Transcript Details
This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/gi-insights/overcoming-controversies-of-irritable-bowel-syndrome/18100/

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Overcoming Controversies of Irritable Bowel Syndrome

Dr. Buch:
This is *GI Insights* on ReachMD, and I'm Dr. Peter Buch. Joining us today to discuss some controversies surrounding irritable bowel syndrome, or IBS, is Dr. Alexander Ford. Dr. Ford is Professor of Gastroenterology and Honorary Consultant of Gastroenterology at Leeds Institute of Medical Research at St. James University of Leeds.

Welcome to the program, Dr. Ford.

Dr. Ford:
Thank you for having me, Dr. Buch. It's a pleasure.

Dr. Buch:
And let's start at the beginning, Dr. Ford. Irritable bowel syndrome, IBS, is diagnosed using ROME 4 criteria. What are these criteria, and what are the chances of missing another illness when using these criteria?

Dr. Ford:
So the ROME 4 criteria consists of abdominal pain occurring at least one day a week over the last three months, and that has to be associated with at least two or three other features. The first is that the pain is related to defecation. The second is that the pain is associated with a change in the frequency of stool. And the third is that the pain is associated with a change in the appearance or the form of the stool. And those criteria have to be fulfilled for six months or more before a diagnosis of IBS is reached. Patients with IBS are subtyped or subdivided according to their predominant stool habits, so they fall into four groups: IBS with constipation, IBS with diarrhea, IBS with a mixed bowel habit, or IBS unclassified, which is that they don't meet criteria for any of those other three. And the risk of missing an organic diagnosis in someone who presents with typical IBS-type symptoms is pretty low, to be honest. We have previously validated the ROME 4 criteria for IBS in an unselected group of over 300 patients with IBS who had baseline bloods, and then the ROME 4 criteria were applied. We investigated those patients as well, but if we just applied the ROME 4 criteria, we would have missed organic disease in probably less than five percent of patients. So overall, patients who meet criteria for IBS clinically are unlikely to have another underlying explanation for their symptoms. That's the bottom line.

Dr. Buch:
Perfect. Can you help the audience with alarm signs, which might help them making that distinction?

Dr. Ford:
So alarm symptoms or signs would be things like rectal bleeding, weight loss, a palpable mass on a rectal examination persistent diarrhea over a certain age, and that age varies according to the country that you're in, and also abnormal blood parameters, such as anemia or a raised CRP. So those would be the main ones that are common across various countries' guidelines. And those alarm signs or symptoms are the things that would make you think about particularly bowel cancer but also other organic explanations for the symptoms, such as inflammatory bowel disease.

Dr. Buch:
Thank you for that. And one of the interesting things, even among medical students, let alone practitioners, is the thought that making a diagnosis of irritable bowel syndrome in their estimation is one of eliminating all other possibilities. Can you just address that fallacy?

Dr. Ford:
So absolutely, yes. So IBS is not a diagnosis of exclusion, and that is a common misconception, as you rightly allude to. So that really

leads to a lot of uncertainty on the part of the patient. IBS is a positive diagnosis supported by what I would refer to as limited judicious investigations. So if this history is typical and a complete blood count and a CRP are normal, then it's very unlikely that the patient has IBS. One would also, in any person who sounds as though they have IBS, certainly in the UK, perform serological testing for celiac disease. Although, in the US, that's only recommended for patients who have diarrhea. But basically, it is not a diagnosis of exclusion.

Now there may be other features in the clinical history that make you suspicious that there are other organic causes of the symptoms, and those would be, in my experience, things like nocturnal symptoms, so pain or diarrhea at night because that's not very typical for IBS, weight loss, and then presence of other autoimmune diseases or middle age. So those sorts of things would make you think about possibly a misdiagnosis of either bile acid diarrhea, particularly if the patient is overweight, or microscopic colitis, particularly if there's been weight loss and the patient is middle-aged and female and has rheumatoid arthritis, for example; but otherwise, it's just a case of taking a history, examining the patient and performing some routine bloods in order to reach the diagnosis.

Dr. Buch:
Perfect. Let's turn to this for a little bit. When assessing a patient for IBS, what should we know about bile acid diarrhea?

Dr. Ford:
So yes, that's a good question and one that I alluded to earlier. So bile acid diarrhea is a completely different condition to IBS and is treated differently. It can be caused by previous surgeries, such as resection of the terminal ilium or a cholecystectomy, but there is also an idiopathic form, which is probably genetic and which can be confused with IBS with diarrhea, so bile acid diarrhea causes chronic diarrhea. As I said earlier, often there are nocturnal symptoms. Their stool frequency tends to be much higher than I would see in a typical patient with IBS with diarrhea, and also, as I mentioned earlier, that it tends to be that the patient has a higher body mass index—the patient with bile acid diarrhea—than someone with irritable bowel syndrome with diarrhea.

In the UK, it's quite easy to diagnose bile acid diarrhea with something called a CCAT test, which is a radioisotope scan, and treatment can be instituted with what's called a bile acid sequestrant. In the US, you don't have access to CCAT scanning, and there are some centers that do fecal bile acid collection and measurement, and that can be used to diagnose bile acid diarrhea; but often, I would imagine practitioners in the US would have to use what's called a therapeutic trial of a bile acid sequestrant, so in other words give the patient a drug, like cholestyramine or colesevelam, to see if their diarrhea improves.

Dr. Buch:
Thank you. So let's talk about other confusing diagnoses, and let's talk about pancreatic insufficiency. How can that be confused with IBS?

Dr. Ford:
Well, I think the literature there is conflicting. There are some studies that suggest that patients who sound as though they have irritable bowel syndrome are more likely to have pancreatic insufficiency, as judged by what's called a fecal elastase. There are other studies that have not replicated those findings and that when they have performed cross-sectional imaging, such as a CT scan or an MRI, in patients with IBS who've had an abnormal fecal elastase have not shown any objective evidence of pancreatic disease. So I think the jury is out on that association, and certainly, guidelines for management of IBS in both the UK and the US do not recommend routinely trying to exclude pancreatic insufficiency in people who have typical symptoms for IBS.

Dr. Buch:
Thank you. For those just tuning in, you're listening to *GI Insights* on ReachMD. I'm Dr. Peter Buch, and I'm speaking with Dr. Alexander Ford about irritable bowel syndrome controversies.

So moving on, do probiotics have any role to play in the treatment of IBS?

Dr. Ford:
Probiotics are something that can be used or can be tried by patients. We completed a meta-analysis very recently, updated meta-analysis of trials of probiotics in irritable bowel syndrome, which was published in *Gastroenterology*, and although that showed some species and strains of probiotics appear to be beneficial, overall, there was no clear signal as to which species or strain or which combination of probiotics were more effective than a placebo, largely because so many different species and strains have been studied. And also, the quality of trials in IBS has been variable to date, and many of the trials are only over a relatively short period-of-time, four to eight weeks, whereas, an FDA recommendation for trials in IBS would be a 12-week trial. And there are lots of other limitations of those trials in terms of the design and methodology that mean that they're at quite high risk of bias.

So probiotics are something that I suggest to patients. They're not things that I can prescribe as an MD. And so I tell them that they could try one of a list of probiotics that I know of to be beneficially randomised trials, but I explain that they may not get a benefit and that

they may need to shop around and that those are things that they would have to fund themselves and obtain themselves.

Dr. Buch:
And a further thought with regard to that, when we're talking about probiotics, which of the symptoms do you expect to be most relieved when using probiotics? Is it bloating, or is it pain?

Dr. Ford:
Well, that's a very good question and one that we tried to address in our meta-analysis. We performed separate analyses according to global symptoms of IBS, abdominal pain, and bloating. And there was very little evidence that any of the strains or species had much of an effect on bloating, which is perhaps, unfortunate because bloating is such a difficult symptom to manage. There was some evidence for particular strains for abdominal pain, but most trials just reported the effect on global symptoms. So again, it was pretty difficult to be able to make any firm recommendations about using a particular species or strain for a specific symptom.

Dr. Buch:
As we come to a close, is there anything else you would like to share?

Dr. Ford:
I think just to say that doctors worry that they might be missing a diagnosis in people with IBS and that when we've validated criteria for IBS in clinical practice, it's clear that the ROME 4 criteria are very good for constipation, IBS with constipation, and IBS with a mixed bowel habit in terms of their diagnostic accuracy. The group that you've always got to be careful of are the ones with diarrhea. Those are the group where you might miss an organic diagnosis. So if there's any atypical symptoms or bloods are abnormal or calprotectin is abnormal or lactoferrin is abnormal, then you would want to investigate that group of people to make sure you're not missing organic disease. But for most people with IBS with constipation and IBS with mixed bowel habits, then the diagnosis usually secure just based on some routine bloods and the clinical history.

Dr. Buch:
What a superb review of IBS controversies. I want to thank my guest, Dr. Alexander Ford, for joining us today.

Dr. Ford, it was a pleasure speaking with you.

Dr. Ford:
Thank you very much for inviting me.

Dr. Buch:
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.