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LETTER TO THE EDITOR

IRRITABLE BOWEL SYNDROME MANAGEMENT: BUMPY ROAD FOR PHYSICIANS

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Irritable bowel syndrome (IBS) is a complex gastrointestinal disorder related to over activity of nerves supplying the gut.[1] It has been matter of enormous concern for both the patients and treating physicians'. The clinical course is diverse and takes different twist and turns. Sometimes it does present with typical symptoms like bloating, flatulence and altered bowel habits. At times there is mental illness like severe depression that comes in the way which is real challenge for the physicians to treat as mere reassurance doesn't suffice. The longer the history of symptoms, more complicated it gets. There are multiple obstacles before making in rows in treatment.[2]

The most frustrating point is when the patient fails to show any improvement after months of treatment. They have symptoms in relapsing and remitting manner. Post infectious IBS is more agonizing as the patient need antibiotics in an era of increasing resistance.[3] Failure of one antibiotic to resolve symptoms leads to usage of multiple ones at the same time. The cramping abdominal pain and the sleepless nights leading to daytime fatigue do have an enormous and disastrous impact on the activities of daily living. After the decades of research, optimization of treatment for irritable bowel syndrome is still a daunting task even for experienced gastroenterologists.[4]

The emergence of alarm symptoms like bleeding per rectum, unintentional weight loss and feeling of abdominal mass in individuals who have altered bowel for years do ring the bell for physicians to act vigilantly who were otherwise complacent.[4] They were relying on traditional treatment regimens like giving laxatives, anti-spasmodic and medications for depression. Some of them do consider expeditious referral to psychiatrist without getting to the bottom of the situation. Colonoscopy is advised at the end when much damaged have been caused already. It will be excellent practice to advised stool routine examination, culture, ESR, CRP and calprotectin levels.[5] They will give an idea of level of inflammation in the gut as invasive investigations are always dangerous in setting of acute flare of disease such as inflammatory bowel disease leading to perforations. Many clinicians do mix up irritable bowel syndrome with inflammatory bowel diseases such as Crohn's disease and Ulcerative Colitis. Remember the bitter reality that IBS is a diagnosis of exclusion that needs sound clinical judgement.

In the 21st century, medicine has revolutionized. There has been great advancement in treatment of IBS. There is concept of more multidisciplinary approach involving gastroenterologist, dietician and psychologists.[6] The high co-morbidity of psychological disorders in gastrointestinal disorders suggests a close and complex connection between the brain and the gut. It will be advisable to have a coordinated approach for its treatment as failure to respond is a misery for the patient and practicing physician both. There is no harm in considering cognitive behavioural therapy (CBT), interpersonal therapy and FODMAP (Fermentable Oligosaccharides, Disaccharides, Monosaccharides and Polyols) diet if traditional long used regimens have failed.[7] The drawback of CBT is that it is time and effort-consuming for therapists, and there is limited availability of competent therapists as well.

The road to IBS treatment has been and will always be complex. It's so easy to be driven away by simple symptoms and missing sinister signs. It so inevitable to keep a threshold for dangerous disease such as colorectal cancer and do refer a patient to gastroenterologist when the clinical suspicion is high. The prompt diagnosis of patient is an art which comes with experience and timely referral of patient is wisdom which we need to have for safe and better clinical practice.[8]

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CONFLICT OF INTEREST

Authors declared no conflict of interest

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