Irritable Bowel Syndrome (IBS) – Updated management

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Rome IV defines:

- **Rome IV defined** irritable bowel syndrome (IBS) as a functional bowel disorder in which recurrent abdominal pain is associated with defecation or a change in bowel habits due to gut-brain interaction.

Epidemiology

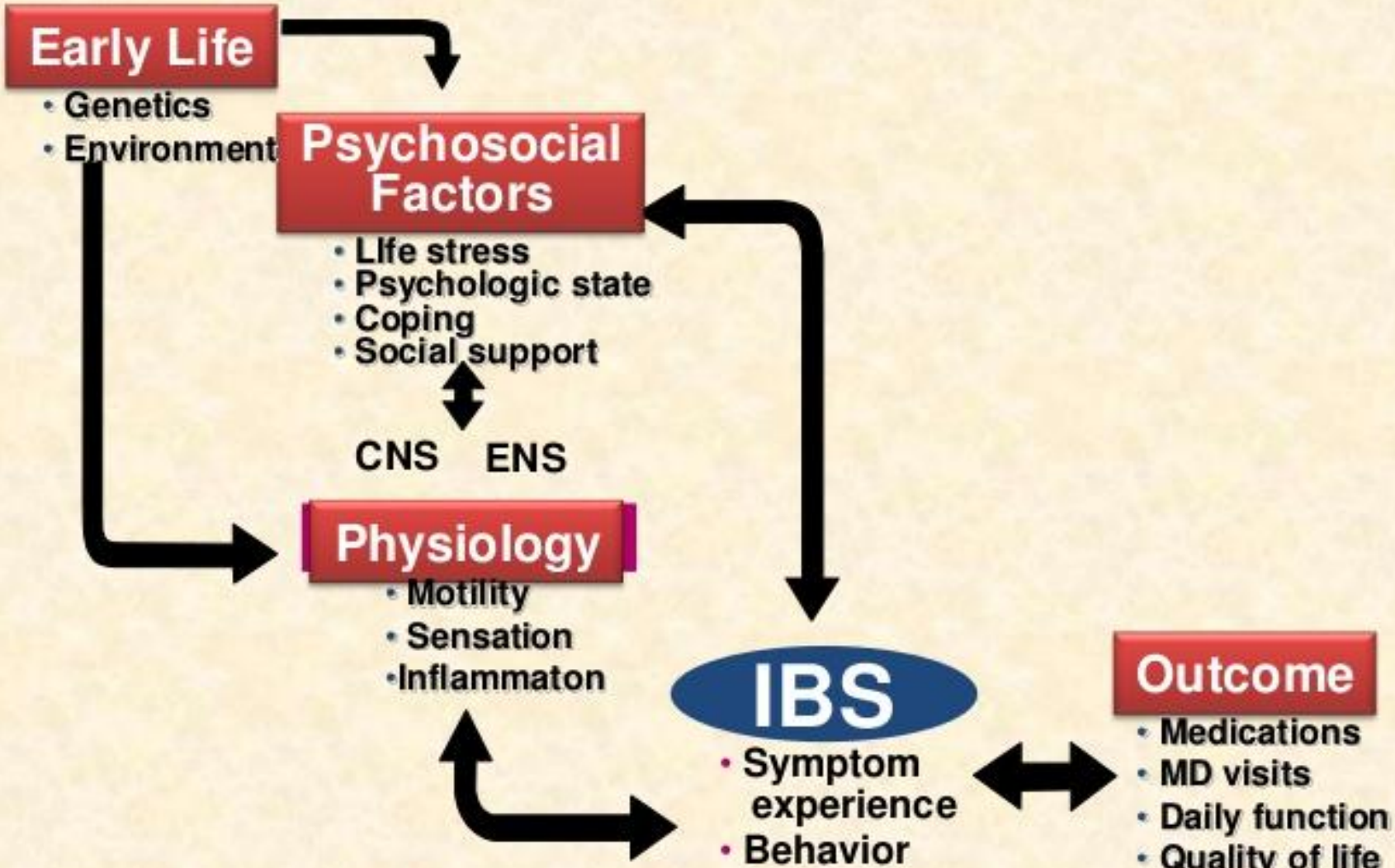
- Probably the most challenging of all functional GI disorders
- 7-32% people worldwide have IBS
- Peaks in the 3rd and 4th decades of life and declines in 6th and 7th decades
- 70% are women
- 50% develops before 35yr and 20% between 35-50yr
- Frequently associated with Psychiatric illness

- 1 Brandt et al., Am. J.Gastro, 2009;104:SI-S-35

Pathophysiology

- Motility disturbance
- Visceral hypersensitivity
- Altered mucosal and immune function
- Altered gut microbiota
- Altered central nervous system processing

IBS - Conceptual Model



Subtypes

- IBS with constipation (IBS-C): Patient reports that abnormal bowel movements are usually constipation.

- IBS with diarrhea (IBS-D): Patient reports that abnormal bowel movements are usually diarrhea.

- Mixed IBS (IBS-M): Patient reports that abnormal bowel movements are usually both constipation and diarrhea.

- Unclassified IBS: Patients who meet diagnostic criteria for IBS but cannot be accurately categorized into one of the other three subtypes.

Subtype depends on Bowel movement

SUBTYPE	STOOL TYPE 1 & 2	STOOL TYPE 6 & 7
IBS with predominant constipation	More than 25%	Less than 25%
IBS with predominant diarrhea	Less than 25%	More than 25%
IBS with mixed bowel habits	More than 25%	More than 25%

IBS Unclassified: Patient who meets diagnostic criteria for IBS but whose bowel habits cannot be accurately categorized into one of the three subtypes above.

Source: Lacy BE, et al. Bowel Disorders. Gastroenterology. 2016;150:1393-1407.

Previous Rome III criteria

- Recurrent abdominal pain or discomfort (defined as an uncomfortable sensation not described as pain) for at least 3 days/month in the last 3 months, associated with two or more of the following:
  1. Improvement with defecation
  2. Onset associated with a change in the frequency of stool
  3. Onset associated with a change in the form (appearance) of stool

These criteria should be fulfilled for the last 3 months with symptom onset at least 6 months prior to diagnosis.

Rome IV Criteria for Diagnosing IBS

Recurrent abdominal pain, on average, at least 1 day/week in the last 3 months, associated with two or more of the following criteria:

- Related to defecation
- Associated with a change in frequency of stool
- Associated with a change in form (appearance) of stool.

- Criteria fulfilled for the last 3 months with symptom onset at least 6 months before diagnosis.

- Source: Lacy BE, et al. Bowel Disorders. Gastroenterology. 2016;150:1393-1407; Rome III Diagnostic Criteria for Functional Gastrointestinal Disorders.

Differential Diagnoses

- Dietary – e.g. lactose intolerance, ↑ caffeine etc.
- Infections – Giardia, Bacterial Overgrowth Syndrome
- Inflammatory Bowel Disease – UC, CD,
- Microscopic Colitis
- Malabsorption syndrome – Celiac Disease
- Pancreatic Insufficiency
- Psychological – Depression Anxiety, Somatization
- Other - Neuroses

Investigation

- The American College of Gastroenterologists recommendation:

  - No laboratory testing or diagnostic imaging in patients younger than 50 years with typical IBS symptoms and without “alarm features.

“Red Flags’” - Alarm Symptoms/Signs

- Onset after 55 years
- Persistent anorexia & weight loss > 10 lbs
- Persistent “fever” in the evening
- Pain – changing pattern or increasing after food and persisting for a few hours
- Awakened by pain &/or diarrhea at night
- Rectal bleeding, not just on wiping
- Stools “like malabsorption syndrome”
- Palpable mass in the abdomen

Management of IBS

- The majority of IBS patients are successfully managed in the primary care setting.
- In mild symptoms- respond well to dietary and lifestyle modifications, education, and reassurance about their disease.
- In moderate to severe symptoms- Gut-directed medical therapy (anticholinergics, antispasmodics and newer IBS-specific agents) is used more frequently.

Management of IBS

- Diet –
  - Low FODMAP diets
  - Exclusion of gas-producing foods
  - Lactose avoidance
  - Gluten avoidance
  - Fiber
  - Food allergy testing

ADJUNCTIVE PHARMACOLOGIC THERAPY for moderate to severe IBS

- IBS-Constipation
  - Osmotic laxatives- polyethylene glycol is best
  - Chloride channel activator (Lubiprostone) - is benefecial
  - Guanylate cyclase agonists-
    Linaclotide and plecanatide
  - 5-hydroxytryptamine (serotonin) 4 receptor agonists – tegaserod (withdrawn from market), Prucalapride

ADJUNCTIVE PHARMACOLOGIC THERAPY

- IBS-Diarrhea
  - Antidiarrheal agents- Loperamide
  - Mu-opioid receptor agonist and a delta-opioid receptor antagonis – Eluxadoline-
  - Hydroxytryptamine (serotonin) 3 receptor antagonists - Alosetron, Cilansetron, Ramosetron
  - Bile acid sequestrants-

    cholestyramine, colestipol, colesevelam

ADJUNCTIVE PHARMACOLOGIC THERAPY
for moderate to severe IBS

- IBS with abdominal pain and bloating

  -Antispasmodic agents- dicyclomine , Mebeverine, hyoscyamine, trimebutine, peppermint oil

  -Antidepressants- Amitriptyline, nortriptyline, and imipramine, SSRI,

  -Antibiotics- Rifaxamin

  -Probiotics- Probiotics are not routinely recommended

Future agents

- Mixed 5-HT_4 agonist/5-HT_3 antagonist - Renzapride
- ATI-7505-cisapride
- Adrenergic modulators- Clonidine
- Somatostatin
- Opioid agents-κ-opioid agonist
- CRH receptor antagonists
- CCK antagonists
- Neurokinin antagonists

- REFRACTORY SYMPTOMS

  -Behavior modification

  -Anxiolytics

  -Other therapies- Ketotifen

Thank You
for patience hearing