake in IBS-C:

- Probiotics? role

Medications in IBS

❖ Antidepressants

Tricyclics e.g. Amitriptyline particularly, IBS-D

SSRI : fluoxetine. IBS-C

- ❖ Rifaximin: 550mg tid x 2weeks: improves bloating, abdominal pain, loose stool
- ❖ Linaclotide: a GC receptor agonist has been approved for IBS-C & can be used for long term
- ❖ Plecanatide : another GC-receptor agonist has also been FDA approved
- ❖ Bulk laxatives