Editorial

Irritable Bowel Syndrome: A Holistic Approach

Wai Choung Ong,[1] *MBBS, MRCP*, Beng Yeong Ng,[2] *MBBS, MMed (Psychiatry), FAMS*

In 1997, the International Foundation for Functional Gastrointestinal Disease (IFFGD) designated April as Irritable Bowel Syndrome (IBS) Awareness Month. This period of awareness was intended to focus the attention on important health messages about IBS diagnosis, treatment, and quality of life. The month of April was first designated as IBS Awareness Month in 1997 and 'Don't Suffer in Silence' was the theme for this awareness campaign.

IBS is one of the most common disorders seen by community doctors. It is the most common functional gastrointestinal disorder affecting approximately 10% to 15% of the general populations. Western countries have a predominance of females with IBS, but this is not seen in Australia or in any other Asian countries.[1,2]

Irritable bowel syndrome (IBS) is a common disorder that affects the large intestine. Patients commonly present with abdominal pain, cramps, bloating, diarrhoea and constipation. Despite these uncomfortable signs and symptoms, IBS does not cause permanent damage to the colon; neither does it lead to colorectal cancer. Irritable bowel syndrome, or IBS, is one of a range of conditions known as functional (i.e. no structural abnormality, leaving only disordered bowel function to account for symptoms) gastrointestinal (GI) disorders. In IBS, this "disorder of functioning" is with the way nerves or muscles are working. On physical examination and laboratory tests, no abnormalities are noted. The bowels look fine macroscopically on endoscopy.

Yet there are pain, discomfort, and other symptoms that keep coming back and will not go away. Irritable bowel syndrome is sometimes known as spastic colon, mucous colitis, spastic colitis, nervous stomach, or irritable colon. Although these are outdated terms, they serve to clinically describe the symptoms and suffering that our patients experienced. It is not a risk for life-threatening diseases, but it can have a major impact on a person's life. Most people with IBS find that their symptoms improve as they learn to control their conditions. Only a small number of people with irritable bowel syndrome have disabling signs and symptoms.

Until recently, IBS was a diagnosis of exclusion, which means that doctors often had to perform many tests in order to exclude other possible diseases. Because of the need for consistency in diagnosis of functional GI disorders, the Rome Criteria were developed and refined through an iterative consensus process. The most recent—Rome III criteria—involved the work of clinicians and researchers from 18 countries around the world.[3] Current guidelines emphasize that irritable bowel syndrome (IBS) is not a diagnosis of exclusion and encourage clinicians to make a positive diagnosis using the Rome criteria alone. Yet many clinicians are concerned about overlooking alternative diagnoses. When beliefs were measured between IBS experts and community providers, most community providers believe IBS is a diagnosis of exclusion; this belief is associated with increased resource use.[4] Experts comply more closely with guidelines to diagnose IBS with minimal testing. Does this disconnect between community providers and experts suggest that better implementation of guidelines is warranted to minimise variation and improve cost-effectiveness of care?

It is fortunate that the Irritable Bowel Awareness month follows the National Bowel Cancer Symptom Awareness Campaign that took place from 31 January 2012 to 31 March 2012. Bowel Cancer Awareness Month dated 1 April 2012 to 30 April 2012 likewise provides an interesting contrast to the management of IBS. The Straits Times article "Early detection of colorectal cancer saves lives"[5] correctly educates that colorectal cancer is one of the most common cancers in Singapore. When the disease starts to develop, there may be no symptoms for several weeks or months. Screening packages for colonoscopy and gastroscopy offer compelling cost saving: advertising fixed price package ($1284), Medisave claimable amount ($1250) and the estimated cash outlay ($34). The lack of a sensitive and specific biomarker for IBS makes a confident diagnosis elusive. Indeed, some studies have reported a false positive diagnosis of up to 5%. Commonly missed diagnoses include celiac disease, pancreatic and thyroid disorders. All patients remain to have a population risk of

[1]Department of Gastroenterology and Hepatology, Singapore General Hospital
[2]Department of Psychiatry, Singapore General Hospital
Address for Correspondence: Dr Ong Wai Choung, Department of Gastroenterology and Hepatology, Singapore General Hospital, Outram Road, Singapore 169608.
Email: wai_choung_ong@sgh.com.sg

disease. Medical Protection Society (Education and risk management) mailers (2012 Essential Risk Management Workshop Series) add on to our cautious medical practice.

IBS has a huge impact on healthcare costs. In the Drossman and colleagues study,[6] it was established that IBS affects 19 to 34 million American adults, and costs almost $10 billion in medical care and leads to possibly 250 million lost work or school days per year. Even in primary care, the costs of IBS can be considerable.[7]

IBS is also marked by impaired health-related quality of life (HRQOL) and diminished work productivity. In the community, health-related quality of life is impaired in subjects with irritable bowel syndrome and dyspepsia; much of this association can be explained by psychological factors.[8] Many of them have their condition compounded by the resulting feelings of fatigue and depression over the lack of a certain cure for their condition. A complex connection exists between the brain and the gut, with bidirectional communication pathways that involve the autonomic nervous system and the hypothalamic-pituitary-adrenal axis. Disruptions along these pathways can result in functional gastrointestinal problems. Depression was found to be an independent predictor of developing post-infectious IBS in a study comparing patients with healthy control subjects.[9] More life events and higher hypochondriasis scores were highly predictive of post-infectious IBS in another group of patients.[10]

To holistically manage this complex condition, clinicians could perform a balanced biopsychosocial history rather than focusing just on bowel symptoms. Those who promote the psychosocial model of IBS advocate counselling as one of the few effective means of treating IBS sufferers. Dr Nick Read, head of the national IBS charity The Gut Trust, says that IBS is a "disease of the whole person". "The emotional area of the brain often shows increased activity in IBS sufferers," says Dr Read, "and that's where psychotherapy can be helpful."

From a patient's perspective, it is frustrating. Patients often hear "Perhaps if you could cease to worry so much, learn to relax, your guts would not be so sensitive." Or "just calm down and stop being so dreadfully neurotic". From a doctor's perspective, "these patients are just mad" is a common corridor comment. "You just have IBS—don't worry" may soothe the doctor more than the patient. IBS is therefore complex.

There is currently no identifiable biological cause for IBS. There is therefore no conventional medical treatment that offers the certainty of hope for all. There's no single treatment or cure. However, there are ways to manage IBS so that the sufferer feels better. Although conventional treatment can often only have a temporary benefit to sufferers, many others find relief through lifestyle and dietary changes. For some, psychotherapy and counselling can be extremely beneficial. The choice of investigations and therapy has to be individualised to a patient. When coping with challenging patient interactions (Workshop 4) which a significant proportion of IBS patients represent, communication, empathy and sympathy are required. When the communication process does go wrong, being able to master the adverse outcome (Workshop 2) is an essential skill. Both modules (Workshop 2 and 4) are represented in the 2012 Essential Risk Management Workshop series.[11] Compassion, experience and time are needed in managing patients with severe IBS. IBS is an expensive disease—consider the value of the medical service provided singularly by a diagnosis of exclusion, laboratory test or endoscopy. This value is therefore provided by management of the patients' symptoms, frustration and suffering. IBS therefore remains a challenging condition to manage.

We often have a choice of taking care of the patient, the disease or the doctor. It is hereby advocated that we ought to take care of the patient first, the disease second and the doctor last. We too believe that IBS is a "disease of the whole person". As doctors, let us educate our patients—for therein lays the value and justification of expense.

REFERENCES

1. Gwee KA. Irritable bowel syndrome in developing countries: a disorder of civilization or colonization? Neurogastroenterol Motil 2005;17:317-24.
2. Talley NJ, Loke GR, Lahr BD, Zinsmeister AR, Cohard-Radice M, D'Elia TV, et al: Predictors of the placebo response in functional dyspepsia. Aliment Pharmacol Ther 2006;23:923-36.
3. Drossman DA (ed): Rome III: The Functional Gastrointestinal Disorders, 3rd Edition. McLean, VA, Degnon Associates, 2006.
4. Spiegel BM, Farid M, Esrailian E, Talley J, Chang L. Is irritable bowel syndrome a diagnosis of exclusion?: a survey of primary care providers, gastroenterologists, and IBS experts. Am J Gastroenterol 2010;105:848-58.
5. Early detection of colorectal cancer saves lives. Mind Your Body, The Straits Times. 29 March 2012.
6. Drossman DA, Li Z, Andruzzi, E, Talley NJ, Thompson WG, Whitehead WE, et al. U.S. householder survey of functional gastrointestinal disorders. Prevalence, sociodemographty, and health impact. Dig Dis Sci 1993;38:1569-80.
7. Akehurst RL, Brazier JE, Mathers N, O'Keefe C, Kaltenthaler E, Morgan A, et al. Health-related quality of life and cost impact of irritable bowel syndrome in a UK primary care setting. Pharmacoeconomics 2002;20:455-62.
8. Agarwal N, Spiegel BM. The effect of irritable bowel syndrome on health-related quality of life and health care expenditures. Gastroenterol Clin North Am 2011;40:11-9.
9. Dunlop SP, Jenkins DJ, Neal KR, Spiller RC. Relative importance of enterochromaffin cell hyperplasia, anxiety, and depression in postinfectious IBS. Gastroenterology 2003;125:1651-9.
10. Gwee KA, Leong YL, Graham C, McKendrick MW, Collins SM, Walters SJ, et al. The role of psychological and biological factors in postinfective gut dysfunction. Gut 1999;44:400-6.
11. 2012 Essential Risk Management Workshop Series. Available at: www.medicalprotection.org Accessed 1 May 2012.