

Irritable bowel syndrome, dyspepsia and other chronic disorders of gastrointestinal function

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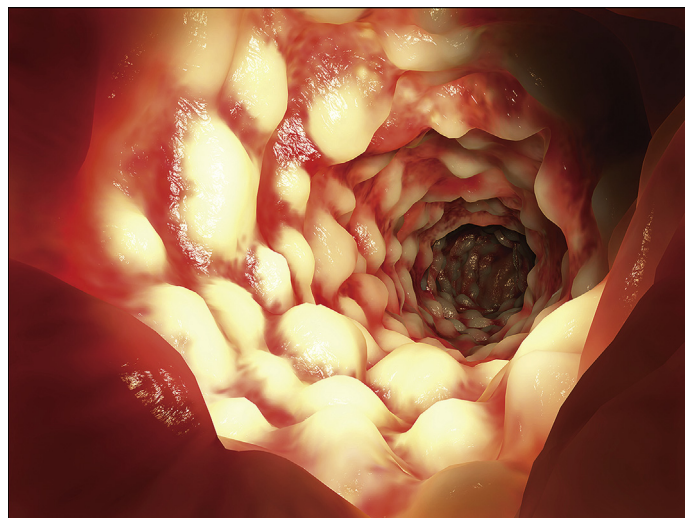
New diagnostic criteria and knowledge are changing how patients are treated

In this issue of the *MJA*, we highlight a number of topics of major interest in gastroenterology, including Barrett's oesophagus,¹ the risks of proton pump inhibitors,² biosimilars for inflammatory bowel disease,³ and gluten intolerance.⁴

Chronic or recurrent gastrointestinal symptoms are frequently encountered in primary care.⁵ Most patients who present with gastrointestinal symptoms do not, however, have inflammatory bowel disease, cancer or another sinister pathology, but rather an unexplained or functional gastrointestinal disorder (FGID).⁶ The best known FGID is the irritable bowel syndrome (IBS), but there are other FGIDs that need to be recognised, as there is effective management that can improve people's lives.⁶⁻⁹ The expert consensus is that clinicians should strive to make a positive clinical diagnosis of an FGID on the basis of the patient's history, and not simply wait for negative test results.⁶ In 2016, new international guidelines on diagnosis were published, the updated Rome (IV) Criteria (www.theromefoundation.org),⁶⁻⁹ and all clinicians who see patients with chronic gastrointestinal symptoms should be familiar with them.

IBS is not a diagnosis of exclusion, but a characteristic symptom complex that can usually be identified by asking a few simple questions. Patients with IBS present with long standing abdominal pain, directly linked to a disturbed bowel habit (diarrhoea, constipation, or both); they often also have bloating (sometimes with visible distention). The pain is often relieved (but is sometimes aggravated) by defaecation, and at the onset of or during pain the stool is often altered in frequency or form (ranging from liquid to separate nut-like lumps).⁶ IBS does not cause vomiting, dysphagia, weight loss, nocturnal diarrhoea, bleeding, or anaemia; if these features are present, another diagnosis should be considered and the patient referred for further investigation. Psychological distress (anxiety or depression) commonly accompanies IBS, and there is increasing evidence that in some cases these symptoms begin after and are secondary to the gut disturbances, including dysbiosis and moderate inflammation, which can induce a circulating low grade cytokine storm.^{5,10}

Unless there are specific red flags or severe symptoms, testing of people with clear-cut IBS should be limited; a full blood count (detecting anaemia, for example) and elevated levels of plasma C-reactive protein (or of stool calprotectin) might suggest inflammatory bowel disease.⁶ If diarrhoea fails to respond to simple interventions, coeliac disease, which can mimic IBS symptoms, should be ruled out by assessing tissue transglutaminase levels; total IgA levels should also be measured, as an IgA deficiency will cause false negative test results.⁶ In older patients (particularly women) with diarrhoea unresponsive to therapy, microscopic colitis, which can be confused with IBS, should be considered; the diagnosis requires colonoscopy and



biopsy (but the yield is low).⁶ New onset IBS symptoms, including constipation, bloating, lower abdominal pain and early satiety, in a post-menopausal woman should raise suspicion of ovarian cancer (although it is rare).

Another cause of constipation that can be confused with IBS is dyssynergic defaecation, which can be a learned behaviour: some patients strain to defaecate, but at the same time involuntarily contract the external anal sphincter, which should be relaxed. A rectal examination can screen for this problem, and biofeedback training can provide long term relief in about 70% of patients.⁸ A further frequently unrecognised possibility in patients taking narcotics (for any reason) is narcotic bowel syndrome. Paradoxically, opiates often aggravate chronic pain, leading the patient to take increasing doses that aggravate rather than relieve abdominal pain, resulting in constipation; opiate withdrawal may be beneficial.⁷

There are further FGIDs that should not be overlooked. A patient who presents with "vomiting" may actually be experiencing effortless regurgitation. The patient's history will be the best guide; the vomiting reflex makes it impossible to keep vomitus in the mouth and to then spit it out. Effortless regurgitation of food after meals is usually related to rumination syndrome, a learned behavioural response now recognised in otherwise healthy adults and children,⁹ diaphragmatic re-breathing training applied during and after meals can reduce and even eliminate the problem.¹¹ Patients presenting with genuine vomiting may report that the attacks occur as clear episodes lasting a few days, and that they are reasonably well between attacks; cyclic vomiting syndrome should be considered in these cases, also recognised as occurring in adults and children.⁹ If the patient indicates that their vomiting is improved by a hot shower or bath (which they will do compulsively), it is highly suggestive of cannabinoid hyperemesis syndrome, and eliminating cannabis use (which many are reluctant to do) usually provides relief.⁹

Dyspepsia is a common presenting complaint. Early satiety (inability to finish a normal meal) and postprandial fullness are more prevalent than epigastric pain, but all can occur together; most of these patients have functional (non-ulcer) dyspepsia (FD).^{9,12} *Helicobacter pylori* is recognised not only as a cause of peptic ulcer, but also of FD, and treatment can provide long term relief, albeit only in a minority of cases.¹³ A newly recognised but common syndrome is duodenal eosinophilia in FD; a duodenal biopsy will indicate low grade inflammation, but the pathologist needs to count eosinophils in five high power magnification fields to avoid overlooking the abnormality.¹⁴ This key finding has opened up new treatment opportunities, and even hopes for a cure.¹²

FGIDs are important and costly conditions.⁶⁻⁹ Diagnosis depends in many cases on taking a good history; pathology tests supplement clinical judgement, but should not dominate deliberation by the clinician. There is no evidence that a negative endoscopy reassures an FGID patient;¹⁵ a positive diagnosis should be based, when possible, on a suggestive history. New insights into the pathogenesis of FGIDs, including the observation of subtle structural changes, suggest that many of these disorders are organic in nature, and cures for some may be available in the near future.¹²

Acknowledgements: Nicholas Talley has received grants from the Rome Foundation.

Competing interests: No relevant disclosures.

Provenance: Commissioned; externally peer reviewed. ■

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