NHS
Vale of York
Clinical Commissioning Group

Referral Support Service
GA01 Gastroenterology

Irritable bowel syndrome (IBS) – diagnosis and management

NB to exclude Red Flag Symptoms – see change in bowel habit

Definition and diagnosis

IBS is a functional bowel disorder characterised by more than 6 months of recurrent abdominal pain/discomfort which may be relieved by defaecation and associated with an alteration in stool form or frequency. Consider in those with abdominal pain, bloating and change in bowel habit[1]. **Faecal calprotectin** may be a useful discriminator and help diagnosis without referral (see below).

IBS affects 1 in 5 people at some point of their lives. Accurate diagnosis is achievable in primary care. NICE suggest 'diagnosing positively, based on symptoms, rather than after exhaustive investigations'[1].

Classification:

- IBS-D (diarrhoea predominant)
- IBS-C (constipation predominant)
- IBS-M (mixed fluctuating picture)

Following exclusion of red flags **(see change in bowel habit)** and a family history of bowel or ovarian cancer, consider diagnosing irritable bowel syndrome only if the person has abdominal pain or discomfort that is[1]:

- relieved by defaecation, **or**
- associated with altered bowel frequency or stool form (see Bristol Stool Chart)

And at least 2 of the following:

- altered stool passage (straining, urgency, incomplete evacuation)
- abdominal bloating (more common in women than men), distension, tension or hardness
- symptoms worse by eating
- passage of mucus.

Lethargy, nausea, backache and bladder symptoms may be used to support diagnosis.

Baseline tests include FBC, CRP, TFT, calcium and coeliac screen. Stool testing may be necessary: M, C + S and/or *C.difficile* screen. Usually **no need for** colonoscopy, radiology or breath tests.

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Faecal calprotectin can help support a positive diagnosis of IBS where there is diagnostic uncertainty, in patients aged 18-60 years. It should not be used if colorectal cancer is suspected. The test costs £27.

Faecal calprotectin <100 mcg/g:

- A diagnosis of IBS is likely and the patient should be offered local management (or a uro-gynaecological diagnosis be considered)[2, 3].
- If still symptomatic after review then the Faecal Calprotectin Care Pathway gives further guidance dependent on age and faecal calprotectin level.
- NB IBS rarely presents for the first time in women >50 years of age and NICE suggests considering the possibility of ovarian cancer. Offer appropriate tests e.g. CA125 +/- USS[3].

Faecal calprotectin ≥100 mcg/g:

- **repeat the test**
- patients with a repeat faecal calprotectin of 100-250 mcg/g should be referred **routinely** to gastroenterology.
- those with a repeat test >250mcg/g should be referred **urgently** to gastroenterology for, if fit, straight to colonoscopy.

Sufficient clinical information should be contained in the referral to inform patient management.

Management of IBS

Soluble fibre

- Increase soluble fibre in diet and reduce insoluble, particularly if IBS-C
- Soluble fibre – oats, ispaghula husk, nuts, seeds eg linseed, flaxseed
- Insoluble – bran, wheat, fruit, vegetables

Dietary management

- The BDA and NICE recommend regular meals, exercise and drinking at least 8 cups of simple fluid per day. Reduce tea, coffee and alcohol. BDA have produced a useful leaflet which is endorsed by NICE: BDA Food Fact Sheet - Irritable bowel syndrome and diet January 2016

Try to identify triggers and eliminate these from the diet, for example:

- Restrict gluten. There is evidence that reducing gluten may improve symptoms even if the coeliac screen is negative[4].
- Reduce lactose containing foods
- FODMAPS (fermentable oligosaccharides, disaccharides, monosaccharides and polyols), which may be poorly absorbed and ferment in the gut. Currently there is insufficient

evidence base to support a FODMAP diet. **NICE states that advice should only be given by a healthcare professional with expertise in dietary management[1].**

Probiotics

Evidence has been published suggesting that probiotics are of benefit in IBS. NICE/BDA recommend a trial period of minimum 4 weeks. Bifidobacteria has been shown to improve symptoms but other products with alternative probiotics are also available[5]. Patients should buy their own probiotics from the supermarket or health food shops, examples include VSL#3® probiotic supplements or Alflorex® Precision Biotics; these products should NOT be prescribed on the NHS.

Antispasmodics and Peppermint Oil

Consider **mebeverine** 135mg tds and **peppermint oil** 0.2ml caps (prescribe as e/c capsules for most cost-effective option) are shown to be effective for pain and diarrhoea.

Laxatives

- Consider **ispaghula powder** or **macrogol** oral powder (as **Laxido®** sachets) if IBS-C

Antimotility agents

- Consider **loperamide** 2mg 1-2 bd if IBS-D

Tricyclic antidepressnts

Consider TCAs as second-line treatment for people with IBS if laxatives, loperamide or antispasmodics have not helped. Start treatment at a **low dose (5–10 mg equivalent of amitriptyline**), taken once at night, and review regularly. Increase the dose if needed, but not usually beyond 30 mg. **Amitriptyline** is 1st line option, **nortriptyline** = second line option.

Consider SSRIs for people with IBS only if TCAs are ineffective and pain is not the predominant factor **e.g. citalopram.**

Latest NICE guidance[1] also suggests “Take into account the possible side effects when offering TCAs or SSRIs to people with IBS. Follow up people taking either of these drugs for the first time at low doses for the treatment of pain or discomfort in IBS after 4 weeks and then every 6–12 months.

At the time of publication (NICE guidance[1], February 2015), TCAs and SSRIs did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision.”

Indications for referral[6]

- Faecal calprotectin ≥100 mcg/g when tested and repeated (urgent if > 250)
- Persistent symptoms not responsive to above approaches (see York Faecal Calprotectin Care Pathway)
- Suspected colorectal cancer (NICE NG12)
    - Unintentional and unexplained weight loss & abdominal pain.
    - Unexplained rectal bleeding.
    - Change in bowel habit in a person over 60 years of age.
    - Abdominal or rectal mass.
    - Anaemia.

Referral Information

- Previous primary care management attempted
- Relevant past medical / surgical history
- Current regular medication
- BMI / smoking status
- Investigations

Patient information leaflets/ PDAs

Irritable Bowel Syndrome Leaflet
Chronic Diarrhoea in Adults Leaflet
York Faecal Calprotectin Care Pathway Leaflet

NICE CKS guidance

IBS assessment and management IBS Management
Elearning module Irritable bowel syndrome in adults: diagnosis and management: putting NICE guidelines into practice IBS - NICE Learning Module

References

1. NICE Guidance CG61 Irritable bowel syndrome in adults: diagnosis and management of irritable bowel syndrome in primary care Feb 2008. Updated Feb 2015
2. Faecal calprotectin diagnostic tests for inflammatory diseases of the bowel Diagnostics guidance Oct 2013
3. NICE Guidance CG122 Ovarian cancer: The recognition and initial management of ovarian cancer April 2011
4. Does gluten sensitivity in the absence of coeliac disease exist? BMJ 2012:345, 7907
5. The efficacy of probiotics in the treatment of irritable bowel syndrome: a systematic review. Gut 2010;59:325-332
6. NICE CKS Assessment and management of irritable bowel syndrome