IRRITABLE BOWEL SYNDROME PATHWAY For Adults

Patient presenting with lower gastrointestinal symptoms for at least 6 months suggestive of irritable bowel syndrome (IBS) WITHOUT ALARM SYMPTOMS:

- **A**bdominal pain (relieved by defaecation, made worse by eating) (IBS-A)
- **B**loating (IBS-B)
- **C**onstipation (IBS-C) } altered bowel frequency or stool form
- **D**iarrhoea (IBS-D) } is common; overlap exists (IBS-M– mixed)

Profuse watery diarrhoea may represent primary bile salt malabsorption
Or microscopic colitis - if suspected, refer to secondary care for investigation

- **Rectal and Abdominal Examination**
- **Bloods:** FBC and CRP
  TFT (if appropriate considering additional symptoms)
  Coeliac screening (IgA tTGA)
- **Faecal calprotectin (FCALP)** (only if diarrhoea is predominant symptom)
- **Stool MCS** (only if diarrhoea is predominant symptom, travel history, etc)

And/or Abnormal blood tests / examination

- Anaemia
- Abdominal masses
- Rectal masses
- Inflammatory markers e.g. ↑CRP

FCALP <50

FCALP 50-150

FCALP >150

Refer as new INFLAMMATORY BOWEL DISEASE

Repeat in 4 -6 weeks and consider IBS advice

>150

≤150

Diagnose IBS and give information

ALARM symptoms

- Unintentional weight loss
- Rectal bleeding
- A family history of bowel or ovarian cancer
- > 60 years of age, a change in bowel habit lasting more than 6 weeks with looser and/more frequent stools

Symptoms suggestive of OVARIAN CANCER

Women (especially if ≥ 50yrs) who reports having any of the following symptoms on a persistent or frequent basis – particularly more than 12 times per month:

- persistent abdominal distension (women often refer to this as 'bloating')
- feeling full (early satiety) and/or loss of appetite
- pelvic or abdominal pain
- increased urinary urgency and/or frequency

Measure serum CA125; ultrasound of abdomen and pelvis

Secondary care

Diet

Assess diet and nutrition and give the following general advice

If predominant symptoms are: **IBS-B, IBS-D, IBS-M**

Refer to DIETITIAN for low FODMAP diet

Physical Activity

Aim for 30 minutes of moderate activity on 5 days of the week or more

Consider IAPT Referral

Response to psychological therapy +/- TCAs (additional benefit over pain)

Pharmacological Treatment (see next page for details)

Decisions about pharmacological management should be based on the nature and severity of symptoms.

Refer to GASTROENTEROLOGIST if all approaches ineffective

South East London Area Prescribing Committee. A partnership between NHS organisations in South East London: Bexley/ Bromley/ Greenwich/ Lambeth/ Lewisham & Southwark Clinical Commissioning Groups (CCGs) & GSTFT/KCH/SLAM/Oxleas NHS Foundation Trusts & Lewisham & Greenwich NHS Trust

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Diet and Lifestyle Advice (Ref: NICE CG61 Feb 2008)

- Have regular meals and take time to eat.
- Avoid missing meals or leaving long gaps between eating.
- Drink at least eight cups of fluid per day, especially water or other non-caffeinated drinks, for example herbal teas.
- Restrict tea and coffee to three cups per day.
- Reduce intake of alcohol and fizzy drinks.
- **It may be helpful to limit intake of high-fibre food (such as wholemeal or high-fibre flour and breads, cereals high in bran, and whole grains such as brown rice); REDUCE INSOLUBLE FIBRE.**
- Reduce intake of 'resistant starch' (starch that resists digestion in the small intestine and reaches the colon intact), which is often found in processed or re-cooked foods.
- Limit fresh fruit to three portions per day (a portion should be approximately 80 g).
- People with diarrhoea should avoid sorbitol, an artificial sweetener found in sugar-free sweets (including chewing gum) and drinks, and in some diabetic and slimming products.
- **People with wind and bloating may find it helpful to eat oats (such as oat-based breakfast cereal or porridge) and linseeds (up to one tablespoon per day); INCREASE SOLUBLE FIBRE.**
- People with irritable bowel syndrome who choose to try probiotics should be advised that these items are not recommended for prescribing on NHS prescription.
- Complementary and alternative medicines are not recommended for managing irritable bowel syndrome, for example:
  - × Aloe vera
  - × Acupuncture
  - × Reflexology
  - × Herbal medicine

Pharmacological Treatment

Choice of single or combination of medications is determined by predominant symptoms.

If predominant symptoms are: **IBS-B, IBS-D, IBS-M**

Refer to DIETITIAN for low FODMAP diet

IBS-C does not respond to low FODMAP diet, follow constipation management

1st line pharmacological treatment

If IBS-A consider antispasmodic agent:	**If IBS-D consider antimotility agent:**	**If IBS-C consider laxative:**
Mebeverine 135mg tablets 1-2 three times a day as required Peppermint oil 0.2ml gastro-resistant capsules 1-2 three times a day	Loperamide 2mg capsules 2-4 a day max.16 mg daily *Adjust dose according to response. The aim is to produce a soft, well-formed stool*	Ispaghula husk 3.5g in water twice daily Docusate up to 500 mg daily in divided doses *Avoid lactulose*

2nd line pharmacological treatment NICE CG61 2008 (TCA and SSRI are unlicensed)

If pain and IBS-D consider TCA:	**If pain and IBS-C consider SSRI:**	**If IBS-C more than 12 months and not respond to maximum dose of different laxatives:**
Amitriptyline 10mg at night *Increase every 2 weeks up to max 30mg daily if tolerated; or reduce to 5mg if not tolerated. No more than 6-8 weeks trial* *Only consider Nortriptyline 5mg-20mg if excessive hangover effect or sedation*	Fluoxetine 20mg once a day Citalopram 10mg-20mg once a day *Review after 4 weeks and then every 6–12 months*	Linaclotide 290 micrograms capsules once daily *Review after 4 weeks and stop if ineffective. Then review every 3 months*

Refer to GASTROENTEROLOGIST if all approaches ineffective

If IBS-D has not responded to other pharmacological treatments (e.g. antimotility agents, antispasmodics, TCAs), or pharmacological treatments are contraindicated or not tolerated. The gastroenterologist might consider eluxadoline at this point:

NICE TA471 4 week trial eluxadoline100 mg twice daily (**AMBER 2** RAG list category - initiation by a specialist, stabilisation for a specified time, then continuation in primary care under an individual management plan.)

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