Primary Care management of Irritable Bowel Syndrome (IBS)

- Consider assessment for IBS if the following symptoms persist for at least 6 months:
  - Abdominal pain or discomfort
  - Bloating
  - Change in bowel habit

- Refer people with possible IBS symptoms to secondary care for further investigation if they have
  1. Any of the following ‘red flag’ indicators:
     - Unintentional and unexplained weight loss
     - Rectal bleeding
     - A family history of bowel or ovarian cancer
     - If aged >60 years, a change in bowel habit lasting >6 weeks with looser and/or more frequent stools
     Or
     - Inflammatory markers (CRP/ESR or calprotectin) for inflammatory bowel disease
     - Anaemia
     - Abdominal or rectal mass

- Faecal calprotectin testing is recommended as an option to support clinicians with the differential diagnosis of inflammatory bowel disease (IBD) or irritable bowel syndrome (IBS) in adults with recent onset lower gastrointestinal symptoms for whom specialist assessment is being considered, if: cancer is not suspected, having considered the risk factors (for example, age)

- Measure serum CA125 in any woman of 50 or over who has experienced symptoms within the last 12 months of IBS; IBS rarely presents for the first time in women of this age (NICE National Guidance 12 – Suspected Cancer)

- People with IBS should be given information about self-help including information on general lifestyle, physical activity, diet and symptom-targeted medication

- Advise people with IBS how to adjust their doses of laxatives or anti-motility agent according to clinical response

- Tricyclic antidepressants may be considered as a second line treatment for people with IBS if laxatives, loperamide or antispasmodics have not helped
Irritable Bowel Syndrome
Initial assessment and diagnosis

Patient history & clinical examination
ABC for at least 6 months
Abdominal pain or discomfort
Bloating
Changes in bowel habit

Diagnosis of IBS only if the person has abdominal pain or discomfort that is either relieved by defaecation or associated with bowel frequency or stool form. This should be accompanied by at least 2 of the following four symptoms:
- Altered stool passage (straining, urgency, incomplete evacuation)
- Abdominal bloating, distention, tension or hardness
- Symptoms made worse by eating
- Passage of mucous
(Lethargy, nausea, backache and bladder symptoms are common and may support diagnosis)

For those that meet IBS diagnostic criteria the following tests to be undertaken to exclude other diagnosis:
- FBC
- ESR or plasma viscosity
- CRP
- Antibody testing for coeliac diseases (EMA or TTG)
- Faecal calprotectin testing

Following tests are not necessary to confirm diagnosis in people who meet the IBS diagnostic criteria
- Ultrasound
- Rigid/flexible sigmoidoscopy
- Colonoscopy; barium enema
- TFT
- Faecal ova parasite test
- Faecal occult blood
- Hydrogen breath test

Ask patients for ‘red flag’ symptoms:
- Unintentional and unexplained weight loss
- Rectal bleeding
- Family history of bowel or ovarian cancer
- Change in bowel habit to looser and/or more frequent stools persisting for more than 6 weeks in a person aged >60yrs or inflammatory markers for inflammatory bowel disease
2WW referral to secondary care if any present

All patients with possible IBS should be assessed and clinically examined for ‘red flag’ indicators
- Anaemia
- Abdominal masses
- Rectal masses
- Inflammatory markers of inflammatory bowel disease
Measure serum CA125 in primary care in women with symptoms that suggest ovarian cancer
2WW referral to secondary care if any present
Irritable Bowel Syndrome
Treatment and management

Dietary & lifestyle advice:
Provide information that explains the importance of self-help in effectively managing their IBS. This should include information on general lifestyle, physical activity, diet and symptom-targeted medication.
Review the patient’s fibre intake and adjust (usually reduce) according to symptoms.
For more information on self-help see: NICE advice IBS and diet – British Dietetic Association NHS choices

Pharmacological treatment
Pharmacological treatment should be based on the nature and severity of predominant symptoms

1st line pharmacological treatment
Choose single or combination medication on predominant symptom(s)
Antispasmodic agent
Mebeverine 135mg 3 times a day
(alternatives hyoscine butylbromide or peppermint oil)
PRN alongside dietary and lifestyle advice

1st line treatment for constipation
Laxatives should be considered in people with IBS:
Ispaghula husk
Use of lactulose should be discouraged

1st line antimotility agent for diarrhoea
Loperamide – max. 16mg daily
Advise how to adjust dose of laxatives or antimotility agent according to clinical response. The dose should be titrated according to stool consistency, with the aim of achieving a soft well-formed stool (Bristol stool form scale type 4)

2nd line pharmacological treatment of IBS symptoms (Unlicensed)
TCAs if laxatives, loperamide or antispasmodics have not helped
Starting with Amitriptyline 5-10mg once daily at night
(review regularly and increase dose if needed (do not exceed 30mg))
Consider SSRIs only if TCAs are ineffective
Fluoxetine 20mg once daily OR citalopram 10-20mg once daily
(Follow-up people taking these drugs at 4 weeks, then every 6-12 months)
Appendix 1 – Appropriate use of linaclotide following gastroenterologist assessment

Gastroenterologist diagnosis of IBS-C (Those with a diagnosis of chronic constipation should be managed using alternative JAPC algorithm)

Advice regarding diet relaxation and self-help as per CG61 Irritable bowel syndrome

Use of fibre, antispasmodics, laxatives and tricyclic antidepressants (2 or more) fail to control symptoms of pain bloating and constipation

Rome III criteria for IBS-C using a one week stool diary AND meets criteria for moderate/severe IBS-C

IBS symptom severity score: IBS-SS (0-500):

- <75 = remission
- 75-175 = mild
- 175-300 = moderate
- >300 = severe

Commence linaclotide for 4 weeks (if maximum dose of previous laxatives from different classes have not helped and the patients had constipation for at least 12 months), complete IBS-SS in final 10 days

50 point reduction in IBS-SS*?

Yes: primary care prescribing responsibilities
Continue linaclotide
Review response at 26 weeks, continue if:
No significant side effects
>3 complete spontaneous bowel movements a week*

No: Review in gastroenterology outpatients and consider alternatives e.g. prucalopride


→ FDA draft guidance for industry IBS clinical evaluation of products for treatment

Secondary care responsibility

Primary care responsibility