IRRITABLE BOWEL SYNDROME

Irritable bowel syndrome

- IBS is not a disease but a common syndrome involving altered intestinal motility, increased sensitivity of the GI tract, and increased awareness and responsiveness of the viscera to enteral and external stimuli
- Irritable bowel syndrome is a common functional disorder that likely involves more than the large intestine but most of the early speculation regarding the pathology of IBS focused on the colon.
- In IBS, no obvious tissue damage, no inflammation, and no immunologic involvement are present.
- In all persons, the enteric nervous system is sensitive to the presence, chemical composition and volume of foods, and the GI tract receives various types of inputs from the brain and the autonomic nervous system.
- Persons with IBS tend to over respond to many of these stimuli. The mediators may be abnormal secretion of peptide hormones or signalling agents (e.g. neurotransmitters secreted in response to the hormones)
- This disease accounts for 50 to 70% of all the gastrointestinal complaints.
- People with IBS appear to react more significantly then normal people to intestinal distention, dietary indiscretions and psychosocial factors.

Aetiopathogenesis

- Many factors contribute to this functional abnormality, among them being:
- Excessive use of laxatives and cathartics and other over the counter medications.
- Excessive amounts of coffee and coarse, fibrous or laxative foods
- Antibiotic therapy
- Enteric evacuation
- Previous GI illness
- Emotional upsets, stress
- A sudden fear produces hyper motility, cramping and diarrhoea in many persons. Nervous and tense individuals are especially sensitive to gastrointestinal neurosis.
- Lack of regularity in sleep, rest and fluid intake
- Faulty eating habits.
- Allergy, hyper sensitivity to certain foods may be the cause of IBS.

Clinical symptoms

- The most common symptoms are altering constipation and diarrhoea, abdominal pain (typically relieved by defecation)
- GI discomfort after meals or with psychosocial distress, bloating, gas heightened gastro colic response, lowered threshold for normal GI discomfort and abnormal bowel movements are common.
- Perception of excessive flatulence, sensation of incomplete evacuation, rectal pain and mucus in the stool may also occur.
- Pain due gaseous distension or vigorous contractions of the colon.
- Pain is described as dull aching, cramping or sharp and intermittent and may be accompanied by anorexia, nausea and vomiting.
- Headache, palpitation and heartburn sometimes occur
- Weight loss is uncommon.
- Symptoms typically first occur between adolescence and the fourth decade of life, but many people do not bring the problem to the attention of a physician.

Medical Management

- Management includes a combination of approaches to deal with the symptoms and factors that may trigger them.
- Education, medications, counselling and diet play a role in the care. Most patients need help in developing good personal and mental hygiene. Through counselling the individual will hopefully gain insight into the relationship between tension and the symptoms.
- Depending upon the predominant pattern and severity of the symptoms, medications may include antispasmoic, anticholinergic, antidiarrheal, prokinetic or anti depressive agents.
- Newer agents are being evaluated to target specific neurotransmitters, peptides or other mechanisms involved in the GI motility and the enteric nervous system.
- Biofeedback, relaxation and stress reduction techniques may also be useful.

Nutrition therapy

- Unlike IBD, IBS is not life threatening and does not result in maldigestion or malabsorption of nutrients.
- The aim of nutritional care is to ensure adequate nutrition intake, to guide the patient towards a diet that is not likely to contribute to symptoms and to explain the role of ordinary dietary practices in producing or avoiding gastrointestinal symptoms.
- A normal diet is recommended, with emphasis on high fibre foods that will add bulk to the stool, thus relieving the constricting pressure and promoting normal bowel motility. Increased amounts of fruits, vegetables and whole grain cereals provide additional bulk.
- A daily fibre intake of 20 – 30 g is recommended. Additional fibre e. g psyllium may also be necessary.
- Consumption of adequate fluid is recommended especially when powdered fibre supplements are used.
- An excess of wheat bran may exacerbate mild cases, commercial fibre supplements are generally beneficial. It is also important that the patient supplements fibre.
- Excesses in dietary fat; caffeine; sugars such a lactose, fructose and sorbitol; large meals; and alcohol are less well tolerated than in normal persons.
- Foods with fibre, resistant starch and oligosaccharides may also serve as prebiotic foods which favour the maintenance of healthy micro flora and resistance to pathogenic infections.

Diagnosis

- The diagnosis is based on international consensus criteria (ROME I or II criteria) and diagnostic algorithms that help to rule out other GI or surgical disorders that may manifest with similar symptoms.
- According to the criteria, symptoms of abdominal discomfort must be present for at least 12 weeks of the past year and include at least two of three features; discomfort relieved by defecation, onset associated with a change in form of stool.
- The diagnosis is usually further refined to categorize the syndrome into subtypes such as predominant patterns of altering constipation and diarrhoea, painless diarrhoea or constipation.
- the common symptoms being constipation, diarrhoea, abdominal pain and bloating.

Preventive aspects

- Making changes n diet and lifestyle such as avoiding foods that trigger your symptoms.
- Regular exercise
- Stress management
- Quit smoking
- Avoiding caffeine
- Avoid consuming refined foods
- Limit fatty food
- If diarrhoea is a symptom avoid dairy products, artificial sweeteners.
- Increase fibre in diet

THANK YOU