

Welcome to this webcast on the Irritable Bowel Syndrome: What Is It? What Causes It? And Can I Do Anything About It? The objectives of our symposium today, are what IBS is and indeed what it is not; the range and impact of IBS symptoms; how to communicate these symptoms more effectively if you're a sufferer; the role of diet and dietary supplements; how the sufferer can reduce their IBS symptoms; the overall management of IBS; and to look at new treatments.

To address these topics in this symposium, I'm joined by Professor Eamonn Quigley from the Division of Gastroenterology, Methodist Hospital in Houston; Professor Pali Hungin, who is Dean and Professor of Primary Care and General Practice at Durham in the U.K.; and Dr. Anton Emmanuel, who is a senior lecturer in neurogastroenterology at University College Hospital in London, where he's also a consultant gastroenterologist.

In addressing irritable bowel syndrome we really need to understand what the definition is and how we see IBS. And to address this question I'm going to turn first to Eamonn Quigley from Houston.

Thank you very much, Richard. I think the first point I would like to make about irritable bowel syndrome is that it's not a single entity; it's actually a collection of abdominal and bowel-related symptoms. And when we think of irritable bowel syndrome the symptoms we think of are first of all pain or discomfort in the abdomen. Secondly, some alteration in bowel habit, and it's very important to understand that this alteration could be constipation for some patients, could be diarrhea for other patients, and for others still it could alternate between diarrhea and constipation. And the third symptom I think about is bloating, which in some patients may be accompanied by actual visible distension.

Now the other important point to make about irritable bowel syndrome is that while each of these individual symptoms are very common in the community, it is when they come together and recur over long periods of time that we begin to describe them as irritable bowel syndrome. Now there are a number of other important features which really begin to make me think about irritable bowel syndrome when I see a patient in the clinic or a patient is seen in primary care. First of all, irritable bowel syndrome typically occurs in episodes. Some people call these "bouts," other people call them "attacks". One phrase patients often use when they see me in the clinic or sufferers may use in the community is that they say, "Oh, I was fine for a week or two, everything was perfect, and then I was terrible, I was really struck down by these symptoms for several days on end."

Typically, at least in our part of the world, and that's in Europe, North America, irritable bowel syndrome is much more common in females. It

can occur at any age, but most commonly the symptoms start either in the late teens, twenties, or thirties. There are another few features that we should emphasize, and when we talk to individuals that have irritable bowel syndrome they'll often say, "my symptoms are worse when I eat. They're worse when I'm stressed." And of course, females notice that their symptoms fluctuate with the menstrual cycle.

The severity of these symptoms varies tremendously. For some patients they're no more than an occasional nuisance, for others they really are totally disabling. Now one of the things we've realized recently about irritable bowel syndrome is that while the classical symptoms tend to involve what we would call the lower gut, a lot of these patients have symptoms in the upper part of the gut, such as heartburn or indigestion or nausea. And even more interestingly, many of these patients have symptoms in other parts of the body, such as fatigue, muscle aches, bladder problems, etc.

Now one of the things that caused a lot of confusion about irritable bowel syndrome is that some people with irritable bowel syndrome have anxiety and depression. But it's important to understand that irritable bowel syndrome is not caused by anxiety or depression. What happens is that if you have irritable bowel syndrome and you have anxiety, or you are depressed, your IBS symptoms are much worse and you're much more likely to come and see a doctor or come and see a specialist.

Now you could ask, why we're spending all this time talking about irritable bowel syndrome. Well, there are several reasons that I think we need to really focus on irritable bowel syndrome.

Firstly, it is common. There are been various surveys done; indeed, Professor Hungin did a very important study here in Europe showing that irritable bowel syndrome occurs in about 10 to 15-percent of the population. Secondly, as we have already mentioned, for some people it can cause very troublesome symptoms. And these symptoms can be so troublesome as to actually impair their quality of life. Very common features that we see in our clinics are patients who say, "I just can't leave the house. I can't leave the house because I'm embarrassed that if I go out I'll have to be positioned right next to a bathroom. I'd have to rush or I could need to rush at any stage during the meal, so I just don't bother going out." And another symptom that we're going to talk about in some detail that can cause great embarrassment is this abdominal distension, which is real. And patients say, "everybody is asking me if I'm pregnant again, and so I just don't go out."

Because of all of this interference with school, with work, with family life, it can have a socioeconomic impact for the individual as well as for society.

The other great pity about all of this is that if we actually diagnose irritable bowel syndrome accurately, and if we treat it well, patients can do well. So it really is a pity that we're not more aware of this condition, that we're not making the right diagnosis, and that we're not managing it properly.

Well thank you for that excellent overview. Now clearly this is a widespread condition which is common in the community, and so I think it's important at this point to turn to Pali Hungin as a general practitioner, and ask you to tell us a little bit more about how sufferers can best communicate their symptoms in order to assist the primary caregiver in making a diagnosis and being as effective as possible in managing this condition.

Richard, as Eamonn has mentioned IBS is a wide spectrum of problems, and a spectrum in terms of severity too. Some people will have rather mild symptoms and others will have troublesome symptoms, but usually it's something that has either occurred or a particular level of severity that has actually driven the sufferer to go and seek medical attention.

I think it's extremely important for the doctor to try to find out what it is that has provoked the consultation, and I think from the sufferer's viewpoint it's important to explain why they've actually consulted. The likelihood is that they've actually had their symptoms for a considerable period of time, but that something has happened which has made them come in to see the doctor. I think identifying that initial reason for consultation is quite important.

From the patient's viewpoint I think my suggestion is that patients should be very open with their symptoms. I think it's extremely easy for people to become rather self-conscious of the fact that they have bowel symptoms. Nobody likes to talk about gastrointestinal problems; it's an unpleasant area for many. But I think just being open about it and explaining the full range of problems that they have without embarrassment is important. I think that helps the consultation.

And in addressing pain, one obviously wants to differentiate IBS pain from other causes of abdominal pain. This differentiation can help by explaining how they look at their pain. Because we do have to admit that not all physicians spend quite as much time selectively asking. So here perhaps we can encourage the sufferer to triage, as it were, some of their own pain features.

Yes, indeed. I think a sufferer can help the situation by trying to go into greater detail about that pain or discomfort, describing its character, whether the pain occurs before or after a bowel movement, the location of

the pain or discomfort, potential timing, things that make the pain better or worse. All these are items which can help to lead onto a more accurate diagnosis, either to decide whether this is irritable bowel syndrome or something else. And of course in most people pain won't occur in an isolated manner without other symptoms. So other problems such as a sense of urgency, perhaps a need to go to the toilet very quickly, or a lack of, frankly, full satisfaction after a bowel movement. These are all symptoms which can occur with pain and discomfort. And having a greater awareness, perhaps having thought through some of these symptoms before going to the doctor, can make the dialogue a little easier.

Gastroenterologists tend to work within the framework of definitions, which have generally been agreed by consensus bodies. How are those seen in terms of working the patient through in the general practice situation?

Yes, indeed. Well, by and large the most commonly accepted working definition of irritable bowel syndrome is probably abdominal pain and discomfort in the presence of an altered bowel habit. I think most of us would accept that as a working diagnosis. And I know from research done by general practitioners themselves that they tend to look at the sufferer as a whole, the kind of total picture of what's going on in the patient's life together with their abdominal symptoms and other symptoms, before reaching a diagnosis of IBS.

Having said that, there are two or three other rather more finite definitions, if I could say that, or formal definitions, if I could put it like that; the Manning criteria and the Rome criteria. The Rome Foundation is an international group of people which has worked hard to try to put specific items into a description for irritable bowel syndrome. And these definitions are often related more to research rather than clinical practice, but they are based on the patient's duration of symptoms, the frequency of symptoms, and, of course, they include items such as abdominal pain and alteration in bowel habit. And also, of course, whether or not the bowel symptoms are of the constipation variety or of looseness variety.

Now Eamonn mentioned bloating and distension. Any sort of comment that you would make in the primary care setting with regard to those symptoms?

Bloating and distension are extremely distressing symptoms, and very common, almost the hallmark of irritable bowel syndrome. And I must say I'm embarrassed at almost the lack of sympathy sometimes doctors have for patients who present with these symptoms. Bloating is a sensation, a feeling of fullness. Distension is something that's rather more visible and something that's palpable. Patients often say, "look, my

clothes don't fit towards the end of the day. I feel that I've actually become distended to the point where people are making a remark about it." Yes, this is one of the features of irritable bowel syndrome, and it's something that the doctor needs to take into account. And it will be good if these symptoms were mentioned by patients early on, because this can help with the diagnosis too.

And you also mentioned that as part of this condition the abdominal pain may fluctuate, would be associated with an alteration in bowel habit. What sort of points about the bowel habit should the sufferer think about presenting to their healthcare provider?

Well, it would be helpful for the doctor to have a clearer idea of the way in which the patient's bowel action had changed in the previous few months or whether in fact the patient had had those kind of symptoms for a very long time. In some people the bowel action might be something that they've just got used to over a period of months and years, and it's perhaps the increased severity of the pain that caused them to come and see the doctor. But there's other things that the doctor is likely to want to know: is there a correlation between the pain and the bowel habit? So for example, a common problem in irritable bowel syndrome is the inability to feel that one has had a satisfactory bowel motion, the need to go back to do the job again, so to speak. Quite often the patient receives a relief of the pain and discomfort from having had a bowel motion, and that's fairly typical of irritable bowel syndrome. So these are the kind of features which would help in the diagnosis and indeed in monitoring the management of the sufferer's problem.

And then in terms of the symptoms what kind of impact should the sufferer bring out and emphasize?

The impact of symptoms in irritable bowel syndrome is underestimated, I think by all of us. Although many people who have mild symptoms can carry on ostensibly living a completely normal life. We know people who are tired all the time, who sleep poorly. We know people who are unable to do their work properly, whose roles from the social viewpoint are quite severely restricted, who cannot go out to meals, to restaurants. Indeed, personal relationships can be disrupted. It's the kind of problem which affects not just the bowel itself, but the patient's entire being, and I think that the overall impact of irritable bowel syndrome can be quite considerable, and I suspect that most people with IBS are paying quite a price for it.

I think the patient should be honest enough to explain the effect that the problem is having on them. Indeed, that might be the reason why some people seek consultation; it may be that they've come to terms with that

distension or that pain or even that bowel habit, but it's the fact that they have somehow become restricted in their overall functioning that they need help with.

So we must really encourage the sufferer to discuss what may be quite personal issues when they see the healthcare provider to really give them an idea of the adverse impact on their quality of life.

I think that personal issues are crucial in irritable bowel syndrome. And I think, for example intimate personal relationships and the ability to form friendships and to be part of a social group, all these items, if they are compromised they create an enormous burden for the individual patient. In these instances it's important to recognize which one of these is the biggest component of the patient's problem, because the management has to be geared to ensuring that we can get an overall improvement in the direction that the sufferer would benefit from.

And they may be developing anxiety about the impact more than about the actual symptoms.

Yes, I think many patients become anxious because of the level of restriction their IBS places on them.

So the sort of last question I think for you is what sort of information should the sufferer give to their healthcare provider about any treatments that they either have tried themselves over the counter, whether they've been seeing naturopaths and actually taking herbal therapies and stuff. What kind of information should they assemble and present to their general practitioner?

Well, doctors are aware and research has indicated that the vast majority of sufferers with irritable bowel syndrome will have tried some sort of therapy or medication or remedy. Many of them will have bought things over the counter that might've helped; they may have spoken with a pharmacist or with a friend with irritable bowel syndrome. People will have tried items that they may have seen in a supermarket or elsewhere or advertised in magazines. I think there's a huge array of treatments out there that people are aware of, some of which are remedies, others are things like relaxational therapies and so on. And it's important for the sufferer to explain to the doctor what they have tried already. This will give some clue as to what might work more effectively in the future, and also eliminate the need to go over ground that's been covered.

Well thank you very much, Pali. So let's turn now to Anton Emmanuel as a gastroenterologist dealing with a referral practice. How do you see

irritable bowel syndrome within-the context of the previous two colleagues' presentations?

Thank you, Richard. I think in hospitals, in secondary care we tend to see two kinds of patients; we tend to see patients whose symptoms are so intrusive that either the sufferer or the GP has felt the need to get further opinions. And the second category of patients we see are the ones who may have had investigations to be sure that there's nothing else going on in their guts and where the diagnosis has come up as being that of irritable bowel syndrome most likely. But in either event, what we are dealing with in hospital care are patients whose symptoms are at the more severe end of the spectrum oftentimes. So they are patients, rather than community-based sufferers by this point, obviously.

And I think one of the key things that I would say is important is to try and engage the patient to be able to explain the limitations on their life, because these symptoms are so intrusive and they're so subtle and they've been often- going on for years, decades, for our sufferers, that actually I think the role of the doctor often times is to just act as a mirror to reflect back to the patient the things that they've had to change, the fact that they've had to wear certain clothes, to avoid certain situations, to get up early in the morning, to go to bed later, to avoid mealtimes and certain situations. Those are the things which are most important, because they also, apart from giving idea of severity, they also allow the doctor and the patient to develop a relationship where the doctor understands what's going on in the patient's life, rather than just being a list of symptoms which one ticks off from things like the Rome Criteria, as Pali mentioned. It becomes something which is much more about understanding the patient's individual situation in the context of their symptoms and their lifestyle.

Well, persistence of symptoms is always worrying, both for the sufferer, but also for the primary care physician particularly if there isn't the expected feature- of some fluctuation in those symptoms. So as a specialist how do you single out particular features of symptoms that you feel perhaps require a more intensive investigation?

I think the first thing is the chronicity of symptoms; that's a rather important point. That's reassuring to me and I try and convey that to the patient as well, that these symptoms have gone on episodically, as Eamonn said, where they have good spells and bad spells. But that chronicity is often terribly reassuring at that point. So there's little fluctuations, but as you say, the overall trajectory is basically flat. Within the individual symptoms then obviously there are particular features which make us worry a little bit more or, equally, to reassure us. So patient symptoms which (where the stool caliber, the kind of consistency of what

comes out), fluctuate with time, especially when that fluctuation is associated with the bouts of discomfort. That's enormously helpful in pointing us toward a certain direction where we can avoid intrusive investigations again.

Eamonn, your experience is largely in the specialist referral population as well. Do you have any comments to add to that?

I would just like to emphasize some points that both Anton and Pali have made. And first is the bloating and distension issue. And I think for a variety of reasons we've tended to underappreciate how frequent these symptoms are among patients and how intrusive they are for patients. And I think it's a major progress for all of us that we are beginning to appreciate the frequency of these symptoms and their impact, and I think it's very important for that reason, as Pali has mentioned, to ask about these symptoms and to differentiate between bloating and distension.

The other area where I think I find the most confusion is about bowel habits. That may sound ridiculous, but- a lot of doctors don't appreciate the range of symptoms that are related to constipation. They just say, "How often do you go?" but they don't ask about, "Do you have difficulty going? Are you straining?" As Pali said, "Do you feel as if you have had an unsuccessful or an incomplete bowel action?" So we need to ask more about exactly what the patient means by constipation, and similarly about diarrhea.

A big mistake that a lot of us make in terms of diarrhea is that we confuse diarrhea with frequent bowel movements, because as Pali mentioned, a lot of patients with irritable bowel syndrome have the urge to go frequently, but a lot of the time they actually just pass a bit of mucus or it's not actually diarrhea. The reason that's important is that if we put them on anti-diarrheals we'd probably make them much worse, because they don't actually have diarrhea.

And there is a very simple tool which was developed actually quite a long time ago, which is called a Bristol Stool Chart. And I know a lot of doctors- have these charts and they give them to the patient, and the patient can look at this chart, which is now on your screen, and you can see what type of stool you have and you can describe that to the doctor. So it gives, if you like, a more objective means of knowing exactly what the problem is with their bowel habit. So I think these are two very important issues that we as doctors need to be better educated on.

Well I think you're making a very important point with respect to stool and frequency and so on, because in my experience a great deal of the problem is the patient's expectation of what a normal bowel habit is. And



I'm afraid to say that I think there's also something of a missed connection in terms of the way that many physicians view what a normal range bowel habit is. And so I think your points are really important to convey to our audience today.

Yes, it's very important, I think, in talking about bowel habits with patients, not to impose your expectations on them, but actually to hear from them. What they feel the problem is. Then I think we'll all be in a better place.

So thank you very much for that Eamonn. And I think we've heard from the three of you some really important points in relation to what matters to the sufferer in terms of how they interpret their symptoms and the key points that they need to transfer to the healthcare provider at their first visit. Thank you very much.