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Dealing with irritable bowel syndrome

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Pages with reference to book, From **78** To **81**

Treatment

i) Establish a successful physician patient relationship

It is of utmost importance to establish a successful physician patient relationship and help the patient to understand the benign nature of the illness. Physician should acknowledge the reality of patient's symptoms and have empathetic behaviour[66]. Any concerns of the patient should be discussed. Some patients may be having fears of underlying cancer. Reassurance helps the patient cope with his symptoms. Emphasis should be on negative findings of the screening investigations.

The complex underlying pathophysiological and psychophysiological disturbances exist in patients with irritable bowel syndrome, treating them may be a difficult task. It has been shown that doctors underestimate patients expectations, anxiety and secondary complaints and overestimate patients' pain related attributions[67]. Any exacerbating factors should be identified and appropriate changes made in the dietary habits and life style. Education of patient and reassurance is importanr[68].

ii) Look after Psychological Aspects

If the symptoms are clearly related to stresses and psychological strain, these patients may require anxioly'tics and antidepressants e.g tricyclic antidepressants or Serotonin reuptake inhibitors. Sometimes need may arise to refer one of these patients to a psychiatrist. Before referring, the patient should be taken into confidence about the need of second opinion, with assurance of continuous medical care. Psychological treatment offered to the patient may include psychotherapy[69], hypnotherapy[70] and biofeedback[71]. Patients with overt psychiatric symptoms and those with diarrhea and intermittent pain exacerbated by stress, show a good response to psychotherapy[72]. In an analysis of controlled studies on psychological treatment, eight studies showed that psychological treatment was superior to the controlled therapy while five failed to detect a significant effect[73].

iii) Dietary Changes

Dietary changes are often effective in alleviating symptoms. Patients who have gaseous symptoms and bloating or diarrhea may be helped by avoiding smoking and caffeine, carbonated drinks, lactose containing foods, sweets and jams containing sorbitol or fructose. They should also avoid gas forming beans, cabbage, lentil and legumes which are fermented in the colon by the bacteria, ending up in gases.

iv) Fiber Supplements

Fiber supplements may help relieve constipation[74,75]. Fiber should be introduced gradually to avoid excessive bloating. Bran, psyllium, ispaghula husk and methylcellulose have the ability to retain watcr thereby increasing stool weight, preventing hard stools and accelerating intestinal transit. Any benefit from Fiber supplementation may be a placebo effect[74-76] but it seems reasonable to utilize this effect and give a trial of fibers to patients with lBS. The agents should be taken within an hour of the meal to allow blending with the fecal matter. A laxative may be given to the patients in constipation phase prior to bulking with Fiber supplements to avoid bloating and satiety and liquid should be consumed in excess alongwith dietary fiber.

v)Medical Treatment

A number of drugs are used in the treatment of lBS. Not a single drug is effective in all the patients[75]. Individual patients may benefit from one of the drugs mentioned in the table 2.

Table 1. Diagnostic criteria for irritable bowel syndrome.

Manning's Criteria:

1. Abdominal distention.
2. Relief of abdominal pain with defecatin.
3. More frequent stoóls with the onset of pain.
4. Looser stools with the onset of pain.
5. Passage of mucus.
6. Feeling of incomplete evacuation.

Rome Criteria:

Continuous or recurrent symptoms for at least three months.

1. Abdominal pain or discomfort that is:

A. Relieved with defecation or
B. Associated with change in frequency of stools or
C. Associated with change in consistency of stools.

2. Two and/or more of the followings at least 25% of the time:

A. Altered stool frequency.
B. Altered stool form (hand or loose/watery).
C. Altered stool passage (straining urgency or feeling of incomplete evacuation).
D. Passage of mucus.
E. Bloating or feeling of abdominal distension.

Table 2. Pharmacotherapy for irritable bowel syndrome.

Smooth muscle relaxants:
Mebeverine, dicyclomine, pepermint oil, belladonna, cimetropium, pinaverium, trimebutine, octylonium, zamifenacin
Antidiarrhoal agents:
Loperamide, diphenoxylate, dioctahedral, smectite, cholestyramine, codeine phosphate.
Prokinetic agents:
Cisapride, naloxone, erythromycin.
Fiber supplements:
Bran, Psyllium, ispaghula, methylcellulose.
Antidepressants:
Amitriptyline, imipramine, doxepin, amoxapine, trazodone.
Benzodiazepines:
Deflatulants:
Simethicone, dimethylpolysiloxane.
Miscellaneous:
- Somatostatin analogue octreotide
- Kappa opioid receptor antagonist fedotozine
- Serotonin (5HT3) receptor antagonists grainsetrone, ondansetron.

These drugs include tricyclic antidepressants, antidiarrheal agents, smooth muscle relaxants, prokinetic drugs, somatostatin agonists, 5HT4 antagonists, Kappa opioid agonists, etc.

Low dose antidepressants are effective in improving global symptoms especially pain, a CNS mediated effect[77,78]. Anticholinergic effect of these medications may also be a contributing factor in relieving abdominal pain. Antidepressants can also modulate intestinal motor function and may have therapeutic effect in IBS, unrelated to mood improvement[79]. Patient should be reassured that these drugs are not being prescribed for any psychiatric illness but for the other useful effects.

Smooth muscle relaxants are effective in improving global symptoms and abdominal pain[80] but not constipation or abdominal distention. Mebeverine is a specific myorelaxant for colon and does not have the side effects of anticholinergic drugs[81]. Zamifenacin is a new potent gut M3 selective muscarinic antagonist. It reduces colonic motility in lBS[82]. Loperamide has a relaxing effect on localized and segmental large bowel spasms. A double blind placebo controlled trial has shown its benefit with regards to stool frequency, stool consistency and the overall pain intensity[83]. Morning dose of loperamide or mebevarine may particularly be helpful for patients who have increased frequency of bowel movements in the morning. Octreotide alters the conscious perception of rectal sensation and

may be useful in chronic pain syndromes[84]. Fedotozine acts on the peripheral opioid receptors modulating sensory afferent pathways[85]. A multicentre controlled trial has shown its effectiveness in reducing abdominal pain intensity[86,87]. The effect of a Serotonin (5-HT3) receptor antagonist, ondansetron has been assessed in a double blind placebo controlled trial in individuals with diarrhea predominant lBS. There was improvement in stool consistency but not in frequency[75,88]. As there is high prevalence of adverse reactions to food in diarrheic IBS, treatment with oral cromolyn sodium may be of value in these patients[76,89]. Cisapride, a prokinetic drug, has Serotonin receptor agonist (5HT3) and antagonist (5-HT4) actions. It influences interdigestive and postprandial small bowel motor activity[90], accelerates colonic transit and decreases the severity of constipation[89].

Conclusion

In short, treatment of lBS has to be individualized according to the predominant symptom of the patient. A combination of psychological support, dietary advice, change in the life style and appropriate selection from the armament of drugs help in effectively combating symptoms and misery of the patient. A positive physician patient interaction is associated with fewer return visits for lBS[92]. lBS patients with short duration and fewer psychological symptoms have a better prognosis than patients with a long history of lBS and associated psychological stresses[93].

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