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IRRITABLE BOWEL SYNDROME: NEW PERSPECTIVES ON MANAGEMENT

Irritable bowel syndrome is the most common disorder of the gastrointestinal tract, yet it is rarely discussed at professional conferences. Until about 10 years ago, it was generally thought of as a classic psychosomatic disorder. However, research during the past decade has shown it to be a motor disorder in which a number of factors may play a role. Meals, intraluminal distention, gastrointestinal and other hormones, and pharmacologic agents all can have a measurable, recordable effect on bowel motility. Stress and psychosocial factors are but two of the many stimulae affecting irritable bowel syndrome.

Patients with irritable bowel syndrome are often relieved to hear that they have a "real" illness—that the problem is not in their heads. This makes them more willing to accept the fact that their symptoms are susceptible to stress, and thus, they are more willing to try stress management techniques.

The physician should use the term *irritable bowel syndrome* to describe the syndrome to the patient and should avoid terms such as nervous colitis, mucus colitis, and unstable colitis. These other terms may frighten patients by mistakenly implying that inflammation exists or that they have ulcerative colitis, which carries with it the possible complication of cancer or the possible need for colectomy.

DIAGNOSIS

Irritable bowel syndrome is twice as likely to affect women as men, and the incidence is higher in whites than nonwhites, and in Jews than non-Jews. The disease usually first presents late in adolescence or early in adulthood, and the onset is gradual. Patients who report initial symptoms later in life or who remember a specific time when the illness first occurred probably do not have the syndrome.

The characteristic features of the disease are altered bowel patterns consisting of small-volume stools (less than 200 mL) with either diarrhea or constipation. The symptoms may vary considerably among patients, but a pattern will be constant for an individual. It is important to recognize changes in a particular patient's pattern of symptoms because this may indicate the presence of a concomitant disease.

Sleep is rarely disturbed by the symptoms. Patients typically complain of lower abdominal pain, abdominal distention, and increased belching and flatulence. The symptoms are aggravated during prolonged periods of stress. A tender, palpable sigmoid cord is indicative of irritable bowel syndrome; weight loss, fever, and a progressive course argue against the diagnosis.

Laboratory findings are generally normal. An elevated sedimentation rate, leukocytosis, or blood and fat in the stool suggest another underlying disorder. Parasites, anemia, and inflammation should be ruled out. Approximately 40% of patients with irritable bowel syndrome also have lactose intolerance. To determine if patients have both conditions, they should be put on a lactose-free diet for 2 weeks. Symptoms will improve but will not be entirely relieved. The diet should then be liberalized until a threshold is found.

KEYS TO TREATMENT

Successful treatment depends on an interested and involved physician who earns the confidence of the patient and deals with any of the patient's concerns or misconceptions. The physician should educate the patient on the symptoms and prognosis of irritable bowel syndrome, emphasizing that while the disease is chronic, it is not serious.

Dietary management and behavioral therapy are the first-line treatment. A high-fiber diet should be prescribed. Fifteen percent of patients will be unable to tolerate the fiber, but the rest will benefit, although approximately half of these will experience bloating and discomfort for the first few weeks on the diet. Hydrophilic colloids may also be useful and should be prescribed in conjunction with meals. Psychological management should consist of identifying anxiety, depression, or other factors that precipitate symptoms and then helping the patient develop coping techniques. Since social reinforcement may perpetuate illness, the patient's family should be encouraged to ignore illness-oriented be-

havior (such as complaining about symptoms) and to reward healthy behavior.

Medications that may be beneficial include antispasmodics and mild analgesics. Tricyclic antidepressants may be helpful, since they have been shown to affect motility and to have an anticholinergic effect. They should be administered in low doses at bedtime. Opiates should be avoided, not only because they are addictive, but because they may aggravate the gastrointestinal spasms responsible for the disease.

It may be necessary to recommend a second opinion to some patients who are discouraged by the lack of a complete cure. They should be reminded that like high blood pressure, arthritis, and diabetes, irritable bowel syndrome can only be managed, not cured.

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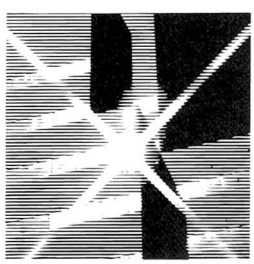

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