International Foundation for Functional Gastrointestinal Disorders
IFFGD
700 W. Virginia St., #201
Milwaukee, WI 53204
Phone: 414-964-1799
Toll-Free (In the U.S.): 888-964-2001
Fax: 414-964-7176
Internet: www.iffgd.org

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Is it IBS or Something Else?

By: George F. Longstreth, M.D., Chief of Gastroenterology, Kaiser Permanente Medical Care Plan, San Diego, C.A.

Physicians can usually identify irritable bowel syndrome (IBS) from patients' symptoms. Many patients additionally require only routine blood tests and a colon evaluation, and some require no tests at all to secure the diagnosis. However, some patients worry that they could have another cause for their symptoms, especially when symptoms are severe and chronic, or they know other people who they think had similar symptoms but a different disorder. Occasionally, another medical problem mimics IBS symptoms. This discussion focuses on how IBS is diagnosed and distinguished from other disorders.

Typical patterns of abdominal discomfort or pain, bowel habit disturbance, and bloating point strongly to IBS. Physicians often rely on the "Manning" or "Rome" symptoms (Table 1), which include abdominal pain or discomfort that is associated with abnormal frequency or appearance of stools and is relieved by evacuation. A patient's age, past history, family history, and particular symptoms help physicians individualize testing. "Alarm signs" are symptoms or laboratory findings that are not explainable by IBS (examples include unexplained weight loss, rectal bleeding, fever, and anemia). However, the presence of these signs often does not indicate an alarming problem. For example, rectal bleeding is much more often a sign of hemorrhoids than cancer. These "alarm signs" and atypical symptoms guide physicians to search for certain diseases.

Colorectal cancer – With so much public attention to the worthwhile goal of detecting colorectal cancer early, it is understandable that some patients worry about it. This cancer rarely causes IBS-like symptoms, but most people should begin periodic screening when they are about 50; a family history of colorectal polyps or cancer might lead to earlier screening. Conventional procedures include testing stool specimens for blood, barium enema x-ray examination, and endoscopy (flexible sigmoidoscopy or colonoscopy). Computerized colon tomography (virtual colonoscopy) and stool DNA testing are new and undergoing evaluation. The selected test depends on whether the patient has an average or higher risk for getting cancer (usually assessed from the family history) and the availability, risk, benefits, and cost of the tests.

Gallstones – Gallbladder stones increase with age and develop in up to 30% of women and 15% of men. When gallstone pain occurs, it is usually severe, located in the upper abdomen, lasts one to several hours, and occurs every few weeks to months. Serious complications can occur, including inflammation of the gallbladder (cholecystitis) or pancreas (pancreatitis), or obstruction of bile flow from the liver. However, most people with gallstones never have symptoms from them. Daily pain is unusual, and it is unrelated in time to abnormal bowel habit and unrelieved by evacuation, as characterize IBS. If the pain of IBS is mistakenly attributed to gallstones, gallbladder removal (cholecystectomy) does not relieve the pain. Gastroenterology consultation can help determine the source of pain when patients have both gallstones and IBS.

Inflammatory bowel disease – Chronic inflammation (swelling, increased white blood cells, and ulcers) of the small or large bowel can cause diarrhea (often with bleeding), pain, weight loss, anemia, and other problems. The two main types of inflammatory bowel disease – chronic ulcerative colitis and Crohn's disease – are usually diagnosed with barium x-ray exams, computerized tomography (CT), and endoscopy with biopsy. These procedures reveal no abnormality responsible for IBS symptoms.

Celiac disease – In the past, this disease (also called celiac sprue) was regarded as an uncommon small bowel disorder, and it was mainly suspected in patients of Northern European ancestry with chronic diarrhea, weight loss, and nutritional deficiency. According to recent studies, celiac disease is more common than previously thought. It can have various manifestations, such as iron deficiency anemia or bone thinning (osteoporosis) with little or no diarrhea, and it responds to restricting the protein gluten from the diet. Patients with dermatitis herpetiformis (an unusual skin disorder), type I diabetes, and thyroid disease have it more often than people without these problems. Some studies identify celiac disease in occasional referral patients with IBS. A special blood test has high diagnostic accuracy, and physicians sometimes obtain it, especially if patients have weight loss, anemia, or other "alarm signs." However, the proportion of patients with IBS who have celiac disease and would be helped by gluten restriction is uncertain.

Gynecological disorders – Women are especially likely to seek care for IBS. Their pain is usually in the lower abdomen and sometimes increased during menstrual periods, so a gynecological origin of the pain is sometimes suspected. Gynecologists often refer to this pain as "chronic pelvic pain" and perform ultrasound exams or diagnostic laparoscopy (endoscopy through a small abdominal incision) to check for disease of the uterus or ovaries. For example, endometriosis can cause chronic pain in the same body area as IBS pain. As applies to gallstone pain, however, this pain usually does not have the typical IBS-type association with evacuation. Women with IBS have more menstrual symptoms than other women and are more likely to undergo hysterectomy, which eliminates abnormal bleeding and can help gynecological pain. However, this operation does not alleviate IBS pain. Ovarian cancer can

cause abdominal pain, but it rarely causes the particular type of pain and bowel disturbance typical of IBS. Most women should have periodic, routine pelvic examinations whether or not they have IBS. A woman's ethnicity, past medical history, and family history might call for special screening for gynecological disease.

It is important to realize that once doctors confidently diagnose IBS, another cause for the symptoms is not often found, even after many years. Also, the common nature of IBS means that patients with it often have another coexisting disorder. In fact, IBS predisposes patients to have other gastrointestinal symptoms and some non-gastrointestinal disorders, such as fibromyalgia and headache, which cause different symptoms than those of IBS. It is when IBS symptoms are atypical or co-exist with another disorder that can cause bowel habit disturbance or abdominal pain that confusion sometimes arises. In such cases, consultation with experienced specialists can help increase diagnostic certainty.

IFFGD Suggested Reading

Thompson W.G. *Irritable Bowel Syndrome: Does it Cause Other Disease?* IFFGD. Fact Sheet No. 193.

Jaffin B.W. *Clinical Features and Treatments of Inflammatory Bowel Disease (IBD) – An Update*. IFFGD Fact Sheet No. 126.

Cash B.D., Chey W.D. *Diagnostic Tests in Irritable Bowel Syndrome Patients.* IFFGD Fact Sheet No. 175.

Longstreth G.F. *Approach to the Diagnosis of Irritable Bowel Syndrome*. IFFGD Fact Sheet No. 163.

Heitkemper M.M., Jarett M. *Gynecological Aspects of Irritable Bowel Syndrome.* IFFGD Fact Sheet No. 123.

References:

Thompson et al. Gut. 1999:45suppl 2:43-47
Drossman et al. Rome II the functional gastrointestinal disorders. Second edition. Degnon Associates, McLean, VA. 2000.

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Table 1

DIAGNOSTIC CRITERIA FOR IBS

The Manning Criteria

In 1978, Manning et al, using questionnaire data from 32 patients with IBS and 33 patients with organic diseases, found symptoms more common in those with IBS.

Symptoms more likely to be found in irritable bowel syndrome (IBS) than in organic abdominal disease:

- Pain eased after bowel movement
- Looser stools at onset of pain
- More frequent bowel movements at onset of pain
- Abdominal distension
- Mucus per rectum
- Feeling of incomplete emptying

Rome III Diagnostic Criteria* for IBS

The Rome III Criteria, published in 2006, were developed by multinational working teams that collaborated to arrive at a consensus for symptom-based diagnostic standards.

Recurrent abdominal pain or discomfort** at least 3 days per month in the last 3 months associated with 2 or more of the following:

1) Improvement with defecation
2) Onset associated with a change in frequency of stool
3) Onset associated with a change in form (appearance) of stool

* Criterion fulfilled for the last 3 months with symptom onset at least 6 months prior to diagnosis.

** "Discomfort" means an uncomfortable sensation not described as pain.