Diagnosis and management of irritable bowel syndrome in primary care

Initial presentation
A person reports having any of the following symptoms for at least 6 months:
• Abdominal pain or discomfort
• Bloating
• Change in bowel habit.

Refer patients with any ‘red flag’ indicators or symptoms (see overleaf) ¹

In people who meet the diagnostic criteria:
• Carry out the following tests to exclude other diagnoses:
  - full blood count (FBC)
  - erythrocyte sedimentation rate (ESR) or plasma viscosity
  - c-reactive protein (CRP)
  - antibody testing for coeliac disease
  - tissue transglutaminase (TTG) or endomysial antibodies (EMA)
• do not do the following tests to confirm diagnosis of IBS:
  - ultrasound
  - rigid/flexible barium enema
  - colonoscopy; barium enema
  - thyroid function test
  - faecal ova and parasite test
  - faecal occult blood
  - hydrogen breath test (for lactose intolerance and bacterial overgrowth)

Positive diagnostic criteria for IBS
• Consider diagnosing IBS only if the person has abdominal pain or discomfort that is:
  - relieved by defaecation OR associated with altered bowel frequency or stool form AND at least two of the following:
  - altered stool passage (straining, urgency, incomplete evacuation)
  - abdominal bloating (more common in women than men), distension, tension or hardness
  - symptoms made worse by eating
  - passage of mucus
• Lethargy, nausea, backache and bladder symptoms may be used to support diagnosis.
A NICE IBS patient information leaflet is available

Treatment options
1. Diet and lifestyle advice
2. First line pharmacological treatment options
3. Second line pharmacological options
See overleaf for more detailed information

Dietician referral
• If diet is considered a major factor in symptoms and dietary/lifestyle advice is being followed, refer to a dietician for single food avoidance and exclusion diets.
• Only a dietician should supervise such treatment.

Referral for psychological interventions
• For people whose symptoms do not respond to pharmacological treatments after 12 months and who develop a continuing symptom profile (refractory IBS), consider referring for:
  - cognitive behavioural therapy (CBT)
  - hypnotherapy
  - psychological therapy

Follow-up
• Agree follow-up with the person based on symptom responses to interventions. This should form part of the annual patient review.
• Investigate or refer to secondary care if ‘red flag’ symptoms appear during management and follow-up

Complementary and alternative medicines
• Do not encourage use of acupuncture or reflexology for the treatment of IBS.

¹See ‘Referral guidelines for suspected cancer’, NICE clinical guidelines 27, for detailed referral criteria where cancer is suspected.
²In certain situations the daily dose of loperamide required may exceed 16mg, an out of licence dose. Informed consent should be obtained and documented.
³TCAs and SSRIs do not have UK marketing authorisation for the indications described. Informed consent should be obtained and documented.

This flowchart is based on NICE clinical guideline 61
Red flag indicators or symptoms - refer to secondary

Refer for further investigation people with possible IBS symptoms presenting with 'red flag' indicators:
- unintentional and unexplained weight loss
- rectal bleeding
- a family history of bowel or ovarian cancer
- in people aged over 60, a change in bowel habit lasting more than 6 weeks with looser and/or more frequent stools

Assess and clinically examine people with possible IBS symptoms. Refer if any 'red flags' are found:
- anaemia
- abdominal masses
- rectal masses
- inflammatory markers for IBD
- Measure serum CA125 in primary care in women with symptoms that suggest ovarian cancer in line with NICE clinical guidelines 122

Lifestyle: diet and physical activity

• Provide information about self-help covering lifestyle, physical activity, diet and symptom-targeted medication.

• Encourage people to identify and make the most of their leisure time and to create relaxation time.
• Assess physical activity levels, ideally using the General Practice Physical Activity Questionnaire (GPPAQ). Give people with low activity levels brief advice and counselling to increase their activity.
• Assess diet and nutrition and give general advice.
• If the person wants to try probiotics, advise them to take the dose recommended by the manufacturer for at least 4 weeks while monitoring the effect. Probiotics are seen as a lifestyle choice and are not recommended for prescribing
• Discourage use of aloe vera for IBS.

General Dietary Advice

• Have regular meals and take time to eat.
• Avoid missing meals or leaving long gaps between eating.
• Drink at least eight cups of fluid per day, especially water or other non-caffeinated drinks such as herbal teas.
Restrict tea and coffee to three cups per day. Reduce intake of alcohol and fizzy drinks.
• Consider limiting intake of high-fibre food (for example, wholemeal or high-fibre flour and breads, cereals high in bran, and whole grains such as brown rice). If more fibre is needed, recommend soluble fibre such as ispaghula powder, or foods high in soluble fibre (for example, oats).
• Reduce intake of 'resistant starch' (starch that resists digestion in the small intestine and reaches the colon intact), often found in processed or re-cooked foods.
• Limit fresh fruit to three portions (of 80g each) per day.
• For diarrhoea, avoid sorbitol, an artificial sweetener found in sugar-free sweets (including chewing gum) and drinks, and in some diabetic and slimming products.
• For wind and bloating consider increasing intake of oats (for example oat-based breakfast cereal or porridge) and linseeds (up to one tablespoon per day).
• NICE & the British Dietetic Association have produced a patient information leaflet on diet in IBS (see CCG website).

First-line pharmacological treatment

• Choose single or combination medication based on the predominant symptom(s).
• Consider antispasmodic agents as required alongside dietary and lifestyle advice.
• Consider laxatives for constipation. Discourage use of lactulose.
• Offer loperamide as the 1st choice antimotility agent for diarrhoea².
• Advise people how to adjust doses of laxative or antimotility agent according to response, shown by stool consistency. Aim for a soft, well-formed stool (Bristol Stool Form Scale type 4).

Second-line pharmacological treatment

• Consider tricyclic antidepressants (TCAs) for their analgesic effect if first-line treatments do not help³. Start at a low dose (5-10mg equivalent of amitriptyline) taken once at night and review regularly. The dose may be increased (but should not usually exceed 30mg)
• Consider selective serotonin reuptake inhibitors (SSRIs) only if TCAs are ineffective³.
• Take into account the possible side effects of TCAs and SSRIs. If prescribing these drugs for the first time, follow up after 4 weeks and then every 6-12 months.