Transcript Details

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Is It Chronic Diarrhea Or Irritable Bowel Syndrome with Diarrhea?

Dr. Buch:
For a number of reasons, many patients with chronic diarrhea are often misdiagnosed with irritable bowel syndrome with diarrhea, or IBS-D for short, and fail to receive effective treatment. So, how can we work to ensure that these patients receive the correct diagnosis right off the bat?

Welcome to *GI Insights* on ReachMD. I'm Dr. Peter Buch, and joining me today to discuss diagnostic tools and testing strategies for chronic diarrhea and irritable bowel syndrome is Dr. Lawrence Schiller, who's the Program Director of the Gastroenterology Fellowship at Baylor University Medical Center. Welcome to the program, Dr. Schiller.

Dr. Schiller:
Well, Thank you, Peter.

Dr. Buch:
Now, Dr. Schiller, many primary care providers still believe that the diagnosis of irritable bowel syndrome is one of exclusion. I often hear the phrase, "What if I miss something?" Can you explain why we no longer evaluate irritable bowel syndrome by excluding other possibilities?

Dr. Schiller:
Well, I think the key observations were developed in the last 20 years or so when we came to understand that patients who meet criteria for IBS and have a specific relationship between abdominal pain and altered bowel habits most likely have IBS and are very unlikely to have other disorders, particularly if the symptoms have been going on for some time. So, for instance, the Rome Committee came together and established criteria for abdominal pain that is associated with defecation or with a change in stool form—that is the shape of the stool—or stool frequency, and so, if you have pain that matches up with those particular symptoms that's been present at least once a week for the last 6 months or so, then it's very likely that you have IBS, and it's very unlikely that you have other problems that might produce similar symptoms, such as Crohn's disease or some sort of bacterial or parasitic infection.

Dr. Buch:
And why are alarm symptoms useful in distinguishing irritable bowel syndrome from other illnesses?

Dr. Schiller:
Well, everyone worries that they will miss something in a particular patient that presents even though IBS is far and away the most common cause for those symptoms that you're likely to see in practice, and because of that, doctors have decided that patients who have particular symptoms need further evaluation. So, for instance, if someone has had unexplained weight loss or if they have had rectal bleeding, those would count as alarm features that need further evaluation even though they may meet the criteria for IBS.

Dr. Buch:
How much testing is sufficient in order for a primary care provider to diagnose irritable bowel syndrome with predominantly diarrhea?

Dr. Schiller:
Well, the first things we want to do are some very simple laboratory tests that you're likely to do in any event on a patient coming with new symptoms. One of these would be a complete blood count. If someone's anemic, that suggests a problem that needs further evaluation. You may want to do a comprehensive metabolic profile as well to look for problems that might relate to the presence of diarrhea, such as electrolyte imbalance. And we now think there are 2 other tests that are probably important to get early on in the evaluation of these patients. One is a serum C-reactive protein, which is a potent marker for inflammatory states and might cue you into

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the idea that the person has something like Crohn's disease, and the other is an IgA anti-tissue transglutaminase, which is a good screening test for celiac disease. If all those tests are normal, then the likelihood becomes very high that the person who meets criteria for IBS does, in fact, have IBS.

Dr. Buch:
For those just tuning in, you're listening to *GI Insights* on ReachMD. I'm Dr. Peter Buch, and today I'm speaking to Dr. Lawrence Schiller about chronic diarrhea and irritable bowel syndrome.

Now, as we know, Dr. Schiller, irritable bowel syndrome can occur with other illnesses, but can you elaborate on this for us?

Dr. Schiller:
Certainly. We now know that patients with irritable bowel syndrome are very likely to have other chronic complaints as well, and these may include other syndromes that don't particularly produce structural problems, like migraine, or people who have other rheumatic complaints, such as pain in various parts of their body, so we think this is part of the brain changes that occur with IBS that allow patients to be hypersensitive to the perception of pain. In addition, because many of these patients present with abdominal pain—and we always run through our list of causes of abdominal pain—these patients are very likely to have had other surgeries, things like cholecystectomy or appendectomy or a hysterectomy. So, if you see a patient with chronic abdominal pain who's had some of these other operations done, go back and check on what was found at the time of operation. Again, if there weren't remarkable findings consistent with diseases of those organs, that may have been an early manifestation of IBS as well.

Dr. Buch:
And based on your experience, what are some effective strategies to prevent misdiagnosing patients with chronic diarrhea?

Dr. Schiller:
I think the key is to get a full history and physical examination on the patient and to give some thought as to the possible causes for their problem. Certainly, one of the things we worry about in patients who have chronic diarrhea is the fact that they might have fecal incontinence and not diarrhea at all. Many people aren't aware of the term fecal incontinence, and hence they call it bad diarrhea, so the key is to ask if the patient has been inadvertently losing stool, and then, when you do your physical examination, to do a careful digital rectal examination to see if that's a problem.

Another issue we have to pay special attention to is the possibility of drug-associated diarrhea. Many of the medicines that are listed in the PDR, approximately half of them, have diarrhea as their common GI side effect, and so it's important to take a good look at the patient's medication list and see if in fact they are on a medicine that might be causing a problem with diarrhea.

When we get beyond that, there are several conditions that are fairly common in people who have chronic diarrhea. One of these is food intolerance. Many patients have foods that disagree with them and trigger diarrhea. A great deal of attention has been placed lately on fermentable carbohydrates, and these are a variety of different foods, substances such as lactose, sorbitol, that can cause diarrhea due as they are poorly absorbed, become fermented in the colon causing extra gas and bloating and retain water causing diarrhea. Diets designed to reduce the intake of these sometimes can be remarkably effective at mitigating chronic diarrhea.

Another problem that we encounter from time to time is bile acid malabsorption. About a third of patients who have problems with chronic diarrhea have evidence for bile acid malabsorption, which drives diarrhea by stimulating secretion in the colon. This is an important condition to recognize because it can be treated with bile acid binders, such as cholestyramine, and mitigate the problem long-term.

A third problem that sometimes causes chronic diarrhea is small intestinal bacterial overgrowth. This condition occurs anywhere from 10–20% of the time in patients with chronic diarrhea and is amenable to treatment with antibiotics.

If any of those particular conditions might be likely in your patients, either an empiric trial of therapy or some studies designed to look for those problems may be useful in helping your patient.

Dr. Buch:
Lastly, Dr. Schiller, let me open up the floor to you. Is there anything else you'd like to share with our audience today?

Dr. Schiller:
Well, I think one of the key things to remember is that not everyone with chronic diarrhea needs to have a colonoscopy, but many do. If you have a patient who is over 50 and is in need of colon cancer screening, that's a good reason to do a colonoscopy. If you have someone who doesn't have much in the way of abdominal pain, yet has chronic watery diarrhea, many of those patients, particularly the older ones, have microscopic colitis syndrome and would benefit from having a colonoscopy. The key though is, if you have a colonoscopy done on one of your patients who has chronic diarrhea, make sure the colonoscopist does biopsies from the colon to look

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for microscopic changes, which can be an important clue as to what actually is going on.

Dr. Buch:
Well, that's all the time we have for today, and I want to thank Dr. Lawrence Schiller for joining me to discuss testing strategies for chronic diarrhea and irritable bowel syndrome.

Dr. Schiller:
Thanks very much, Peter; I appreciate it.

Dr. Buch:
For ReachMD, I'm Dr. Peter Buch. To access this episode and others from *GI insights*, visit ReachMD.com\gi-insights, where you can Be Part of the Knowledge. Thanks for listening!

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