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Discussing the Complications of IBS Mimickers

Dr. Buch:
Welcome to *GI Insights* on ReachMD. I'm Dr. Peter Buch, and joining us today to discuss mimickers of irritable bowel syndrome, or IBS, is Dr. Michael Camilleri. Dr. Camilleri is a Professor of Medicine at the Mayo Clinic College of Medicine and Science.

Welcome back to the program, Dr. Camilleri.

Dr. Camilleri:
Thank you so much. Thanks for the invitation.

Dr. Buch:
It's a pleasure. So, Dr. Camilleri, let's start with some reassurance for our audience. There seems to be a lot of confusion, particularly among primary care providers. How do we make a diagnosis of irritable bowel syndrome? And what are the risks of missing something?

Dr. Camilleri:
That's a very fundamental question. The symptoms of irritable bowel syndrome are those that we have recognized for decades, so the occurrence of abdominal discomfort or pain in association with a change in bowel function, either stool consistency or stool frequency, and then there are some clues that we need to pick up when we're taking the history that might point us in a certain specific direction to try to identify mimickers of irritable bowel. But basically, there have been symptom-based criteria that have been proposed. There are, for instance, four sets of Rome criteria. There may be a fifth one coming up quite soon in the next couple of years. But essentially, we're back to the principles we all learned—the concurrence of abdominal pain, the alteration in bowel habits, and also the relief of pain, discomfort, and bloating with having a bowel movement. Those remain the fundamental principles.

Dr. Buch:
And what are the risks of missing something, Dr. Camilleri?

Dr. Camilleri:
So because those symptoms are relatively nonspecific, it's important to keep in mind that there are certain specific diagnoses that we can make where we can individualize or more specifically treat the underlying problem that's causing the symptoms that suggest irritable bowel syndrome. So let me give you three or four examples. In the context of irritable bowel syndrome with constipation, the main thing I always want to exclude when I see patients is the concurrence of an evacuation disorder, a disturbance of the evacuative process because the pelvic floor or the anal sphincters are not working in a coordinated manner with the colon to allow the stool to come through the anal canal.

Now what might be the symptoms we should look out for? First of all, patients report that they strain excessively to have a bowel movement. Second, they have a sense of incomplete evacuation of the rectum. And some patients may even volunteer the information, or we may have to ask for it to get that information, that they sometimes have to place a finger into the anal canal to help the bowel movement out, or in women, push on the back wall of the vagina to help the bowel movement out, and this last symptom may be suggestive of a rectocele, which is holding the stool and preventing it from being expelled from the anal canal. So the first thing I always say is let's take a good history. Let's make sure that there aren't symptoms of an evacuation disorder because the symptoms are exactly those of IBS—abdominal pain, constipation, difficulty with evacuation, reduced frequency of bowel movements, and if the patient is fortunate enough to pass a bowel movement, then relief of the abdominal pain, distension, and bloating. So that's the constipation major mimicker.

With regard to the diarrhea side of things, there are now conditions that we can identify where we can, again, be much more specific in our treatment, and those main conditions we need to probably think of are things like celiac disease or chronic exocrine insufficiency, pancreatic insufficiency, but more subtle are the ones that really confuse us sometimes because they are real mimickers, and they are conditions like bile acid diarrhea and microscopic colitis, which will present with symptoms virtually identical to those of functional diarrhea or irritable bowel syndrome with diarrhea.

Dr. Buch:
Well, thank you for that. And just again for our primary care listeners, can you just please describe how we use alarm signs in our diagnosis?

Dr. Camilleri:
That's critically important. So in all of these patients, the first thing we have to make sure is that there are no alarm symptoms or signs. So the passage of rectal bleeding, the unintentional weight loss, the recent onset of severe constipation, these are symptoms that may alert us to the possibility that the patient has colon cancer presenting with those symptoms of unintentional weight loss, rectal bleeding, or recent onset of constipation. Those are the three I keep in mind.

Dr. Buch:
And one last thing just to summarize this section. And it's just amazing that I still see that because I do lots of lectures with medical students, and they are still saying the diagnosis of irritable bowel syndrome is one of exclusion. Please comment.

Dr. Camilleri:
Well, it's one of exclusion, but we need to be cognizant of the fact that it is such a common condition, affecting probably 12 percent of the population, and in the absence of alarm symptoms, to pursue the tests that would require unequivocal exclusion is probably not necessary. What would be those tests that would be required for unequivocal exclusion of organic disease? Well, they would be colonoscopy. They would be maybe even a CT scan of the abdomen and pelvis. So I think we need to be good clinicians. We need to ascertain whether there are alarm features, and then we need to focus if there are no such alarm features on the possibility that there are conditions that may be mimicking the garden variety irritable bowel syndrome.

And I think it will be good, if I may, to just explain two or three other things about those mimickers because there are now relatively easy tests that can be done, particularly in the gastroenterology practice, that will help us be much more specific and allow us to individualize treatment of our patients with apparent irritable bowel. So let me tell you what those tests are. First of all, if you are thinking about the patient with a possible rectal evacuation disorder, the first most important test is a digital rectal examination. Don't forget to do that. For the past 30 or more years, I've recorded for every patient in whom I do a digital rectal examination the following features. First of all, place the patient in the left lateral position. Ask the patient to push down, to strain as though they are having a bowel movement to see how much perineal descent there is. There should be a descent of about two centimeters. If it's less than 1.5 centimeters, or if it's more than four centimeters, then there's a problem with the pelvic floor that could be causing the evacuation disorder. When you put your finger into the anal canal, is the anal sphincter tone very high such that you can hardly get your finger in? Can the patient squeeze and have normal contraction of the external anal sphincter? And then ask the patient to bear down as though they're having a bowel movement while your finger is in the anal canal and see if you can feel the paradoxical contraction of the anal sphincter and the pelvic floor. That tells you that there is dyssynergia of the pelvic floor, and the patient should be referred for anorectal manometry with balloon expulsion. So that's the constipation thing that I do routinely for patients. That's what I want to exclude because it's not treatable with surgery or medication, but it is treatable with physical therapy, with biofeedback.

From the diarrhea standpoint, we now have very simple biochemical tests of either blood or stool to make the diagnosis of bile acid diarrhea, and these are available through reference laboratories, but they should be available. And the good news about that is we know that about a third of patients with diarrhea-predominant irritable bowel actually have bile acid diarrhea, and the bile acid diarrhea is eminently treatable with bile acid sequestrants like cholestyramine, colesevelam, or cholestipol. So those would be the things that I look out for always.

If we're thinking about the possibility of microscopic colitis, that's going to require a full colonoscopy with biopsies taken in the proximal colon and the distal colon. But again, the good news is that there are eminently efficacious treatments, including bismuth compounds, and also anti-inflammatory approaches or locally active corticosteroids. So I think there are really significant things that we can do for the mimickers of IBS.

Dr. Buch:
Thank you. And, Dr. Camilleri, please elaborate the overlay between non-celiac gluten sensitivity and IBS.

Dr. Camilleri:

Yes. So this is a little bit more controversial, and what we can say about non-celiac sensitivity is that the symptoms overlap with those of IBS. Who is more likely to develop non-celiac gluten sensitivity? These are the patients, and they are about 55 to 60 percent of the general population who have the immunogenotypes that predispose them to possible gluten sensitivity. They are the same genes that patients have if they actually have real celiac disease. So here what we do know is that the permeability of the intestine, the leakiness of the intestine is greater in these patients who have the immunogenotype, the HLA-DQ2/DQ8, that make people susceptible to non-celiac gluten sensitivity, and I think finding on the blood test the patient is susceptibility because of that immunogenotype may lead us to proposing a period of time on a gluten-free diet to see whether we can treat the non-gluten celiac sensitivity. So thank you for reminding me about that.

Dr. Buch:
For those just tuning in, you're listening to *GI Insights* on ReachMD. I'm Dr. Peter Buch, and I'm speaking with Dr. Michael Camilleri about mimickers of IBS.

So, Dr. Camilleri, what should we know about functional dyspepsia?

Dr. Camilleri:
Okay. So functional dyspepsia refers to the upper gastrointestinal symptoms, like nausea, fullness postprandially, and particularly, sometimes abdominal pain or discomfort and vomiting. And bloating is also a common symptom. I think what I keep in mind is that there are two main symptoms or symptom complexes. One is epigastric pain syndrome, which is dominated by pain, as the name would imply, discomfort and upper abdominal bloating. These patients usually have increased sensitivity of the stomach. They don't have delayed stomach emptying, for example. And the other type of functional dyspepsia is postprandial distress syndrome. These are patients who have nausea, fullness, postprandial bloating, sometimes, rarely, vomiting, and abdominal discomfort, but not really significant pain. These patients may have a slight delay of stomach emptying but not to the point where we would diagnose gastroparesis. Those are the patients that may respond better to agents that might help the stomach to empty better or to changing the diet, reducing the amount of nondigestible fiber, maybe using more of an easily digested meal in order for the stomach to empty the patients to empty better, and therefore, relieve the patient's symptoms. So those are the two main ways I think about functional dyspepsia.

There's a lot that's confusing at the present time because of overlap with gastroparesis, but I think if you have a really good gastric emptying test and you use very high diagnostic criteria and cutoffs, then you're not going to confuse functional dyspepsia and gastroparesis. So to be specific, here at Mayo, I never diagnose gastroparesis unless there's more than 25 percent of an egg meal retained in the stomach at four hours or more than 75 percent retained in the stomach at two hours, or the gastric emptying T 1⁄2 needs to be more than 175 minutes for me to make a diagnosis of gastroparesis. So that's how I think of the spectrum of functional dyspepsia and the differentiation from gastroparesis.

Dr. Buch:
In the last few minutes of our conversation, are there any additional insights you would like to share with our audience?

Dr. Camilleri:
I'd like to go back to the principle that the symptoms of IBS and functional dyspepsia are not specific, and we as providers for that patient's care have opportunities to be more specific in identifying the underlying problem. There are now very simple tests that are available, especially in gastroenterology practice, that will allow us also to make those specific diagnoses. And just to summarize, I emphasized evacuation disorder in the context of constipation, bile acid diarrhea, microscopic colitis, non-celiac gluten sensitivity, and of course, making sure patients don't have celiac disease as well in the patients who present with symptoms suggestive of functional diarrhea or irritable bowel syndrome with diarrhea.

Dr. Buch:
Those are great points. And I want to thank my guest, Dr. Michael Camilleri, for joining us today. Dr. Camilleri, it was a pleasure speaking with you.

Dr. Camilleri:
As always, thank you so much, Peter.

Dr. Buch:
I appreciate it. For ReachMD, I'm Dr. Peter Buch. To access this and other episodes in this series, visit *GI Insights* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening, and looking forward to learning with you next time.