Hull University Teaching Hospitals Trust – Guide to support management of Irritable Bowel Syndrome in Primary Care

Overview

Irritable Bowel Syndrome (IBS) affects up to 5-10% population and is associated with a significant impact on psychological health, reduced work productivity, reduced quality of life and many patients experience significant overlap with other symptoms such as dyspepsia. Most of the patient care occurs in primary care and this document aims to support an evidence-based approach to management, identify first line therapy options, and to support clinicians to access routes of advice or referral. This document accompanies the Hull University Teaching Hospitals Faecal Calprotectin Pathway and draws from the previous NICE guidelines for management of IBS (1) and recent British Society of Gastroenterology IBS guidelines (2).

Diagnosis

- The basic screening blood tests are summarised in the HUTH FC pathway document.
- Patients who do not meet criteria for a 2WW colorectal referral pathway AND with symptoms compatible with IBS should be offered a faecal calprotectin stool test prior to referral via the pathway.
- The current British Society of Gastroenterology IBS guidelines emphasise a need to make a positive diagnosis of IBS wherever possible.
- Consideration should be made to the pattern or commonest stool subtype for each patient i.e. are they typically passing looser motions (IBS-D), passing less frequent stools (IBS-C), or reporting a mixed pattern (IBS-M).
- If the most prominent symptoms include pain and bloating then treatment may focus on managing these symptoms.

Treatment advice:

1. **Dietary strategies**

    - We recommend patients are directed to access first line dietary advice from the British Dietetic Association available online at: Irritable Bowel Syndrome Food Fact Sheet (bda.uk.com).

    - Patients may wish to consider a trial of probiotics and, in some individuals, these have reduced abdominal pain or global IBS symptoms. The BSG guidelines do not give a specific recommendation on specific types or products but advise that patients may consider using probiotics for up to 12 weeks and suggest to stop if there is no improvement in symptoms.

    - For patients who do not find the written advice helpful please consider referral to the community dieticians for review. Further strategies including the low FODMAP diet could be considered but are best supported by a registered dietician.

2. **First line medications**

The BSG guidelines recommend several first line options for IBS state recommendations although these are made based on limited data and low quality evidence:

- The guidelines firstly mention the benefit of encouraging increased physical exercise in all patient with IBS symptoms.
- Soluble fibre supplements such as Isphagula started at a low dose and increased based on symptoms can reduce global IBS symptoms and discomfort.
- Anti-spasmodic medications such as hyoscine (Buscopan), Mebeverine, or other over the counter preparations have been used effectively in some patients with IBS. The data for hyoscine preparations is stronger in previous meta-analyses (1). Patients should be counselled on the potential side effects including dry mouth, visuals disturbance, and dizziness.
- Peppermint oil preparations can also reduce overall symptoms and abdominal pain but may lead to gastro-oesophageal reflux.
- For patients with diarrhoea, loperamide can be effective but can lead to abdominal pain, constipation and bloating. It may be preferential to initiate a low dose before titrating based on symptoms.
- For patients with constipation, some may derive benefit from regular laxatives. The evidence for a specific type of laxative is limited but some patients may benefit from polyethylene glycol.

3. Psychological health

The BSG guidelines discuss the role of various psychological interventions for patients with ongoing IBS symptoms. These are supported by the NICE IBS guideline where patients with symptoms for >12 months despite basic dietary advice and first line drug therapy could be considered for referral for certain interventions.

The two recommended interventions were:

- Cognitive Behavioural Therapy
- Gut directed hypnotherapy

We recognise that some patients may have more obvious and significant psychological comorbidity and that the availability of these type of therapies is limited. Therefore, if individuals do have significant features including, but not limited to, anxiety, low mood, and depression then consideration of input from the mental health team could be considered.

Referral to secondary care

Specific details of how to access both the Gastroenterology Advice and Guidance or to make a referral are included in the HUTH Faecal Calprotectin Pathway. We are more than happy to be involved if there is diagnostic uncertainty, in those with severe symptoms, and in those who do not respond well to first line treatment. In addition, patients with persistent watery diarrhoea, nocturnal symptoms, and marked incontinence are likely to benefit from referral to rule out microscopic colitis or even bile salt malabsorption.

Useful references:

1. National Institute of Health and Clinical Excellence. Clinical Guideline (CG61). 2008. Available at: Overview | Irritable bowel syndrome in adults: diagnosis and management | Guidance | NICE
2. Vasant DH, Paine PA, Black CJ, Houghton LA, Everitt HA, Corsetti M, Agrawal A, Aziz I, Farmer AD, Eugenicos MP, Moss-Morris R, Yiannakou Y, Ford AC. British Society of Gastroenterology guidelines on the management of irritable bowel syndrome. Gut. 2021 Jul; 70(7):1214-1240. doi: 10.1136/gutjnl-2021-324598. Epub 2021 Apr 26. PMID: 33903147.
3. McKenzie YA, Bowyer RK, Leach H, Gulia P, Horobin J, O'Sullivan NA, Pettitt C, Reeves LB, Seamark L, Williams M, Thompson J, Lomer MC; (IBS Dietetic Guideline Review Group on behalf of Gastroenterology Specialist Group of the British Dietetic Association). British Dietetic Association systematic review and evidence-based practice guidelines for the dietary management of irritable bowel syndrome in adults (2016 update). J Hum Nutr Diet. 2016 Oct; 29(5):549-75. doi: 10.1111/jhn.12385. Epub 2016 Jun 8. PMID: 27272325.
4. Ford AC, Sperber AD, Corsetti M, Camilleri M. Irritable bowel syndrome. Lancet. 2020 Nov 21; 396(10263):1675-1688. doi: 10.1016/S0140-6736(20)31548-8. Epub 2020 Oct 10. PMID: 33049223.