PJ PRACTICE CHECKLIST

IRRITABLE BOWEL SYNDROME

A number of different over-the-counter products are now available to treat the symptoms of irritable bowel syndrome. This card discusses which treatments to recommend for symptomatic control of the condition. It also emphasises the importance of interviewing the patient when counter-prescribing

WHAT IS IRRITABLE BOWEL SYNDROME?

Irritable bowel syndrome (IBS) is a disorder of the gut characterised by:

- Intermittent and colicky abdominal pain
- Abdominal distension, which is often worse in the morning, and is quantifiable by computer tomographic studies but is of unknown aetiology
- A range of other non-specific signs and symptoms, eg, a feeling of incomplete evacuation on defaecation and passage of rectal mucus

Some patients report urgency of defaecation and painless diarrhoea while others complain of constipation. In some patients, episodes of diarrhoea alternating with constipation are experienced. Faecal incontinence, which is particularly distressing, affects a small number of IBS patients.

Non-colonic symptoms include nausea, early satiety, dysphagia, back pain, urinary frequency and urgency, fibromyalgia and dyspareunia (painful sexual intercourse experienced by women). The concurrent presence of non-colonic symptoms with the more common colonic ones is claimed to improve the reliability of diagnosis of IBS.

In 1989, an international consensus conference led to the publication of a set of guidelines for the diagnosis of IBS. These guidelines are commonly referred to as the Rome criteria (see Panel).

WHAT IS THE CAUSE OF IBS?

Despite the common occurrence of the disease, its aetiology is still unknown and the consensus is that it is multifactorial with a range of well-accepted trigger or exacerbating factors. Trigger factors include antibiotic treatment, abdominal surgery and diet. Gut motility or sensitivity is altered, with exaggerated responses to both chemical and physical stimulation. Sufferers of IBS also seem to have a heightened perception of these motor events explaining the previously common, but now less popular, view that the disease was largely psychogenic. However, psychological factors, eg, stress are still thought to be important.

HOW COMMON IS IBS?

IBS is reported to affect some 15 to 20 per cent of the Western population. The disease appears to be as common in the Third World as it is in the West. Women appear to be twice as likely as men to suffer from the condition. The reported high prevalence of the disease is not surprising given the non-specific nature of the symptoms. As yet, there are no reliable diagnostic tests for IBS.

HOW SEVERE IS IBS?

The severity of the condition ranges from mild to incapacitating. The disease can be easily misdiagnosed because the symptoms can be confused with those of gynaecological or urological disorders. Even if only a proportion of referred cases attend the clinic because of misdiagnosis of IBS, the burden of the disease on both patients and society as a whole is considerable.

COUNTER-PRESCRIBING

There is no cure for IBS. From a counter-prescribing viewpoint, the pharmacist's role is to ensure that no serious illness is misdiagnosed as IBS, and to recommend appropriate treatment for symptomatic control. Given the many presentations of the disease as indicated by the term "syndrome", there is no single remedy appropriate for IBS. Therefore, interviewing the patient to identify the most distressing symptom is essential if proper medication is to be recommended.

ROME CRITERIA FOR DIAGNOSIS OF IBS

The following symptoms experienced continuously or recurrently for at least three months:

1. Abdominal pain relieved by defaecation or associated with a change in frequency or consistency of stool and/or

2. Defaecation disturbed by two or more of the following:

- Altered stool frequency
- Altered stool form
- Altered stool passage — straining, urgency, feeling of incomplete defaecation
- Passage of mucus

Both 1 and 2 usually occur with bloating or a feeling of abdominal distension

WHAT ADVICE SHOULD BE GIVEN TO PATIENTS?

The non-specific nature of the symptoms of IBS leads to great anxiety in patients. Patients with IBS might worry that they have a serious underlying disease, such as cancer. Explanation and reassurance about the benign nature of the condition is required. When counter prescribing in IBS, referral may be necessary to ensure that the requisite clinical examination and diagnostic tests are undertaken.

Explanation of the episodic nature of the disease and the value of control of known trigger factors, such as avoidance of perceived offending foods, may be helpful and reassuring to patients.

LAXATIVES

Dietary fibre was for a long time held to be the logical first-line therapy for IBS. While this approach is still worth a try in the presence of constipation, it is important to recognise that some patients will get worse. The same applies to other bulking agents, such as

ispaghula husk, and other laxatives, eg, lactulose. OTC stimulant laxatives, such as bisacodyl and sennosides, also have their proponents but there is little good clinical trial data to validate their use in IBS; their effectiveness as laxatives is not, however, disputed.

ANTIDIARRHOEAL AGENTS

Diarrhoea is generally of low grade but if persistent, dehydration may ensue. Rehydration fluids are generally not first-line anti-diarrhoeal therapy in IBS. Instead, opioid antidiarrhoeal agents, such as loperamide, codeine, opium extracts and diphenoxylate are preferred. These agents decrease bowel motility by inhibiting acetylcholine release via activation of the μ opioid receptors of the myenteric plexus.

Of the opioid compounds available, loperamide is the most appropriate because of its poor penetration of the blood-brain barrier and hence low incidence of central nervous system side effects, including dependence. This good risk-benefit ratio in adults explains why loperamide became an OTC medication.

Codeine and morphine continue to be available for self medication as compound preparations for historical reasons and because of the careful control over the sales of these compounds by pharmacists. Whenever there has been any evidence of abuse, pharmacists have been quick to respond to tighten control so that responsible OTC use can continue. Despite the long history of use, the value of these opiates at OTC doses is questionable.

PEPPERMINT OIL

Enteric-coated peppermint oil capsules, which release oil in the distal small bowel, are claimed to have both antispasmodic and carminative effects. The oil relaxes intestinal smooth muscle and a few small, but not entirely convincing, clinical studies suggest that it may be marginally more effective than placebo. The long history of use of peppermint oil in carminative formulations for upper intestinal complaints provides some reassurance about its safety and the enteric formulations do not seem to be associated with any more adverse effects than conventional formulations. However, a recent meta-analysis of smooth muscle relaxants suggests that except for dicyclomine (see below), peppermint oil is the only agent producing more adverse effects than placebo.

MUSCARINIC ANTAGONISTS

Muscarinic antagonists, such as atropine present in belladonna extracts, propantheline and dicyclomine, exert an antispasmodic effect. All are poorly selective in action with potential for anticholinergic side effects, such as dry mouth, blurring of vision, arrhythmias and urinary flow problems. Because of these side effects, effective doses are restricted to prescription-only supply. The doses present in OTC compound belladonna preparations are generally safe but also have poor efficacy.

ALVERINE AND MEBEVERINE

Both alverine and mebeverine are antispasmodics. There is little good data on the clinical efficacy of alverine citrate and its continued use is justified, essentially, only on the basis of its long history of safe use. Mebeverine hydrochloride has been more extensively investigated but it is only of marginal efficacy. Indeed, in some studies placebo has actually outperformed mebeverine, although a recent meta-analysis suggests that, based on global improvement, mebeverine is a little better than placebo.

Both alverine and mebeverine benefit from the fact that patients with IBS are highly susceptible to the placebo effect. In the placebo arms of randomised controlled trials, the response rate has often exceeded 50 per cent and has been as high as 70 per cent. The advantage of alverine and mebeverine over the antimuscarinic agents is their relative selectivity for smooth intestinal muscle and hence absence of anticholinergic effects.

WHEN TO REFER

Ideally, only patients who have been diagnosed as having IBS should be treated on a self-medication basis.

- In practice, patients who meet the Rome criteria for IBS and those with recurrence may justifiably be given a short course of laxatives, antidiarrhoeal agents or selective antispasmodics, depending on the most distressing symptom
- Patients with acute symptoms, experienced for the first time, should be carefully assessed
- Patients with blood in the stools, fever or weight loss should be referred
- A history of recent travel to warmer climates might suggest an unusual intestinal infection requiring further investigation
- Sensitive questioning may elicit a history of serious abdominal illness in the family and reassurance is essential. Under such circumstances, referral is appropriate

PATIENT INFORMATION

Patients can obtain infomation about IBS from the IBS network, St John's House, Hither Green Hospital, Hither Green Lane, London SE13 6RU.

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