

TREATING IBS IN PRACTICE



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Almost 5 million patients a year complain of IBS type symptoms (1). A large number say they want dietary advice but few receive it from registered dietitians (RDs)(2). This is despite NICE guidance that IBS sufferers should be referred to RDs(3).

As a dietitian in private practice, a large proportion of my patients present with IBS and many say they have never had the opportunity to see a dietitian before. Around 50 percent of my patients are self-referred and 50 percent are referred by consultant gastroenterologists. Very few are referred by GPs. This article aims to provide a practical overview of the current evidence base and BDA guidelines for the management of patients with IBS.

My experience matches the data which places pain and bloating as the two most common IBS symptoms driving patients to seek help (4). Other common IBS symptoms include flatulence, diarrhoea (IBS/D) or constipation (IBS/C) or a mixture of the two (IBS/M). Feelings of incomplete evacuation and urgency are also common IBS symptoms.

Of course these symptoms may fluctuate in individuals. The patient's description of their symptoms is subjective

and based on how they look and feel e.g. "I look pregnant" or "I'm doubled up with pain", "I don't want to leave the house" for instance(5). Some practitioners might dismiss these symptom descriptions as unhelpful exaggerations which blur making a clinical diagnosis. However, we need to be aware that these symptoms are very real, and they're severe enough to prompt the patient to seek help. Importantly, any improvement in these symptoms is the benchmark upon which the patient will rate treatment success. It's vital therefore to listen to the patient, try to assess how severe the symptom is today, and then how severe it is at its most severe. I ask patients to rate these on a scale of 1-10, with 1 being "barely noticeable" and 10 being "unbearable". The Bristol Stool Scale (Lewis and Heaton, 1997) also remains a useful aid for patients to describe their stool consistency. I want to understand how the condition is affecting the patient's day to day life. ▶

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I also ask patients what they expect from dietetic input, and what they hope for as an outcome; this enables us to start out with agreed, realistic targets and outcome measures. I am fortunate in that I can allow up to one hour for my consultation.

As with any dietetic consultation a thorough dietary history is the cornerstone and essential baseline tool for the RD. Irregular eating patterns, fibre, fruit and vegetable intake, eating on the run, high caffeine, alcohol and/or carbonated drink intakes can all be contributors to IBS symptoms. As can stress, so it's essential to get an overview of the patients day to day routine and stress levels.

SIMPLE SOLUTIONS:

Patients with constipation predominant IBS-IBS/C accompanied by pain and bloating may have low intakes of dietary fibre and fluid. It never ceases to amaze me that so many patients are still not aware of the role of fibre in promoting healthy digestion. If I aim to increase dietary fibre as part of the plan then using two tablespoons (24g) of milled linseeds, providing 6.5g NSP can be a simple and effective solution (6,7).

These can easily be added to cereals, salads and homemade smoothies. Increasing dietary fibre from whole grains, especially oats, buckwheat, rye and wild rice (rich in soluble fibre) as well as nuts, seeds, fruits, vegetables and pulses is far more effective than simply increasing fibre from wheat bran - which can make the problem worse.

I remind the patient to increase their fibre intake gradually and ensure fluid intake increases appropriately. We also consider relaxation techniques such as yoga, gentle stomach massage or even simple regular time out in the bath. In addition I talk to the patient about eating slowly and also advise including daily physical activity into their routine.

LESS OBVIOUS CAUSE

It's vital to establish that the patient has been clinically assessed for coeliac disease (while they were eating gluten) before embarking on any dietary manipulation(6). There are significant cross over between symptoms of coeliac disease and IBS. This is particularly important in patients who self-refer.

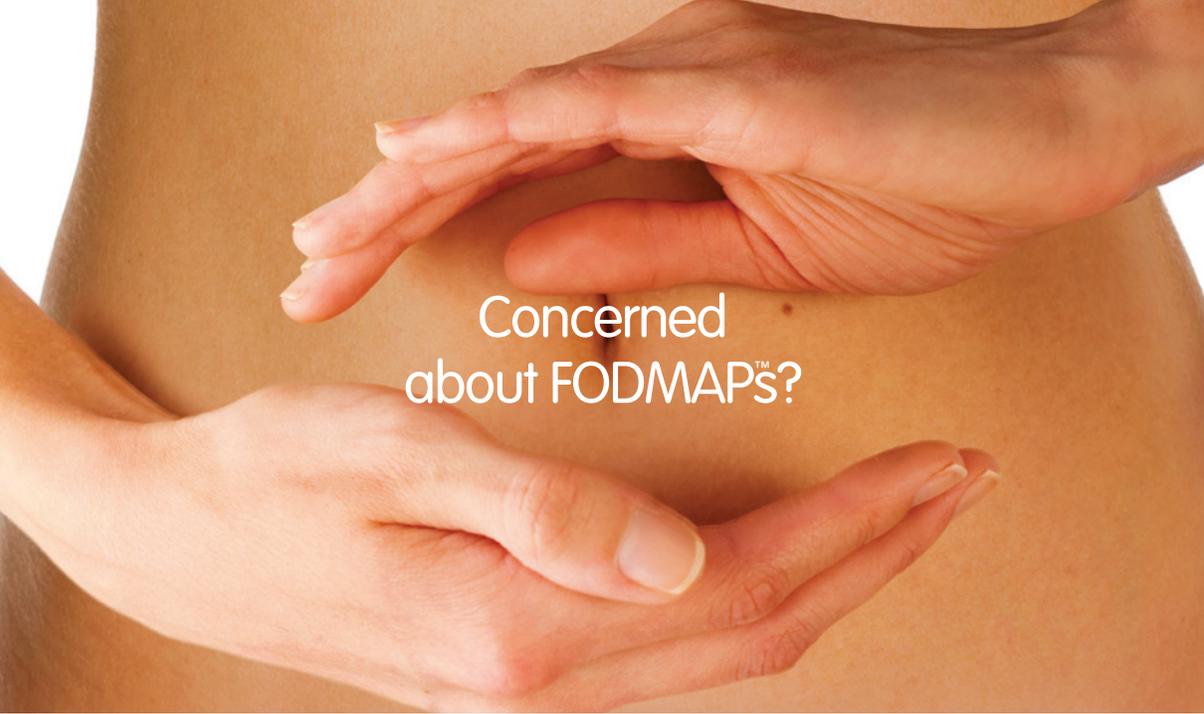
Lactose and/or fructose intolerance also warrant consideration. Lactose intolerance affects approximately 1 in 10 people with IBS in the UK; however the avoidance of lactose alone doesn't usually provide symptom relief (8). The prevalence of fructose intolerance is not known in the UK, it's as high as one in two caucasian IBS sufferers in Australia and the incidence is being recorded in the USA (9). It's therefore likely that some UK IBS sufferers will be fructose mal-absorbers too. In the past, when there appeared to be no obvious dietary reason for their symptoms, this group may have been told "it was all in their mind". Thankfully now we have a little more empathy as well as the low FODMAP diet. This can be effective in improving symptoms in as many four out of five patients (10) so should not be underestimated. In my experience, the low FODMAP diet is a revolutionary upgrade in my dietetic tool kit for treating IBS.

The low diet reduces the patient's intake of short chain carbohydrates through the avoidance of fructans, galacto-oligosaccharides, lactose, fructose and polyols. It's no small undertaking for the patient and requires intensive support by the RD. After 6-8 weeks on the avoidance phase of diet the patient gradually reintroduces FODMAPS, together we identify which carbohydrates are tolerated and plan a long term eating strategy. Further information about the low FODMAP diet, training and resources for RDs is available at <http://www.kcl.ac.uk/medicine/research/divisions/dns/projects/fodmaps/index.aspx> ▶



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Concerned about FODMAPs™?

Try adding something structurally and functionally different

FODMAPs is an acronym that stands for Fermentable Oligo-, Di- and Mono-saccharides, and Polyols.

This term was coined by a group of Australian researchers¹, who theorise that foods that contain these forms of carbohydrate exacerbate the symptoms of functional gastrointestinal disorders, particularly Irritable Bowel Syndrome (IBS), where fermentation of these carbohydrates, by gut bacteria, may produce symptoms such as wind and bloating.

FODMAPs usually include oligosaccharides with a beta-fructosidic and alpha-galactosidic linkage.

In contrast, Bimuno-GOS is a mixture of oligosaccharides with beta-glucosidic and beta-galactosidic linkages. Moreover, it is highly selective towards bifidobacteria, which do not produce gas during their fermentation.

Bifidobacteria are one of the most important bacteria groups in the gut. They specifically stimulate the immune

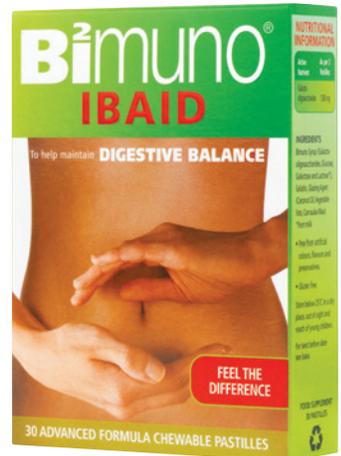
system and enhance overall gut health² and have been linked to increased resistance to infection³. Moreover, IBS sufferers generally have lower levels of bifidobacteria⁴.

A low FODMAP diet has been linked to a significant decrease in bifidobacteria in IBS patients⁵.

Studies have shown that Bimuno-GOS has a unique dual action in providing nutritional support specifically for bifidobacteria so that their numbers and activity is significantly increased within 7 days⁶.

A placebo-controlled, randomized, double-blind, parallel study on the effect on microbiota and symptoms of IBS⁷, showed significant differences between Bimuno-GOS and placebo in abdominal pain, bloating, flatulence and quality of life assessment. Moreover, Bimuno-GOS significantly increased bifidobacteria.

In conclusion, Healthcare Professionals may wish to consider adding Bimuno-GOS to their recommended low FODMAP diet.



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When supporting a patient on a low FODMAP diet, I usually recommend they take a probiotic supplement after the initial 6-8 weeks following the diet. Faecal bifidobacteria concentrations are reduced in people following a low FODMAP diet and the existing guidance suggests there is no associated harm with this precautionary approach(6).

The general health of the gut flora is in fact one of the main areas I concentrate on when working with most IBS sufferers. Gastroenteritis remains the strongest risk factor for developing IBS (11). Symptoms may manifest some 2-8 years post infection so it's always worth asking about historical travel related gastric infections or attacks of food poisoning which the patient may not relate to their current symptoms (12).

A number of systematic reviews have shown improvements in IBS symptoms after probiotic treatment, however many of the RCTs have been criticised for their size and design which fail to identify the strain, dose and symptom specific links for each various bacteria. (13,14,15). We need to be confident in recommending specific types of probiotics for patients to try and this means recommending specific brands which have been through rigorous trials.

For patients with constipation predominant IBS, urgency and pain we can suggest the patient tries two pots of Activia yoghurt for four weeks (6). The yoghurt, produced by Danone contains bifidobacterium lactis DN-173 010,

1.25x10¹⁰ cfu. It's a simple and effective strategy and costs the patient less than £20.

Alternatively VSL#3 taken as two sachets daily for four weeks may reduce flatulence and bloating in constipation predominant IBS(6). This preparation contains a combination of eight different bacterial strains. It should be kept refrigerated and can be taken mixed with food or water. The four week course costs approximately £100. VSL#3 is produced by Ferring Pharmaceuticals.

I don't claim to be an IBS expert, I do however know that my private patient list contains a high proportion of IBS sufferers who want my help and at times they feel desperately unsupported. It's therefore in my and their best interest for me to take the available evidence and guidance for managing IBS, and incorporate this into my clinical practice. IBS remains a complex condition to treat, sufferers invariably pick up a mass of mis-information from their own research and from unqualified practitioners.

Some of these dietary interventions may initially appear very mainstream and simplistic to a patient who is looking for a miracle cure. However, by really listening to the patient's story and how their IBS affects them; by explaining the potential causes of their symptoms and by devising a plan based on this information the results can be impressive and dramatic.

This can be a truly rewarding and effective area of dietetics to work in.

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Questions relating to: *Treating IBS in practice*

Type your answers below and then **print for your records** or print and complete answers by hand.

Q.1 What are the common symptoms of Irritable Bowel Syndrome (IBS)?

A

Q.2 What methods can be used to assess the severity of a patient's symptoms?

A

Q.3 What dietary factors can influence IBS symptoms?

A

Q.4 Describe the role that fibre can play in alleviating IBS symptoms.

A

Q.5 Outline the reasons why lactose/fructose intolerance should be considered when assessing IBS.

A

Q.6 How can the low FODMAP diet help in providing symptom relief?

A

Q.7 Why is it important to assess the health of gut flora in a patient suffering from IBS?

A

Q.8 How can probiotics alleviate symptoms?

Q.9 Describe a holistic dietary approach to the management of IBS.

Please type additional notes here . . .