Irritable Bowel Syndrome

edited by

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Preface

The irritable bowel syndrome (IBS) is one of the commonest conditions referred to a gastroenterologist, but one of the least well understood. Part of the reason for this is the lack of real concensus of opinion regarding the nature of the complaint. The problem is confounded by the absence of anatomical, biochemical or even physiological markers, and the variation in symptomatic presentation. We are not sure, for example, if abnormalities in the function of the upper gastrointestinal tract should be included in the spectrum of the irritable bowel syndrome. The symptoms of IBS mimic those of many other gastrointestinal diseases and the challenge to doctors is to establish a confident diagnosis based on the symptomatic presentation, without the need to carry out multiple investigations to eliminate organic disease of the bowel. The pathogenesis of the condition is virtually a mystery. Some investigators have suggested that intolerance to food substances may play an important role. Others would disagree with this. Most doctors would not consider IBS to be a "proper" disease at all, but view it as a physiological alteration in intestinal function, brought about by psychological disturbance. But if IBS is caused primarily by a disturbance in the mind, then why are we using bran or antispasmodics to treat it and how can we ever assess the value of such treatment? It was with the aim of addressing these and other important questions that a symposium on the irritable bowel syndrome was convened at the Chateau Impney in Droitwitch, England, in June, 1983.

The symposium provided a forum for communication between clinical investigators, who had all made important contributions to our understanding of IBS in recent years. The meeting was subdivided into separate sessions, each addressing a particular question. Each session consisted of a short keynote summary of present knowledge, followed by ample time for group discussions so that the problems could be adequately explored. In the event, the meeting developed into an exciting interchange of ideas.

The purpose of this book is to make the shared experiences of our meeting available to a wider audience in the hope that this will provide the clinician with a more complete understanding of such a common condition and stimulate the clinical investigator to take an interest in solving some of the important problems it raises.

The book, as the meeting, is divided into four parts. The first, "Nomenclature and Diagnosis" is concerned with definition, classification and the need to establish a positive symptomatic diagnosis. The second part, "Pathogenesis", includes important new contributions regarding the roles of psychological stress, the gastrocolonic response and intestinal secretion in IBS and an illuminating discussion on whether or not a disorder in colonic motility, specific to IBS, really exists. The third part, "Disease Mechanisms", contains new data on constipation, abdominal pain, food intolerance as a cause of diarrhoea and anorectal disorders. Two papers each on constipation and abdominal pain provide a particularly valuable balance of opinion and emphasis. Finally, the fourth part, "Treatment", contains important assessments of the roles of dietary fibre, drugs and psychotherapy in the management of IBS, with detailed practical advice on how to design an effective clinical trial for this condition and how the clinician could institute simple forms of psychotherapy.

A fundamental aim of this symposium was to establish a definition and classification of the irritable bowel syndrome. This would allow investigators working in different parts of the world to carry out studies on similar population groups so that the data from such studies could be usefully compared. In the event, a rigid definition and classification remained elusive. The major stumbling block was that while everybody recognized that gastrointestinal irritability could be expressed as abnormalities throughout the gastrointestinal tract from oesophagus to anus, knowledge of these physiological disturbances and the resulting symptoms is at present too nebulous to permit a definition that would discriminate IBS from a host of other conditions. We can, however, be more confident about the manifestations of colonic irritability, such as a disturbance in bowel habit, abdominal pain, urgency, frequent call to stool and incomplete evacuation. Furthermore, the abnormal sensitivity to balloon distension of the rectum and the generation of regular rectal contractions and anal relaxations at low rectal distending volumes may prove to be important physiological markers (see Chapters 14 and 17). Thus, for the purposes of carrying out clinical trials, we could define the irritable *colon* syndrome symptomatically as abdominal pain together with a disturbance in bowel habit, which may be either diarrhoea or constipation or both and often encompasses urgency, frequent call to stool and feelings of incomplete evacuation. The definition should also include the statement that these symptoms cannot be explained by

specific pathology of the colon. Clearly, this definition excludes patients who have painless diarrhoea, painless constipation and patients with abdominal pain but no alteration in bowel habit. In other words, the best we can do at present is to try and identify and define a subgroup, which may be called the irritable colon (or rectum) syndrome and can form a basis for clinical trials, while at the same time recognizing that gastrointestinal irritability has much wider manifestations which require further characterization.

N. W. Read *May 1984*

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Part One

Nomenclature and Diagnosis

Contents

Part One

Nomenclature and Diagnosis

1. The Irritable Bowel: One Disease, or Several, or None?

W. Grant Thompson

The irritable bowel syndrome (IBS) consists of altered bowel habit, abdominal pain and gaseousness, each of which are present to a variable degree, but is without any recognized organic gastrointestinal pathology. The diagnosis depends upon normal diagnostic tests. Nonetheless, most experienced gastroenterologists can recognize this condition at the first clinical encounter. The basis of this recognition is difficult to quantify. At this colloquium we shall be endeavouring to agree upon what constitutes the IBS, what is the underlying mechanism and how the condition may be most efficiently diagnosed and treated. Before we begin, it is useful to ask ourselves three questions: Is the IBS a disease? Is it organic? And is it a single entity?

I. IS IT A DISEASE?

In apparently healthy British people, we found that 30% had abdominal gastrointestinal syndromes (Thompson and Heaton, 1980). Specifically, 21% had abdominal pain more than 6 times per year; in 14% it was relieved by defecation and in 7% it was unaffected by defecation (Fig. 1). The former were more likely to have all six IBS-related symptoms (Manning *et al.*, 1978) (Table 1), while pain in the latter tended to be in the upper abdomen, related to meals and associated with heartburn. An additional 6% had constipation as defined by straining at stool more than 25% of occasions, and this group had more scybalous stools and less frequent bowel movements. Finally, 4% had diarrhoea as defined by painless, runny stools on more than 25% of occasions. They had more urgency and more frequent bowel movements.

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