New Zealand Society of Gastroenterology | NZgNC NZNO Gastroenterology Nurses' College

ANNUAL SCIENTIFIC MEETING 2021 TOWN HALL, CHRISTCHURCH 17-19 NOVEMBER 2021

Irritable Bowel Syndrome

Targeted management that isn't just FODMAPS

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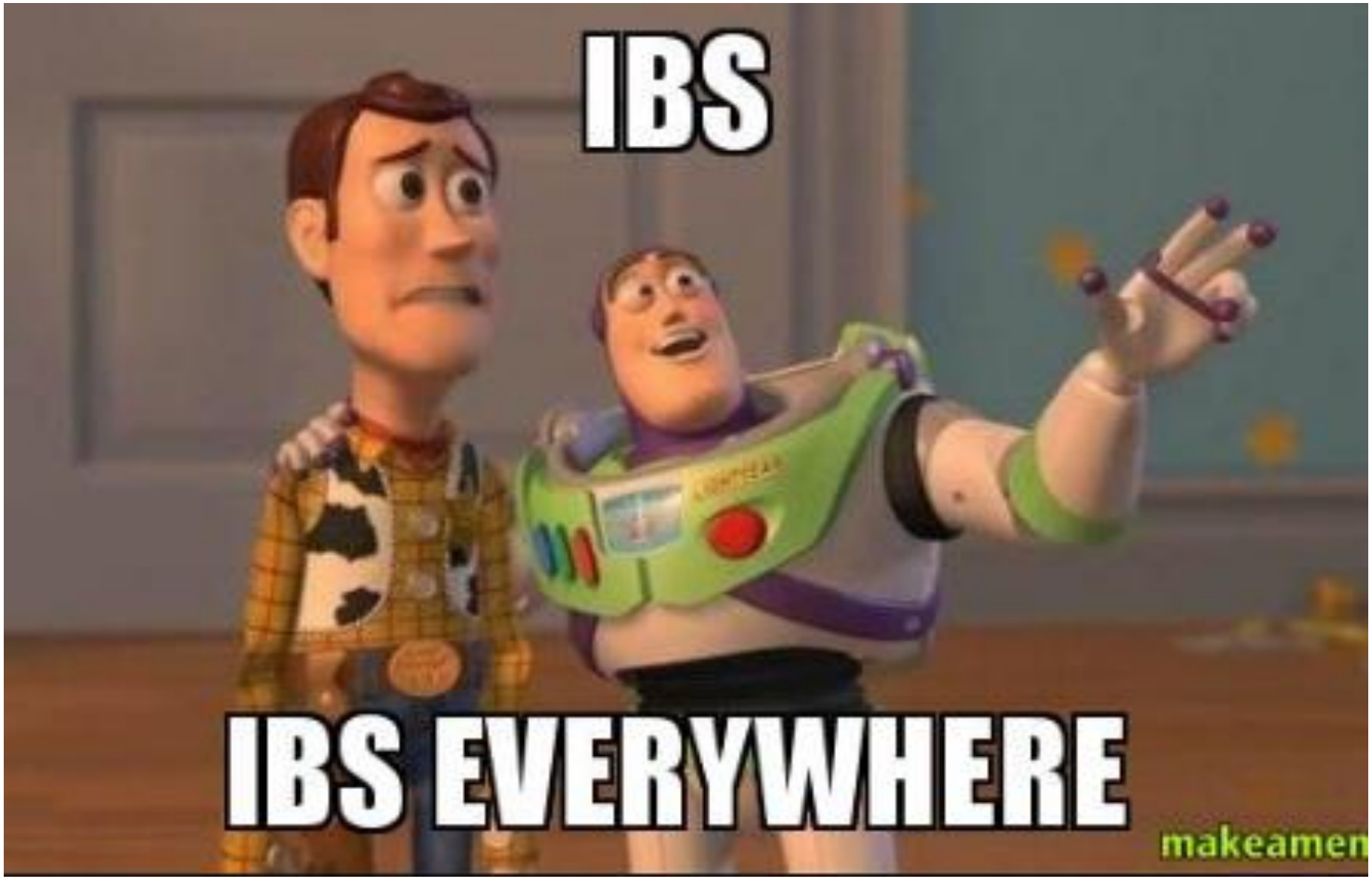
Gastroenterologist
President of NZSG

"best care for everyone"
everyone matters | with compassion | better, best, brilliant | connected

Waitemata District Health Board
Best Care for Everyone

Thanks & Credit:
Dr John Perry
Gastroenterologist


IBS
IBS EVERYWHERE
makeamem

Disclaimers!

- Come at this as a public and private system gastroenterologist with an interest in functional GI disturbance
- I respect the diversity of experience in the audience
- I acknowledge significant regional inequity of resource
- Massive topic! Leaving out differential diagnosis and utility of investigations, with a focus on some evidence
- Include some tips ‘what actually works in the real world’

Lacy, Pimental, Brenner et al. Am J Gastro. Jan 2021

BSG Guidelines on the Irritable Bowel Syndrome
Spiller, Aziz, Creed et al Gut 2007; 56

IBS ….

- Common, debilitating chronic disorder of **gut-brain interaction**
- Reduces QOL & social functioning
- Characterised by
  - Recurrent **abdominal pain** – at least 1 x PW.
  - **Disordered defaecation** – frequency, form, relief OR worsening of pain with defaecation
  - +/- Bloating – not compulsory

  - <In the absence of structural abnormalities>
- Female predominance, younger patients **… but not always!**
- Time line: usually >6 months
- **Prognosis:** chronic ongoing life stress – 0% recovery. No ongoing life stress: 41% recovery. Not associated with long-term development of serious disease

Lacy, Pimental, Brenner et al. Am J Gastro. Jan 2021
Bennett et al: Levels of chronic stress predicts clinical outcome in IBS. Gut, 1998 (cited)

What do IBS patients want from their doctors? IBS Network via BSG Guidelines on the Irritable Bowel Syndrome Spiller, Aziz, Creed et al Gut 2007; 56	What do they often get from their doctors?	How can we do better with IBS patients?
Clear knowledgeable explanation: What IBS is	Waffle, contradiction and uncertainty	Explanation that embraces uncertainty and science
Statement: no miracle cure	Overly optimistic or far too pessimistic	Realistic
Clear indication: my body, my illness. It is up to me to take control	Control taken away by doctors and other well meaning professionals	Patient centered approach
Clear explanation: good days & bad days. Light at the end of the tunnel	Assumed they know this	Honesty, and hope
Recognition: IBS is an illness	Told outright or made to feel that IBS is all in their head and doesn't really exist	Recognition
Consider and discuss alternative/complimentary therapy	Undermining of complimentary therapy they've tried makes the patient feel bad, and they lose trust	Understand uncertainty, at least reasons behind why CAM are sought
Offer at least one complimentary therapy	See above	Offer CAM that is evidence based (e.g. peppermint … MgLax … Phloe …)
Be aware: conflicting emotions in a newly diagnosed IBS person	Ignore or even blame emotion	Acknowledge emotions

How to diagnose IBS:

Manning Criteria for IBS	
1	Pain relieved by defaecation
2	More frequent stools at onset of pain
3	Looser stools at onset of pain
4	Visible abdominal distension
5	Passage of mucous per rectum
6	Sense of incomplete evaculation

Manning, Thompson et al. Towards a positive diagnosis of the irritable bowel. BMJ 1978

2016: Rome IV diagnostic criteria for IBS	
Recurrent abdominal pain on average at least 1 day/week in the last 3 months, associated with two or more of the following criteria:	
1	Relation to defaecation
2	Associated with a change in frequency of the stool
3	Associated with a change in the form (appearance) of the stool
These criteria should be fulfilled for the last 3 months with symptom onset at least 6 months before diagnosis	

Bowel Disorders. Gastroenterology 2016, AGA institute. Elselvier

Initial Assessment

The History:

- **Ask the ROME IV questions**
  - Is bloating present?
- **Dietary history (brief!)**
  - **Fibre content**
  - Excess fruit, alcohol
  - Lactose intolerance
  - Sorbitol, fizzy drinks, gum
- **Medication history**
  - New meds causing constipation or diarrhoea
- **Any alarm symptoms?**
  - PR bleeding, weight loss, nocturnal symptoms, new incontinence
  - Progressive pain
  - Family Hx – Colorectal Cancer, IBD, Coeliac

Examine the patient's abdomen and do a PR exam: Big cross over with DD / pelvic floor dysfunction and IBS

Initial Assessment

Laboratory Investigations:

- Full blood count
- TSH, Ca/PO4
- CRP, Coeliac antibodies

Thyroid function, Calcium

Stool specs:

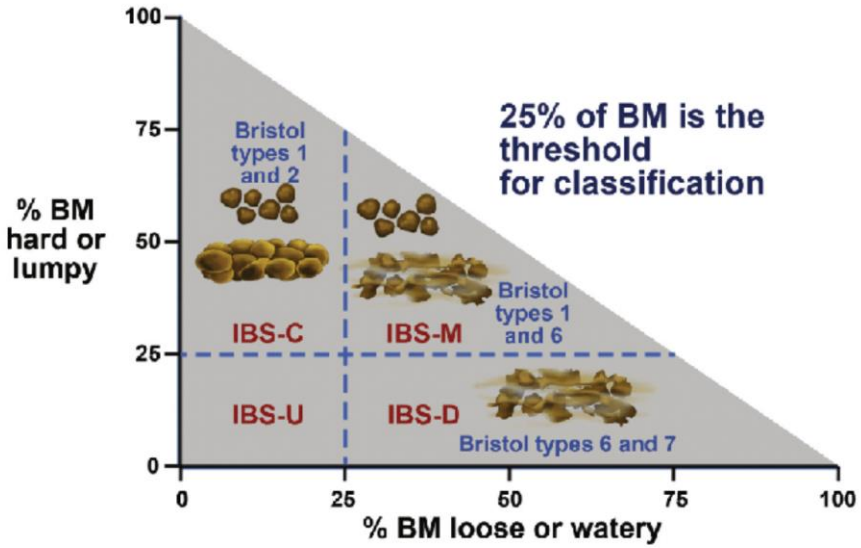
- M,C&S
- C. dif
- Calprotectin
- Giardia
- Elastase (diarrhoea)

Faecal Calprotectin

- "Like CRP for the gut"
- Protein produced by neutrophil degranulation
- Non-specific, any inflammation with put it up
- Use for chronic symptoms, not for acute symptoms
- Overly sensitive for distal inflammation
  eg fissures, inflamed haemorrhoids

Divide and conquer: the IBS Subtypes

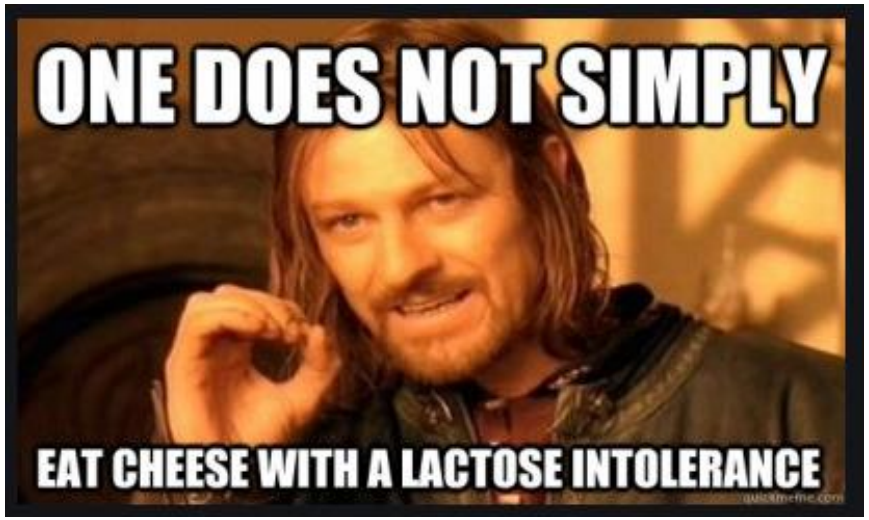
IBS-D	IBS-C	IBS-M	IBS-U
Diarrhoea > 25% of bowel motions BSFS 6/7 < 25% 1/2	Constipation >25% BSCS ½ <25% 6/7	Mixed >25% BSFS ½ >25% 6/7	Bloating BMs cannot be determined
50% of patients change over a one year period			



Simple Rules for Managing IBS:

1. **Make a confident and positive diagnosis to the patient and GP**
2. Divide **IBS into subtypes**: guides initial management
3. **Empower the patient**: put them in the driving seat
4. **Try *easier* solutions first**

   eg. Low fibre diet *before* low FODMAPS
5. **Don't miss:**
   - lactose intolerance
   - Occult constipation as the underlying cause
   - Other diagnoses. Look for red flags, especially in older people



How I think about IBS.


I GOT 99 PROBLEMS
VEE DUB
AND MY VW IS ALL OF THEM


WHY ON FIRE?
BECAUSE FERRARI


818 × 544

Offer Hope & Empowerment

IBS-C

Case 1

- 35 yr old woman
- Abdo pain
  - after meals
  - central and lower abdomen
  - relieved with defecation
- Bowels open every 3rd day for last 6 years
- No bloating
- Incomplete evacuation, straining
- Occasional bright-red PR blood with hard stool
- Diet: Muesli, vogels

- Which subtype?
  - Constipation-Predominant
  - Diarrhoea-Predominant
  - Alternating Constipation/Diarrhoea
    - Wind/Bloating? No

- What management?
  a) High-fibre diet
  b) Low-fibre diet
  c) Prunes
  d) Kiwifruit
  e) Mucilax/Metamucil
  f) Laxatives
  g) Low FODMAP

Case 1

- 35 yr old woman
- Abdo pain
  - after meals
  - central and lower abdomen
  - relieved with defecation
- Bowels open every 3rd day for last 6 years
- No bloating
- Incomplete evacuation, straining
- Occasional bright-red PR blood with hard stool
- Diet unremarkable

- Which subtype?
  - Constipation-Predominant
  - Diarrhoea-Predominant
  - Alternating Constipation/Diarrhoea
    - Wind/Bloating? No

- What management?
  - ✗ a) High-fibre diet
  - ✓ b) Low-fibre diet
  - ✓ c) Prunes
  - ✓ d) Kiwifruit
  - ✓ e) Mucilax/Metamucil
  - ✗ f) Laxatives
  - g) Low FODMAP

Myth Busting: laxatives

- **Don’t forget water**

- **Which laxatives can be given regularly?**
  - Osmotic (Lactulose, Molaxole)
  - Bulking agents (Psyllium, Benfibre)
  - Stimulant (Senna, Cascara, Bisacodyl)

- **Do stimulant laxatives cause a lazy bowel?**
  - Historical observation based on poor evidence - now conclusively disproven
  - No convincing evidence of damage to enteric nerves or intestinal smooth muscle [1]

- **My usual recommendation: Take this regularly**
  - Regular prunes, kiwifruit, Psyllium, ground linseeds
  - MgLAX, Phloe, KiwiCrush
  - Try laxsol PRN or regularly, then experiment with others.
  - ”one patient’s rocket fuel is another’s dud”

- **Often nothing works when full up – consider ‘The Weekend Clean Out’**

- **If a trial of laxatives is successful, then you can backtrack to dietary/natural options**

1. J Clin Gastroenterol 2003 May-Jun;36(5):386-9

IBS-V

Case 3

- 30 yr old man
- Alternating constipation and diarrhoea for 3 years
- No Bowel motion for 2 - 3 days, then abdo pain + loose/diarrhoea 3 - 4 times in one day
- Significant urgency – housebound on bad days
- Managed with
  - Diastop PRN
  - Codeine/Paracetamol for pain

- Which subtype?
  - Constipation-Predominant
  - Diarrhoea-Predominant
  - Alternating Constipation/Diarrhoea
    - with Wind/Bloating?

- What management?

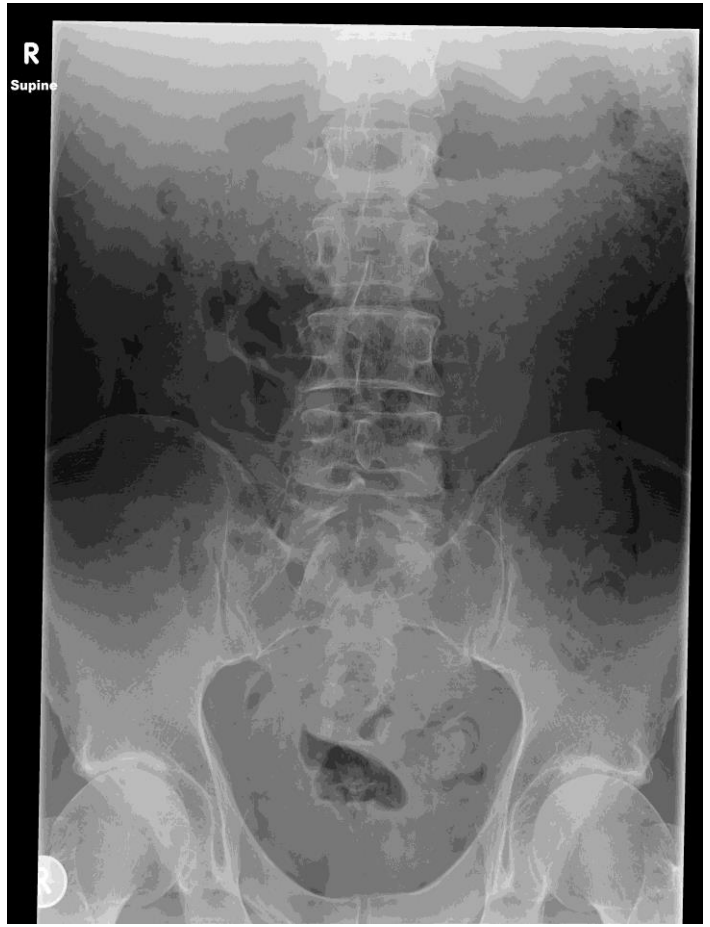
X a) High-fibre diet
✓ b) Low-fibre diet
✓ c) Prunes
✓ d) Kiwifruit
✓ e) Mucilax/Metamucil
✓ f) Other Laxatives
✓ g) Antispasmodics
h) Diastop - Emergencies only
✓ i) Low FODMAP

Case 3

Alternating Constipation/Diarrhoea

- Constipation is the underlying cause
  - Patients think they have a diarrhoea
  - Doctor has to tackle the constipation
  - Patients may not accept this for a number of visits
  - Consider AXR as proof

- **<u>So manage as for constipation</u>**
  - low fibre diet
  - consider trying low FODMAPS
  - Regular laxative of some kind
    - Mucilax/Metamucil may cause pain/bloating
    - Consider ‘the weekend clean out’ with Lax sachets
  - Add antispasmodic if significant pain
  - Consider SSRI or Tricyclic if still struggling
  - Don’t miss Lactose intolerance – it can mimic this pattern



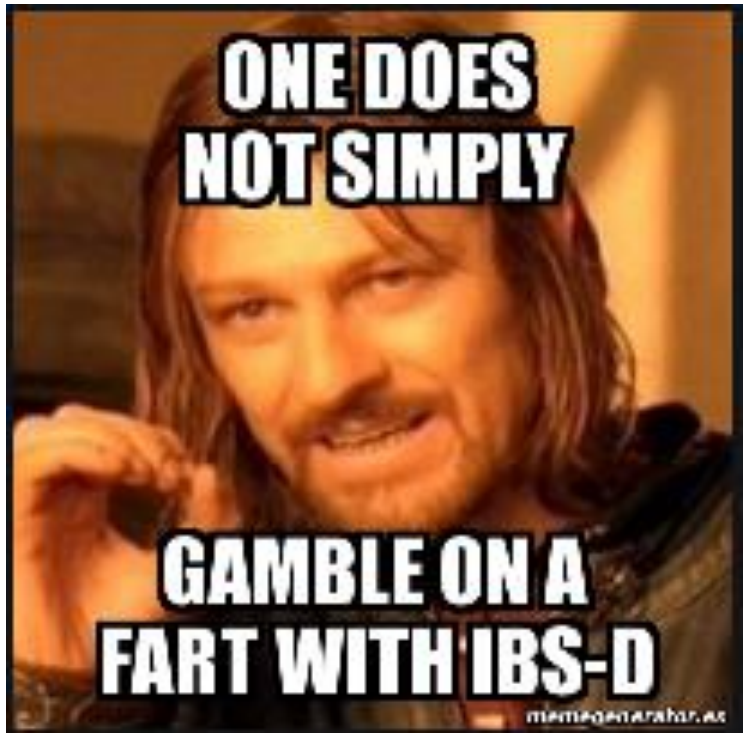
IBS-D – the ferrari

Case 4

- 45 yr old man
- Approximately 7 yr Hx of loose bowels 5x/day
  - Only occasional nocturnal symptoms
  - Mild discomfort before motions
- Systemically well
- Weight stable/No alarm symptoms/No family Hx
- Average diet
- Managed with Diastop PRN at work

Case 4

- Diarrhoea-Predominant IBS Vs Chronic diarrhoea



Chronic diarrhoea

Chronic diarrhoea - aetiology	Clue	Treatment
Unusual infection – parasite (giardia, amoeba)	Travel Hx, camping. Stool and serology	Eradicate the pathogen
Bile Acid Malabsorpbtion	R hemi. IC resection. Lap chole. Idiopathic BAM. +SeHCAT scan. Awful acidic diarrhoea with urgency	Colestipol / colestid sachet
Bacterial overgrowth	Previous surgery. Hydrogen breath testing	Rifaxamine $ Cycling ABx
IBD, Microscopic colitis (collagenous, lymphocytic)	Horrific watery diarrhoea with FI PPI, coeliac, older age	Budesonide
Everything else!		

Bloating


"PREGNANT AGAIN?"
"NO, BLOATED FROM A BAD IBS DAY"
400 × 256
memegenerator.net

Fibre and IBS

- Bloating + Fibre = 

- In many IBS patients, insoluble fibre leads to
  - Bloating (small bowel gas)
  - Pain
  - Diarrhoea

- A brief low fibre diet is an *easy* intervention to try
  - 1 to 2 weeks at the most
  - Keep bowels moving with laxatives if required
    “low fibre, bowels moving daily”

  - If successful then modify according to symptoms and nutritional needs
    (modified fibre diet, with less insoluble fibre)

With bloating: *reduce* High Fibre Foods

FOODS HIGH IN FIBRE
1. wholemeal/granary bread, added fibre white bread, wholemeal chapatti 2. wholegrain pasta 3. brown rice 4. wholegrain cereals, e.g. Bran Flakes, Weetabix, muesli, porridge, Ready Brek 5. rye crispbreads, wholemeal crackers, oatcakes 6. jacket potato skins
1. berry fruits, unripe bananas, dried fruit, grapefruit, kiwi fruit, mango, rhubarb, oranges 2. brussel sprouts, cabbage, garlic, green beans, okra, onions, leeks, mushrooms, peas, sweetcorn 3. beans and pulses, chick peas, split peas
1. all types of nuts and seeds
1. yoghurts containing nuts or cereal
1. wholemeal biscuits e.g. digestives 2. biscuits containing dried fruit or nuts e.g Garibaldi, Fig rolls 3. cakes, puddings and pastries made with wholemeal flour and/or nuts, dried fruit 4. flapjack, cakes and puddings made with oats 5. jams with seeds or skin, thick cut/chunky marmalade, sweet mincemeat, pickles or chutneys 6. sweets and chocolate with fruit or nuts, muesli bars

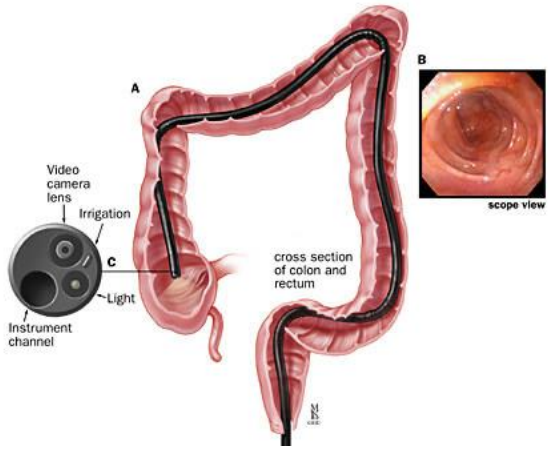
With bloating: *increase* Low Fibre Foods

FOOD GROUP	FOODS LOW IN FIBRE
BREAD, OTHER CEREALS AND POTATOES	• white bread, white chapatti • white pasta • white rice • rice or corn based cereals • cream crackers, rice cakes • boiled, mashed or roast potatoes (no skin) • yams, sweet potato
FRUIT AND VEGETABLES	• fresh, tinned or stewed: apples, apricots, cherries, fruit cocktail, grapes, lychees, nectarine, melon, ripe banana, pears, peaches, pineapple, plums, avocado (**avoiding pips, skin and pith**) • carrots, celery, beetroot, broccoli or cauliflower florets, courgette, lettuce, marrow, skinned cucumber, skinned/pipped tomatoes, pepper, radish, spinach, squash, swede, turnip
MEAT, FISH AND ALTERNATIVES	• all meat, poultry and fish • Quorn • smooth nut butters • eggs
MILK AND DAIRY PRODUCTS	• milk • plain or fruit yoghurts • cheese
FOODS CONTAINING FAT, FOODS CONTAINING SUGAR	• butter, margarine, oil • plain biscuits e.g. Rich Tea, Morning Coffee • cakes, puddings and pastries made with white flour • cream, jelly, ice-cream, milk puddings, sorbet • honey, sugar, syrup, 'jelly' type jams and fine cut marmalade • boiled sweets, chocolate, plain toffee without dried fruit or nuts

Who needs colonoscopy/other imaging?

- Persistent new symptoms - each case on it's merit
- Alarm symptoms
  - Weight loss, recurrent bleeding, progressive pain
- FHx
  - Colorectal Cancer
  - IBD
- Anaemia, raised calprotectin, +ve iFOB, raised CRP
- Diarrhoea-predominant symptoms (for biopsies)

- Consider gastroscopy plus duodenal biopsy for disaccharidases
  - Bloating, diarrhoea-predominant



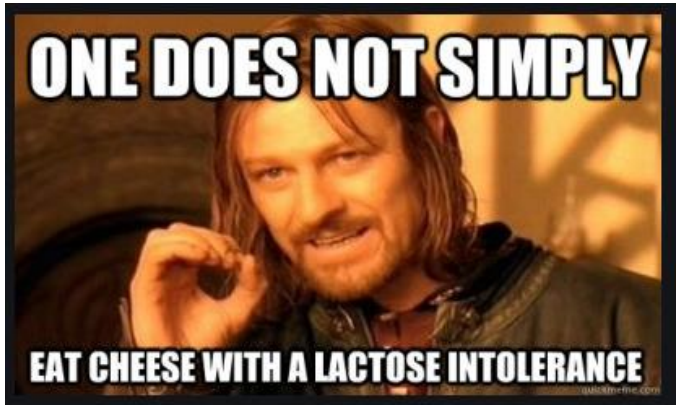
Bowel prep can be diagnostic

- **A window of opportunity**…
- Take note of whether there is an improvement, and how long until the previous symptoms return.

- Did the symptoms improve for a while, or the bowels stop moving?
  - Suggests constipation component
- Did the diarrhoea return the next day?
  - Suggests chronic diarrhoea rather than functional
- Did they still bloat with an empty bowel
  - Suggests true food intolerance rather than constipation

- **Ask them to pay attention day 1 – 5 post procedure, write it in their phone**

A word on lactose intolerance



- Easy to diagnose if it's classical
  - Cramps, explosive diarrhea
- Some patients may just have bloating or delayed stinky wind
- Some may have chronic loose bowels

- Easily tested
  - A week of going dairy-free
  - Glass of milk challenge
  - (Disaccharidases during gastroscopy)

- Lactase capsules are very helpful in difficult situations

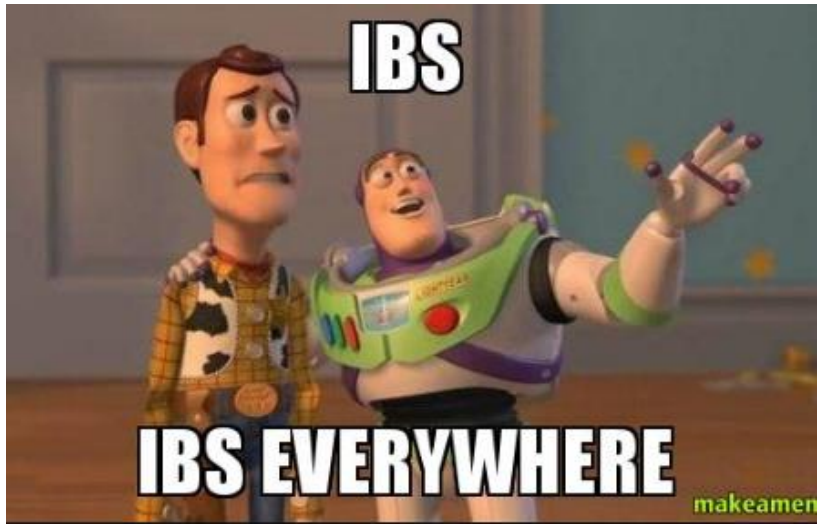
What about a low FODMAP diet?

- FODMAPS
  - Fermentable Oligo-, Di- and Mono-saccharides, and Polyols.
  - Basically foods containing Fructose, Lactose, and other sugars that may cause bloating
  - Short-chain carbohydrates that are poorly absorbed and readily fermented by bacteria
- Does it work?
  - RCT evidence for effectiveness
- But…..
  - Long, complex, often completely unnecessary!
  - Some patients end up restricted forever, yet still symptomatic
  - Look for an easier option first. I try this last.

IBS Management According to Subtype

Subtype	Management
IBS-C Constipation-Predominant	Constipation:Laxatives Diet: High soluble fibre Visceral pain: Antispasmodics, Tricyclics
IBS-C Constipation-Predominant + wind/bloating	Constipation: Laxatives initially Diet: Low fibre, limit fruit first
IBS-V Alternating Constipation/Diarrhoea	Treat as for constipation Diet: low fibre or low FODMAP diet
IBS-D Diarrhoea-Predominant	Diet: low fibre, limit fruit AXR to exclude constipation-driven ? chronic diarrhoea rather than IBS - consider referral

Take Home Messages



- **Make a positive diagnosis and put the patient in the driving seat**
- **History:**
  - Dietary history
  - Alarm symptoms
- **Divide IBS into subtypes to determine initial management**
  - Constipation-predominant +/- bloating
  - Alternating constipation-diarrhoea
  - Diarrhoea-predominant
- **Try easy things first**
- **All IBS symptoms and subtypes can be constipation-driven**
  - Consider an AXR if there is doubt
- **Bowel prep can be diagnostic** – get patients to pay attention afterwards

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