

Irritable bowel syndrome

Are complementary and alternative medicine treatments useful?

Richard V. Birtwhistle MD MSc CCFP FCFP

Irritable bowel syndrome (IBS) is a complex multifactorial disorder resulting from brain-gut dysregulation.¹ It has elements of motor and sensory gut abnormalities that might be related to postinflammatory, genetic, and psychological causes. Irritable bowel syndrome results in various functional gastrointestinal symptoms such as recurrent abdominal pain, changes in bowel habits, diarrhea or constipation, bloating, and bowel urgency. It is a clinical syndrome without evidence of structural abnormalities. The diagnosis can be made using the Rome III criteria in the absence of “red flag” symptoms.²

Irritable bowel syndrome is classified by constipation-predominant symptoms, diarrhea-predominant symptoms, or alternating symptoms of diarrhea and constipation. The hallmark symptom is recurrent abdominal pain that improves with defecation.²

With a prevalence of 10% to 15% in the general population, IBS is one of the most common functional gastrointestinal disorders worldwide. Most people with IBS do not seek medical care; however, those who do have reduced quality of life, have increased absenteeism from work, and utilize health services at higher rates,³ which has substantial direct and indirect costs for the health system. In the United States, IBS resulted in more than 3.6 million physician office visits in 1998 and cost about \$1.7 billion (US) in 2000.⁴

Personal effect

A qualitative study done by Bertram et al highlights the profound effect that IBS can have on patients' lives and well-being.⁵ The study brought together 51 patients with physician-diagnosed IBS and asked them how their symptoms affected their lives. The results showed that this “benign” condition did not have a benign effect. The diarrhea and abdominal cramping brought most people to their physicians. The themes that emerged from the focus groups were frustration, social isolation, and mismatch between how they perceived their illness and how they thought others around them perceived their illness. The frustration was with the lack of understanding of family and co-workers about the disease, the unpredictability of symptoms, the social isolation, and physicians' failure to view the problem as serious.⁵

Cet article se trouve aussi en français à la **page 128**.

We must keep an open mind

Most people with IBS receive their care from family physicians, but many also consult with specialists. One study suggests that IBS accounts for about 20% of referrals to gastroenterologists.⁶

Although understanding of the complexity of the neuroendocrine function of the gut has been increasing, managing IBS is difficult because it is a heterogeneous condition that lacks effective treatment. Serotonin inhibitors (eg, tegaserod) showed some promise, but this hope was dashed by the association of these drugs with cardiovascular morbidity and ischemic colitis; they have since been taken off the market for general use.^{1,7} A recent systematic review of antispasmodics, however, does show some benefit. The review found a number needed to treat of 5 for the class to prevent symptoms in 1 patient. Unfortunately the authors found some evidence of publication bias in the studies they reviewed. They also found that 14% of patients suffered adverse reactions (usually anticholinergic side effects such as dry mouth, dizziness, and blurred vision). The number needed to harm was 17.5.⁸

Alternatives

As a result of the general failure of medicine to find effective therapies and owing to how IBS sufferers feel about their treatment by the medical system, it is not surprising that patients look to other approaches to manage this difficult condition. The use of complementary and alternative medicine (CAM) in IBS has been increasing. Complementary and alternative medicine use is common in general (12.8% of the general population),⁹ and it is estimated that 50% of patients with IBS use some form of CAM.¹⁰

The 2008 National Physician Survey showed that younger physicians were more likely to consider incorporating CAM into their management armamentarium.⁹ Unfortunately, many CAM treatments have not been studied adequately to provide the evidence of treatment effectiveness that we have come to demand. For IBS specifically, however, a number of CAM treatments have been studied.


In this issue of *Canadian Family Physician*, Shen and Nahas have provided a very thorough review of CAM treatments for IBS (**page 143**).¹¹ One of the important messages is that a general recommendation to people with IBS to increase “fibre” is not helpful and can actually make symptoms worse. Insoluble fibre, such as wheat

bran, does not work and should not be used. Soluble fibre (psyllium or ispaghula) can be effective in constipation-predominant IBS but does not do much for abdominal pain. The evidence for peppermint oil shows promise for that treatment (number needed to treat=3), with only minor adverse effects, and is worth a trial of therapy.⁸

Because of the psychiatric morbidity associated with IBS, a number of psychological approaches have been used in its treatment. Results have been mixed, but these are also worth a trial in selected patients. As with any disorder for which the cause is not well explained and the treatments not effective, family doctors must focus on the patients and their illness experiences and provide support and guidance despite feeling helpless. We must keep an open mind about potential new treatments, regardless of whether they are CAM approaches or not. That does not mean, however, that we should not look for evidence of effectiveness of these new treatments.

Another cause of abdominal pain and diarrhea

Another paper in this issue, by Rashid and colleagues (page 151), relates to gastrointestinal disorders and reports on a home test for celiac disease.¹² This paper reminds us that celiac disease is more common than we previously thought (1% of the population) and that it should be included in the differential diagnosis of IBS. Patients with celiac disease can present with diarrhea and recurrent abdominal discomfort only and might not have some of the other signs and symptoms, such as nutritional deficiencies, weight loss, and anemia, found in more severe cases. This self-test allows patients who are concerned about celiac disease to use a highly sensitive test in the comfort of their own homes. Positive test results will bring these patients to their family physicians or result in self-treatment with a gluten-free diet. The authors' conclusion is an important one for all physicians to heed—this home test is only for screening, and, before recommending a lifelong restrictive diet, patients should have a confirmatory small bowel biopsy.

Both of these papers describe bowel disorders that will present challenges to family physicians and provide useful information on the diagnosis or management of these conditions. Do CAM provide useful ways of treating IBS? A definite Yes. 

Dr Birtwhistle is a family physician and a Professor in the Department of Family Medicine and Community Health and Epidemiology at Queen's University in Kingston, Ont. He is also Director of the Centre for Studies in Primary Care at Queen's University.

Competing interests

None declared

Correspondence

Dr Richard V. Birtwhistle, Queen's University, Family Medicine, 220 Bagot St, Kingston, ON K7L 5E9; telephone 613 533-9300, extension 73934; fax 613 533-9302; e-mail birtwhis@queensu.ca

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