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[1]:

- **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

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
- Persistent 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

- **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)
- **Faecal Immunochemical Test** (symptom suggestive of colorectal cancer)
- **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 as below:

Patient information available via NHS website: https://www.nhs.uk/conditions/irritable-bowel-syndrome-ibs/

Diet

Assess diet and nutrition and give the following general advice

Physical Activity

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

Consider referral for Psychological intervention[1]

Response to psychological therapy: CBT, hypnotherapy, psychological therapy

Pharmacological Treatment (see next page for details)

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

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

Refer to DIETITIAN for low FODMAP diet
(fermentable oligosaccharides, disaccharides, monosaccharides and polyols diet)

Refer to GASTROENTEROLOGIST if all approaches ineffective

South East London Area Prescribing Committee. A partnership between NHS organisations in South East London: South East London Clinical Commissioning Group (covering the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark) & GSTFT/KCH/SLaM/Oxleas NHS Foundation Trusts/Lewisham & Greenwich NHS Trust

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Diet and Lifestyle Advice[1] from NICE Pathways – updated May 2019

Assess diet and nutrition and give the following general advice:

- Have regular meals and take time to eat.
- Avoid missing meals or leaving long gaps between eating.
- Drink at least 8 cups of fluid per day, especially water or other non-caffeinated drinks such as herbal teas.
- Restrict tea and coffee to 3 cups per day.
- Reduce intake of alcohol and fizzy drinks.
- Consider limiting intake of high-fibre food (for example, wholemeal or high-fibre flour and breads, cereals high in bran, and whole grains such as brown rice).
- Reduce intake of 'resistant starch' (starch that resists digestion in the small intestine and reaches the colon intact), often found in processed or re-cooked foods.
- Limit fresh fruit to 3 portions (of 80 g each) per day.
- For diarrhoea, avoid sorbitol, an artificial sweetener found in sugar-free sweets (including chewing gum) and drinks, and in some diabetic and slimming products.
- For wind and bloating consider increasing intake of oats (for example, oat-based breakfast cereal or porridge) and linseeds (up to 1 tablespoon per day).

Review the person's fibre intake and adjust (usually reduce) according to symptoms.

- Discourage intake of insoluble fibre (for example, bran).
- If more fibre is needed, recommend soluble fibre such as ispaghula powder, or foods high in soluble fibre (for example, oats).

If the person wants to try probiotics, advise them to take the dose recommended by the manufacturer for at least 4 weeks while monitoring the effect **(not for prescribing on FP10)**

- Complementary and alternative medicines are not recommended for managing irritable bowel syndrome, for example:
  - û Aloe vera
  - û Acupuncture
  - û Reflexology
  - û Herbal medicine

Encourage the person to identify any associated stress, anxiety, and/or depression, and manage appropriately. See the NICE CKS topics on Generalized anxiety disorder and Depression for more information

Physical Activity[2]

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

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: Self-care with OTC if effective continue for 4 weeks then review and prescribe on FP10

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 Initially 4–8 mg daily, maintenance up to 16 mg daily in 2 divided doses. Adjust according to response 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 or Senna*** *advise how to adjust dose of agent according to clinical response. Titrate according to stool consistency, aim to achieve soft, well-formed stool (BristolStool scale type 4)*

2nd line pharmacological treatment NICE CG61 2008 (after failure of clinical response to OTC)

If pain and IBS-D consider tricyclic antidepressant (TCA*):	**If pain or TCA ineffective/not tolerated and IBS-C then consider 2nd line treatment selective serotonin reuptake inhibitor (SSRI*):**	**If IBS-C more than 12 months and not respond to or not helped with optimal or maximum tolerated doses of previous laxatives from different classes[2]**
Amitriptyline 5mg-10mg at night *(10mg tabs can be halved if needed)* *Increase every 2 weeks up to max 30mg daily if tolerated; or reduce to 5mg if not tolerated.* *No more than 6-8 weeks. Only consider Nortriptyline[2] 5mg-20mg if excessive hangover effect or sedation* ****unlicensed indication***	Fluoxetine 20mg once a day Citalopram 10mg-20mg once a day *Review after 4 weeks and then every 6–12 months* ****unlicensed indication common GI side effects: diarrhoea, constipation dyspepsia. Check spc[3]***	Linaclotide 290 micrograms capsules once daily[5] *Review after 4 weeks and stop if ineffective. Then review every 3 months* *SEL APC Formulary Recommendation for linaclotide*

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.

References: (1) NICE Pathways IBS in adults last accessed 26th May 2020 (2) NICE CG Irritable bowel syndrome in adults: diagnosis and management last accessed on 26th May 2020 (3) Therapeutic advances in gastroenterology, the treatment of irritable bowel syndrome available at: https://www.ncbi.nlm.nih.gov/pmc/articles (4) Specific product characteristics available at: https://www.medicines.org.uk/emc

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