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Editorial

The Many Faces of Irritable Bowel Syndrome

K A Gwee

INTRODUCTION

The irritable bowel syndrome (IBS) is a benign chronic functional disorder typically presenting with abdominal pain, which is relieved on defecation, and associated with diarrhoea, constipation or an alternating bowel habit[1]. Despite the existence of clear guidelines[1], the diagnosis is often missed and attributed to unrelated pathology; one-third of patients are discharged from surgical wards with a diagnosis of non-specific abdominal pain[2], and nearly half of all women referred to a gynaecology clinic for chronic pelvic pain[3], had IBS.

The diagnosis of IBS may be missed because physicians are unaware that IBS can be associated with extraintestinal symptoms. Significantly more IBS patients complained of headache, breathlessness, chest pain, back pain, thigh pain, urinary frequency and urgency, and dyspareunia, than age- and sex-matched controls[4]. Although in some patients this multiplicity of symptoms may be part of a somatisation disorder, there is also objective evidence of a physiological basis. Disorders of oesophageal motility and acid reflux form a major cause of non-cardiac chest pain and these have been demonstrated in as many as 80% of IBS patients[5], and bladder dysfunction such as detrusor instability, has been demonstrated in about 50% of IBS patients[6].

Doctors may fail to recognise IBS because they are unfamiliar with the distribution pattern of pain arising from the bowel. The pain in IBS is produced by distension of the colon for which IBS patients have a lower threshold[7]. Distension of the bowel can also produce pain referred to areas outside the abdomen. When the colon is distended at various sites this produces not only the typical abdominal pain in many IBS patients, but also reproduces pain arising from the back and thigh regions[7]. In addition, colonic pain referred to the right hypochondrium, right iliac fossa, left iliac fossa and suprapubic regions, may be mistaken for biliary colic, appendicitis and chronic pelvic pain.

IBS pain may be confused with pain of gynaecological origin because IBS symptoms are often exacerbated during menstruation[8], and because many women with IBS experience dyspareunia (pain during sexual intercourse)[4]. When 71 consecutive patients referred to a gynaecology clinic for abdominal pain were independently assessed by a bowel symptom questionnaire, IBS was identified in 37 (52%)[3]. Investigations revealed gynaecological pathology in only 3 of these women with IBS. The gynaecologist enquired about bowel habits in only 13 of the 71 patients, and not surprisingly, identified IBS in only 6 women.

Recognition of the multifacetted nature of IBS is important for at least two reasons: reducing health care costs and reducing unnecessary surgery for what is after all a benign condition. A survey has shown that IBS patients have four times as many physician visits for nongastrointestinal as gastrointestinal symptoms[9]. The cost of caring for an IBS patient was found to be 73% more than for a patient without gastrointestinal symptoms and in the US the annual cost of treating IBS is about $8 billion, excluding the costs of prescription drugs and work absenteeism[9]. Failure to

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recognise IBS may have contributed to the excess surgery reported. In one study, IBS patients were 4 times more likely to have appendicectomy, and 3 times more likely to have hysterectomy, than their counterparts with organic diseases[10].

What should the conscientious physician do? On the one hand he is justifiably concerned about the loss of patient confidence arising from missing an important organic disease. On the other hand, failure to recognise IBS could trigger off a "cascade effect" whereby tests done without clear indications prove to be counterproductive by detecting minor abnormalities that pose therapeutic dilemmas. For instance, when an abdominal ultrasound examination was done routinely in 100 women with a diagnosis of IBS, intraabdominal pathology was detected in 20%[11]; consisting of uncomplicated gallstones, fibroids and benign cysts, none were considered to be related to the presenting symptoms. Both the doctor and patient confronted with a gallstone, may feel compelled to submit for cholecystectomy. In one study close to half of the patients who had undergone cholecystectomy were dissatisfied because symptoms such as flatulence, dull abdominal pain and diarrhoea, which had been attributed to gallstones, persisted after surgery[12].

A careful history is the most important tool against unnecessary investigations and surgery. Although there is no structural or physiological diagnostic marker, a positive diagnosis can be made by identifying bowel symptoms, checking for symptoms and signs suggestive of organic disease, and ordering a limited set of investigations consisting of blood tests, stool examinations and imaging of the colon[1]. The clinician would be reassured to know that this approach is safe[1].

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Cover picture:
A typical hot early afternoon image of the Indian Quarter in Serangoon Road. The brightly coloured, flowing saris catch the eye, adding to the pastel hues of the traditional shophouses. There is much movement on wheels and on foot, in particular the couple hurrying across.

– Dr Winston Oh