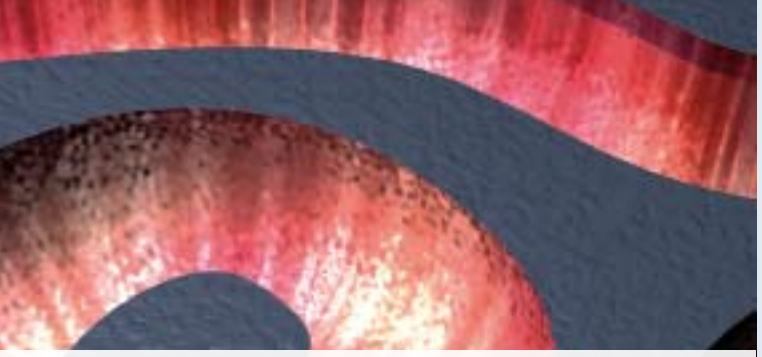


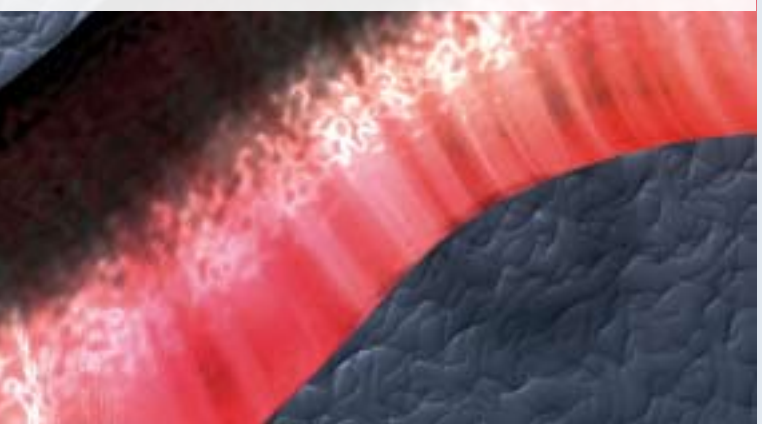
Looking back

In the first of an ongoing series, we look back at the key messages and practice points from selected articles in BPJ 58 (Feb, 2014).

We have added some suggested discussion questions for peer groups, or for personal review.

As this is a new feature of Best Practice Journal, we would be very interested in getting feedback from our readers as to whether this is useful. Please email your comments to: **editor@bpac.org.nz**

Tear off along perforation



Irritable bowel syndrome in adults: Not just a gut feeling

IBS should no longer be regarded as a diagnosis of exclusion

- IBS is diagnosed based on the presence of characteristic symptoms: **a**bdominal pain or discomfort, **b**loating, **c**hange in bowel habit
- The Rome III criteria can be used for diagnosis: the patient has recurrent abdominal pain or discomfort for at least three days per month, in the last three months, and onset of symptoms is associated with a change in frequency or appearance of stool and there is an improvement with defaecation (two out of three of these associations must be present)
- IBS is not associated with structural damage to the bowel
- IBS symptoms are influenced by psychological (e.g. stress), social (e.g. support systems) and biological (e.g. gut motility) factors
- There is no specific diagnostic laboratory test for IBS; tests are requested as appropriate to rule out other causes such as inflammatory bowel disease, coeliac disease and gastric cancer in older patients with new onset of symptoms

For all patients with IBS:

- Assess diet to ensure that it is well-balanced and nutritionally adequate and to identify possible trigger foods, intolerances or allergies
- There is evidence that a low FODMAP diet can improve symptoms in patients with IBS
- Probiotics may be trialled for four weeks to improve symptoms of bloating, but there is less evidence of their effectiveness for improving diarrhoea and constipation
- Exclusion or elimination diets should only be considered if multiple food intolerances are suspected and there has been no improvement in symptoms with other dietary measures

For patients with constipation as their predominant symptom an increase in soluble dietary fibre may be beneficial. This should not be considered in patients with diarrhoea as their predominant symptom, as it will worsen symptoms. Fibre intake should be reviewed, and potentially reduced, in patients with diarrhoea-predominant IBS, as they may have had previous advice to increase fibre intake.

Pharmacological treatment, if required, is based on the patient's predominant symptom:

Predominant symptom	Considerations for treatment
Diarrhoea	■ Daily loperamide (antimotility) and mebeverine (antispasmodic) ■ Ondansetron (serotonin antagonist) has also been used with some benefit to reduce diarrhoea
Constipation	■ Macrogol (an osmotic laxative), however, patients must meet Special Authority criteria for funding ■ Psyllium husk (bulk-forming laxative) may also be useful
Pain	■ Mebeverine for the relief of abdominal pain or discomfort ■ Low dose codeine may be beneficial if diarrhoea is also present as it can firm the stool, but avoid opioid analgesics if constipation is present ■ Domperidone can be used for nausea ■ Nortriptyline can reduce abdominal pain

Peer group discussion points

- IBS is common in the general population – do you regularly ask patients about bowel symptoms?
- How do you currently diagnose patients with IBS?
- Is it a change of thinking to make a "positive diagnosis" of IBS rather than regarding it as a diagnosis of exclusion?
- How do you currently manage patients with IBS?
- Have you heard of a low FODMAP diet and would you recommend this to patients with IBS?
- What have been your recommendations in regards to fibre intake in people with IBS and will your advice change after reading this article?

Original articles in BPJ 58 (Feb, 2014)