

# IBS: Irritable Bowel Syndrome

## Information and Practical Approaches for Management

### Irritable bowel syndrome

In Canada, approximately 12% of all adults have symptoms of IBS. It is one of the most common reasons for visits to a family doctor. Women are more likely to be afflicted than men. The average age for the onset of IBS is around 35.

Characteristic symptoms of IBS include abdominal cramping and bloating as well as changes in stool consistency: either alternating between diarrhea and constipation, or predominately at one extreme (diarrhea) or the other (constipation). Approximately 15% of the cases of IBS occur as a consequence of bowel infection (food poisoning, parasitic or viral infections). Many foods, such as coffee, are found to trigger the symptoms.

The diagnosis of IBS is one of exclusion, that is, it is based upon finding nothing amiss with standard medical tests. Tests commonly done (or that should be requested) are

- Blood work
- Barium swallow with follow-through
- Colonoscopy
- Abdominal ultrasound
- Stool samples
- Breath tests (to look for small bowel bacterial overgrowth, and sugar malabsorption)

Many people with IBS are able to control their symptoms with diet, stress management and medications.

For others, though, IBS can be disabling and increase in severity over time.

Shortcomings of the IBS diagnosis:

For some patients, IBS can be disabling and increase in severity over time. Others find that the intensity of their symptoms waxes and wanes unpredictably, frequently disrupting work and social functions.

The label or diagnosis of IBS is frustrating for everyone. Since the diagnosis is based upon subjective diagnostic criteria as well as on the absence of evidence of an underlying, organic cause such as blood, pus, scars or ulcers, it tells us very little. Therefore, IBS, in one way or another, is diagnosed based upon symptoms.

People who suffer from IBS also frequently suffer from upper digestive symptoms of: nausea, a feeling of fullness after a few bites of food, occasional vomiting, acid reflux/heartburn, bloating, belching and upper abdominal discomfort—especially soon after eating. These upper digestive symptoms are often referred to as functional dyspepsia, and the patient may be given two labels: IBS plus functional dyspepsia. Or, all of the GI symptoms may be lumped into the category of IBS. Regardless, there is more than likely one disorder (that affects the gut nerves) underlying the whole spectrum of these digestive symptoms; hence, the shortcomings of using a subjective symptom nosology for the current classification of functional gastrointestinal disorders.

The treatment for IBS has tended to emphasize a psychological approach, and, in fact, a considerable amount of research money has been spent looking for a correlation between psychological problems and digestive symptoms. Psychological approaches can help as an adjunctive treatment—but should not be considered as the only treatment option.

Problems arise when some medical professionals, to explain the cause of IBS symptoms, lay the blame on the individual's emotional dynamics. Patients—both adults and children—are often labelled with psychological, maladaptive behaviors, or their families are labelled as dysfunctional.

Some research has shown that patients presenting to a GI specialist's office with IBS symptoms have a higher rate of psychological problems than the general population. However, these findings could indicate nothing more than an under-appreciation, on the part of researchers, of the impact of constant GI symptoms on psychological well-being.

Doctors often report that IBS patients are overly anxious—not surprising since these are very frustrated people who feel that no one in the medical profession is listening to them or taking their digestive complaints seriously. Their digestive symptoms have turned their lives upside down. More than anything these people seek relief, only to be shown the door by the physician. In an endless search for help, some patients expend copious time and finances to locate a specialist who believes them.

There is no question that what underlies IBS symptoms is a faulty gut nervous system that is yet to be adequately studied and articulated by the scientific community. We do not currently have diagnostic tools to define the problem and medications for treatment are very limited. Money to tackle this research has been scant.

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When abdominal pain is a predominating feature needing prescription pain killers—then the disorder may not be IBS, but instead a more pronounced motility (neuro-muscular) disturbance in the mid-bowel. A referral to a gastroenterologist with training in the recognition and diagnosis of GI motility disorders is warranted.

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IBS Latest research notes:

Several research centres in the US have published some very interesting findings in regards to both IBS-D (irritable bowel syndrome, diarrhea predominate) and IBS-C (constipation predominate). Their findings? IBS was found to be related to an overgrowth of bacteria in the small intestine. A very simple treatment using a poorly absorbed antibiotic (one that stays in the gut and has very few side effects) cleared up the IBS symptoms. For more information about IBS, please [see our GPDA publication on “Small Bowel Bacterial Overgrowth”](#).

Role of inflammation in IBS

Post-infectious IBS is now a commonly recognized problem. Up to one third of individuals recovering from infectious gastroenteritis (inflamed stomach and intestines) remain with persistent GI symptoms such as IBS. Many of these individuals may slowly—over the course of a year or two—recover normal bowel function; but for others, chronic IBS symptoms persist. Researchers have conjectured that the initial insult caused by the infection has left the body with a lingering, low-grade inflammation within the layers of nerve and muscle of the digestive tract; the result is a hypersensitivity of the nerves to the normal stretching involved in digestion. As well, researchers have speculated that neuro-modulating

chemicals (serotonin, for example) released by disordered gut nerves lead to conditions of either overly rapid motility (diarrhea) or sluggish motility (constipation).

### Mast cells and IBS

A few small research studies examining bowel tissue samples from patients suffering with IBS found that these samples contained a greater number of mast cells than would be found in healthy people. Mast cells are specialized immune cells widely distributed throughout the gastrointestinal tract (as well as other organs such as the lungs). Stress, allergies, and small chemical proteins discharged from nerve cells can trigger mast cells to release their defensive chemicals. We all know what mast cells do to people with allergies—they cause asthma, anaphylactic allergic reactions, and seasonal hay fever.

One researcher found that the number of mast cells lying in close proximity to the nerve endings within the bowel correlated to the degree of pain expressed by patients. Novel approaches to treatment using mast cell-stabilizing drugs (the medications also used to treat asthma) may help IBS sufferers.

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Some old and some new treatments to try beyond the usual approach:

- A new, natural product called Florastor by Medical Futures is available over the counter and has been found in clinical trials to be a safe and very effective treatment for chronic diarrhea from a variety of causes. It is a natural yeast (not all types of yeast are bad) that acts as a probiotic and helps to stabilize the lining of the digestive tract. Ask your pharmacist for Florastor or request that it be ordered for you.
- Medications commonly used for treating pain and discomfort from irritable bowel syndrome may also be of help in treating diarrhea. This class of medications—called antispasmodics/anticholinergics—help to relax smooth muscle and have been used for decades in the treatment of spastic bladder and bowel conditions. The anticholinergic effects help to slow transit along the entire length of the digestive tract and alleviate diarrhea. This class of drugs, however, may not provide much relief for the symptom of bloating. You may ask your physician for a short-term prescription to see if one of these medications helps relieve your symptom of diarrhea:
  - Bentyl® (dicyclomine)
  - Levbid®, Levsin® (hyoscyamine)
  - Buscopan® (butylscopolmine)
  - Donnatal®
- For those suffering from abdominal pain along with diarrhea—or constipation—relief may be found through the addition of another drug called:
  - Modulon® (trimebutine maleate). Licensed by Axcan Pharma (a Canadian pharmaceutical company), the drug has been available since the late 1960s. Classified as an antispasmodic, it also helps to regulate lower bowel motility.
- Another drug, which had been formerly used for the treatment of diarrhea-predominating IBS, is Lotronex®, (alosatron). Lotronex proved to be a very potent 5-HT<sub>3</sub> antagonist, which resulted in deleterious side effects of ischemic colitis. This rare, but very serious side effect was found to be associated with a number of deaths. Lotronex has since been placed under a special-access program by the US Food and Drug Administration. However, there is another option from this same pharmacological class of drugs: Zofran®. Zofran (ondansetron), too, is a 5-HT<sub>3</sub> antagonist, but it does not nearly as potently bind to the 5-HT<sub>3</sub> receptors. Zofran is a very expensive drug—but if you are housebound and disabled due to diarrhea, then the cost of the medication (if it

helps) is justifiable. It comes in a liquid or pill formulation. The liquid allows you to fine-tune dosages.

As well, this category of drugs possesses anti-nauseant effects. Many people suffering from lower bowel IBS-D (diarrhea-predominate IBS) symptoms also have trouble with upper digestive symptoms such as nausea. Therefore, relief for diarrhea and nausea can be effectively achieved with Zofran.

- Dietary manipulation can also prove to be highly effective in controlling problems of rapid transit diarrhea. By manipulating the body's normal physiological response to fats when present in the small intestine, it is possible to trigger the ileal break and slow down small bowel transit, thus halting diarrhea. To use this dietary technique requires pure oleic acid (olive oil is primarily oleic acid, but since it contains other acids as well, it won't work) from a food chemical supply house. For more details on how to use this dietary method, please see our patient educational booklet titled: "[Gas, Bloating and Belching](#)".
- Intolerance to dietary sugars can also be another cause of IBS symptoms.. Having chronic upper digestive problems makes it very difficult to sort out contributing factors to digestive distress and problems like diarrhea/bloating. Other sugars, too, like fructose, sucrose and especially sorbitol (found in numerous foods marketed to the diabetic population) can cause persistent diarrhea/bloating. Limit your consumption of simple sugars. Also, using a dietary approach to help reduce a suspected low-grade inflammation (as perhaps is found in post-infectious IBS) may be of help. A suggested book: *Breaking the Vicious Cycle—Intestinal Health through Diet*, by Elaine Gottschall.
- Finally, coconut meat (fresh or dried), or coconut oil, has been found to alleviate IBS-D. The fat found in coconuts is primarily made up of medium-chain triglycerides (MCT). Interestingly, there have been a few studies looking at the impact of MCT on gut motility. Interdigestive motility patterns (the motility activity that takes place between meals) were shortened in length, therefore dampening gut motor activity.
- What about anti-depressants to help curb symptoms of IBS? Some have found this approach helpful, and others did not gain any benefit. Just be aware that most antidepressants have what are called anti-cholinergic side effects, which slow down the motility of the digestive tract.
- Probiotics, available from natural health food stores and some pharmacies, can be very helpful in alleviating constipation, bloating and pain but can aggravate diarrhea. Few antibiotics have undergone clinical studies to help determine their effectiveness; however, one antibiotic (TuZen by Ferring Pharmaceuticals) that has undergone clinical testing was demonstrated to be very effective in the treatment of IBS.
- Sacral nerve stimulation is showing promise for the treatment of fecal incontinence and/or constipation. However, you may have some time to wait before you can access this treatment in Canada. A non-surgical way to achieve the same results as sacral nerve stimulation and recently approved for sale in Canada is Urgent® PC Neuromodulation System.

Offered here are suggestions and tips—but it must be remembered that you should not try anything without the guidance of your physician.