National Institute for Health and Clinical Excellence

Quick reference guide

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Irritable bowel syndrome in adults

Diagnosis and management of irritable bowel syndrome in primary care

NICE clinical guideline 61
Developed by the National Collaborating Centre for Nursing and Supportive Care

About this booklet

This is a quick reference guide that summarises the recommendations NICE has made to the NHS in 'Irritable bowel syndrome in adults: diagnosis and management of irritable bowel syndrome in primary care' (NICE clinical guideline 61).

Who should read this booklet?

This quick reference guide is for GPs and other staff in primary care who care for people with irritable bowel syndrome.

Who wrote the guideline?

The guideline was developed by the National Collaborating Centre for Nursing and Supportive Care, which is based at the Royal College of Nursing. The Collaborating Centre worked with a group of healthcare professionals (including consultants, GPs and nurses), patients and carers, and technical staff, who reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

For more information on how NICE clinical guidelines are developed, go to www.nice.org.uk

Where can I get more information about the guideline?

The NICE website has the recommendations in full, reviews of the evidence they are based on, a summary of the guideline for patients and carers, and tools to support implementation.

National Institute for Health and Clinical Excellence
MidCity Place
71 High Holborn
London
WC1V 6NA

www.nice.org.uk

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This guidance is written in the following context

NICE clinical guidelines are recommendations about the treatment and care of people with specific diseases and conditions in the NHS in England and Wales.

This guidance represents the view of the Institute, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.

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Introduction

Irritable bowel syndrome (IBS) is one of the most common gastrointestinal disorders, with a prevalence estimated at between 10% and 20%. People present to primary care with a wide range of symptoms, some of which overlap with other gastrointestinal disorders. Key elements of management are establishing a positive diagnosis; identifying symptoms that require prompt referral; and working in a long-term partnership with the person with IBS. This represents a significant change from current practice: diagnosis has been predominantly by exclusion of diseases, which has often led to unnecessary investigations and referrals.

Patient-centred care

Treatment and care should take into account patients' individual needs and preferences. Good communication is essential, supported by evidence-based information, to allow patients to reach informed decisions about their care. Follow Department of Health advice on seeking consent if needed. If the patient agrees, families and carers should have the opportunity to be involved in decisions about treatment and care.

Diagnosis
Management
Follow-up

Diagnosis and management of irritable bowel syndrome in primary care

In people who meet the diagnostic criteria:

- carry out the following tests to exclude other diagnoses:
  - full blood count (FBC)
  - erythrocyte sedimentation rate (ESR) or plasma viscosity
  - c-reactive protein (CRP)
  - antibody testing for coeliac disease (endomysial antibodies [EMA] or tissue transglutaminase [TTG]).
- **do not** do the following tests to confirm diagnosis of IBS:
  - ultrasound
  - rigid/flexible sigmoidoscopy
  - colonoscopy; barium enema
  - thyroid function test
  - faecal ova and parasite test
  - faecal occult blood
  - hydrogen breath test (for lactose intolerance and bacterial overgrowth).

Box 1 General dietary advice

- 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 such as herbal teas.
- Restrict tea and coffee to three 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 three 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 one tablespoon per day).

Referral for psychological interventions

- For people whose symptoms do not respond to pharmacological treatments after 12 months and who develop a continuing symptom profile (refractory IBS), consider referring for:
  - cognitive behavioural therapy (CBT)
  - hypnotherapy
  - psychological therapy.

Initial presentation

A person reports having had any of the following symptoms for at least 6 months:

- **Abdominal pain or discomfort**
- **Bloating**
- **Change in bowel habit.**

Positive diagnostic criteria for IBS

- Consider diagnosing IBS only if the person has abdominal pain or discomfort that is:
  - relieved by defaecation, **or**
  - associated with altered bowel frequency or stool form

  and at least two of the following:
  - altered stool passage (straining, urgency, incomplete evacuation)
  - abdominal bloating (more common in women than men), distension, tension or hardness
  - symptoms made worse by eating
  - passage of mucus.
- Lethargy, nausea, backache and bladder symptoms may be used to support diagnosis.

Lifestyle: diet and physical activity

- Provide information about self-help covering lifestyle, physical activity, diet and symptom-targeted medication.
- Encourage people to identify and make the most of their leisure time and to create relaxation time.
- Assess physical activity levels, ideally using the General Practice Physical Activity Questionnaire (GPPAQ).
  - Give people with low activity levels brief advice and counselling to increase their activity.
- Assess diet and nutrition and give general advice (see box 1).
- 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.
- Discourage use of aloe vera for IBS.

Referral to dietitian

- If diet is considered a major factor in symptoms and dietary/lifestyle advice is being followed, refer to a dietitian for single food avoidance and exclusion diets.
- Only a dietitian should supervise such treatment.

Follow-up

- Agree follow-up with the person based on symptom responses to interventions. This should form part of the annual patient review.
- Investigate or refer to secondary care if 'red flag' symptoms appear during management and follow-up.

Symptoms requiring referral to secondary care[1]

- Refer for further investigation people with possible IBS symptoms if any of the following 'red flag' indicators are present:
  - unintentional and unexplained weight loss
  - rectal bleeding
  - a family history of bowel or ovarian cancer
  - in people aged over 60, a change in bowel habit lasting more than 6 weeks with looser and/or more frequent stools.
- Assess and clinically examine people with possible IBS symptoms and refer if any of the following 'red flags' are found:
  - anaemia
  - abdominal masses
  - rectal masses
  - inflammatory markers for inflammatory bowel disease.

If symptoms may suggest ovarian cancer, consider performing a pelvic examination.

First-line pharmacological treatment

Choose single or combination medication based on the predominant symptom(s).

- Consider offering antispasmodic agents. These should be taken as required alongside dietary and lifestyle advice.
- Consider offering laxatives for constipation, but discourage use of lactulose.
- Offer loperamide as the first choice of antimotility agent for diarrhoea.[2]
- Advise people how to adjust doses of laxative or antimotility agent according to response, shown by stool consistency. The aim is a soft, well-formed stool (Bristol Stool Form Scale type 4).

Second-line pharmacological treatment

- Consider tricyclic antidepressants (TCAs) for their analgesic effect if first-line treatments do not help.[3]
  - Start at a low dose (5–10 mg equivalent of amitriptyline) taken once at night and review regularly. The dose may be increased (but should not usually exceed 30 mg).
- Consider selective serotonin reuptake inhibitors (SSRIs) only if TCAs are ineffective.[3]
- Take into account the possible side effects of TCAs and SSRIs.
  - If prescribing these drugs for the first time, follow up after 4 weeks and then every 6–12 months.

Complementary and alternative medicines

- Do not encourage use of acupuncture or reflexology for the treatment of IBS.

Diagnosis

Management

Follow-up

[1] See 'Referral guidelines for suspected cancer', NICE clinical guideline 27, for detailed referral criteria where cancer is suspected.

[2] In certain situations the daily dose of loperamide required may exceed 16 mg, which at the time of publication (February 2008) was an out of licence dose. Informed consent should be obtained and documented.

[3] At the time of publication (February 2008) TCAs and SSRIs did not have UK marketing authorisation for the indications described. Informed consent should be obtained and documented.

Key priorities for implementation

- Healthcare professionals should consider assessment for IBS if the person reports having had any of the following symptoms for at least 6 months:
  - **A**bdominal pain or discomfort
  - **B**loating
  - **C**hange in bowel habit.
- All people presenting with possible IBS symptoms should be asked if they have any of the following 'red flag' indicators and should be referred to secondary care for further investigation if any are present:[4]
  - unintentional and unexplained weight loss
  - rectal bleeding
  - a family history of bowel or ovarian cancer
  - a change in bowel habit to looser and/or more frequent stools persisting for more than 6 weeks in a person aged over 60 years.
- All people presenting with possible IBS symptoms should be assessed and clinically examined for the following 'red flag' indicators and should be referred to secondary care for further investigation if any are present:[4]
  - anaemia
  - abdominal masses
  - rectal masses
  - inflammatory markers for inflammatory bowel disease.

  If there is significant concern that symptoms may suggest ovarian cancer, a pelvic examination should also be considered.
- A diagnosis of IBS should be considered only if the person has abdominal pain or discomfort that is either relieved by defaecation or associated with altered bowel frequency or stool form. This should be accompanied by at least two of the following four symptoms:
  - altered stool passage (straining, urgency, incomplete evacuation)
  - abdominal bloating (more common in women than men), distension, tension or hardness
  - symptoms made worse by eating
  - passage of mucus.

  Other features such as lethargy, nausea, backache and bladder symptoms are common in people with IBS, and may be used to support the diagnosis.
- In people who meet the IBS diagnostic criteria, the following tests should be undertaken to exclude other diagnoses:
  - full blood count (FBC)
  - erythrocyte sedimentation rate (ESR) or plasma viscosity
  - c-reactive protein (CRP)
  - antibody testing for coeliac disease (endomysial antibodies [EMA] or tissue transglutaminase [TTG]).

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[4] See 'Referral guidelines for suspected cancer', NICE clinical guideline 27, for detailed referral criteria where cancer is suspected.

Key priorities for implementation *continued*

- The following tests are not necessary to confirm diagnosis in people who meet the IBS diagnostic criteria:
  - ultrasound
  - rigid/flexible sigmoidoscopy
  - colonoscopy; barium enema
  - thyroid function test
  - faecal ova and parasite test
  - faecal occult blood
  - hydrogen breath test (for lactose intolerance and bacterial overgrowth).
- People with IBS should be given 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.
- Healthcare professionals should review the fibre intake of people with IBS, adjusting (usually reducing) it while monitoring the effect on symptoms. People with IBS should be discouraged from eating insoluble fibre (for example, bran). If an increase in dietary fibre is advised, it should be soluble fibre such as ispaghula powder or foods high in soluble fibre (for example, oats).
- People with IBS should be advised how to adjust their doses of laxative or antimotility agent according to the clinical response. The dose should be titrated according to stool consistency, with the aim of achieving a soft, well-formed stool (corresponding to Bristol Stool Form Scale type 4).
- Healthcare professionals should consider tricyclic antidepressants (TCAs) as second-line treatment for people with IBS if laxatives, loperamide or antispasmodics have not helped. TCAs are primarily used for treatment of depression but are only recommended here for their analgesic effect. Treatment should be started at a low dose (5–10 mg equivalent of amitriptyline), which should be taken once at night and reviewed regularly. The dose may be increased, but does not usually need to exceed 30 mg.[5]

[5] At the time of publication (February 2008) TCAs did not have UK marketing authorisation for the indication described. Informed consent should be obtained and documented.

Implementation tools

NICE has developed tools to help organisations implement this guidance. These are available on our website (www.nice.org.uk/CG061).

Further information

Ordering information

You can download the following documents from www.nice.org.uk/CG061

- A quick reference guide (this document) – a summary of the recommendations for healthcare professionals.
- The NICE guideline – all the recommendations.
- 'Understanding NICE guidance' – information for patients and carers.
- The full guideline – all the recommendations, details of how they were developed, and reviews of the evidence they were based on.

For printed copies of the quick reference guide or 'Understanding NICE guidance', phone NICE publications on 0845 003 7783 or email publications@nice.org.uk and quote:

- N1463 (quick reference guide)
- N1464 ('Understanding NICE guidance').

Related NICE guidance

For information about NICE guidance that has been issued or is in development, see the website (www.nice.org.uk).

- Faecal incontinence: the management of faecal incontinence in adults. NICE clinical guideline 49 (2007). Available from: www.nice.org.uk/CG049
- Physical activity. NICE public health intervention guidance PHI002 (2006). Available from: www.nice.org.uk/PHI002
- Referral guidelines for suspected cancer. NICE clinical guideline 27 (2005). Available from: www.nice.org.uk/CG027
- Depression: management of depression in primary and secondary care. NICE clinical guideline 23 (2004). Available from: www.nice.org.uk/CG023

Updating the guideline

This guideline will be updated as needed, and information about the progress of any update will be posted on the NICE website (www.nice.org.uk/CG061).

National Institute for
Health and Clinical Excellence
MidCity Place
71 High Holborn
London
WC1V 6NA

www.nice.org.uk

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