

Diagnosis and Management of IBS

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What is IBS?

- Irritable bowel syndrome (IBS) is a chronic, relapsing and often life-long disorder
- Abdominal pain or discomfort
- Change in bowel habit – constipation/diarrhoea or both
- Abdominal distension, usually referred to as bloating
- Symptoms overlap with other GI disorders such as non-ulcer dyspepsia or coeliac disease and IBD

Looking after you.

Prevalence

- Affects people between the ages of 20 and 30 years
- Twice as common in women
- Prevalence in the general population is between 10% and 20%.
- Recent trends indicate that there is also a significant prevalence of IBS in older people.

Aim of NICE guidelines

- Provide positive diagnostic criteria for symptoms suggestive of IBS
- Provide guidance on clinical and cost-effective management of IBS in primary care
- Determine clinical indications for referral to secondary care

Initial assessment

- **Initial assessment**

- Consider assessment for IBS if any of the following symptoms are present for at least 6 months:

- **A**bdominal pain or discomfort
- **B**loating
- **C**hange in bowel habit

Assess for 'red flag' indicators and refer to secondary care

- Unintentional and unexplained weight loss
- Rectal bleeding
- Family history of bowel or ovarian cancer
- Change in bowel habit to looser and/or more frequent stools persisting for more than 6 weeks in a person aged over 60 years

Primary care assessment

- Patients presenting with IBS symptoms should be referred to secondary care if following are present:
- anaemia
- abdominal masses
- rectal masses
- inflammatory markers for inflammatory bowel disease.

Measure serum CA125 in primary care in women with symptoms that suggest ovarian cancer in line with the NICE guideline on [ovarian cancer](#)

Diagnostic tests

- In people who meet the IBS diagnostic criteria, the following tests should be undertaken:
 - FBC
 - CRP
 - Coeliac serology
 - Faecal calprotectin

Diagnostic tests

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

- Abdominal ultrasound
- Rigid/flexible sigmoidoscopy
- Colonoscopy; barium enema
- Faecal ova and parasite test
- Faecal occult blood
- Hydrogen breath test

IBS management

Dietary and lifestyle advice

- Information on general lifestyle, physical activity, diet and symptom-targeted medication
- Review fibre intake. Discourage insoluble fibre (for example, bran) and encourage soluble fibre such as ispaghula powder or foods high in soluble fibre (for example, oats)
- Role of FODMAP diet

Pharmacological therapy

Pharmacological therapy

- Laxative according to clinical response. Dose titrated - aim for soft, well-formed stool (Bristol Stool type 4).
- Anti diarrhoeal for diarrhoea predominant IBS
- Antispasmodics
- Tricyclic antidepressants - second-line treatment

My doctor
recommended a
stool softener.



Psychological intervention

- For people whose symptoms do not respond to pharmacological treatments after 12 months and who develop a continuing symptom profile (refractory irritable bowel syndrome), consider referring for: CBT hypnotherapy, psychological therapy.

Calprotectin

- Calprotectin is a protein present in large amounts in neutrophils
- Calprotectin is found in stool and several biologic fluids as serum, saliva, cerebrospinal fluid and urine.
- Extremely stable in faeces, for more than 7 days

Faecal calprotectin

- Non-invasive method to evaluate intestinal Inflammation
- Faecal calprotectin is a neutrophil derivative released from inflamed gut
- NICE recommends FC to distinguish between inflammatory bowel diseases and IBS

Faecal calprotectin

- Faecal calprotectin is a non-specific marker of gastrointestinal disease of both inflammatory and neoplastic character
- Its high sensitivity and negative predictive values can be useful to select patients for colonoscopy.
- It may also be useful for early detection of relapse in IBD and response to treatment
- **Patients with irritable bowel syndrome may have unnecessary invasive hospital investigations.**
Faecal calprotectin testing aims to reduce this.

BTUH recommendations based on local audit

Faecal calprotectin levels:

- 60 - 109 ug/g.

Result consistent with a diagnosis of IBS

- 109 - 250 ug/g.

Result - indeterminate. Repeat after 4 weeks unless symptoms present

- >250 ug/g

Result - raised suggestive of IBD. Also, consider other causes e.g. infection, polyps, malignancy and NSAID use

Causes of raised FC

Raised faecal calprotectin:

- IBD
- NSAID treatment
- GI malignancy
- Infections - salmonella and C. diff infections

Case scenario 1

- 35 year old lady – diarrhoea 2 months
- Bloods normal but FC raised at 800
- Colonoscopy – active colitis in right colon/transverse colon
- Pentasa commenced – asymptomatic after 1month. Stopped all treatment. DNA clinic appointment
- Recurrence of symptoms after 3 months – seen in clinic – restarted Pentasa. Good compliance -minimal improvement after 3 months.

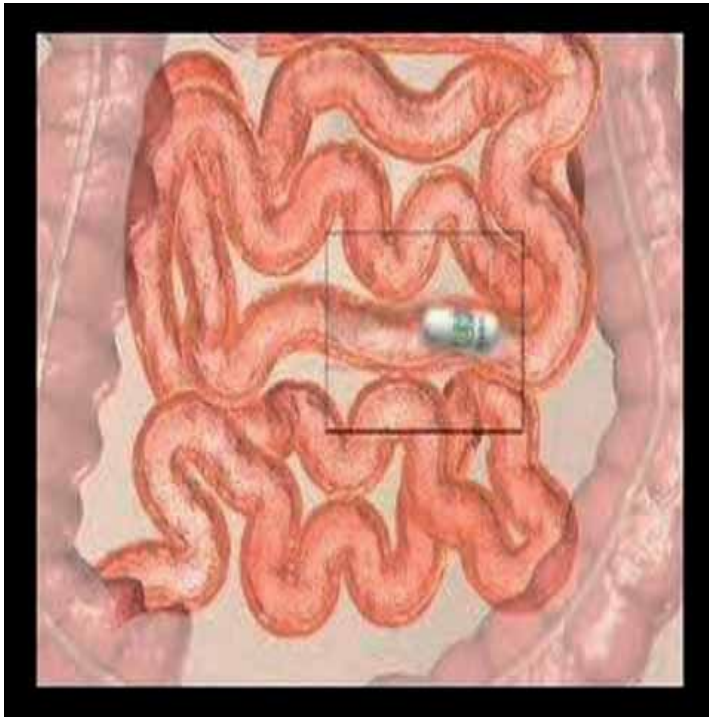
Case scenario 1

- Seen in IBD clinic – **history reviewed** and measures undertaken
- Seen after stopping all medications– asymptomatic. Repeat FC-100
- Colonoscopy – scarring in right colon and transverse colon
- ?Diagnosis

Case scenario 2

- 29 year old lady with diarrhoea
- Bloods – normal, FC 180 (Indeterminate result)
- Gastro referral – underwent OGD/colonoscopy
- Colonoscopy – few aphthous ulcers in TI (biopsies normal)
- MRE – normal
- What is the next step? Is this IBS or IBD?

Capsule Endoscopy



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you.



Thank you