



## International Foundation for Functional Gastrointestinal Disorders

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# Irritable Bowel Syndrome: An Approach to Treating Patients

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# Irritable Bowel Syndrome: An Approach to Treating Patients

From an IFFGD interview with Peter Whorwell, BSc, MD, PhD, FRCP, Professor of Medicine and Gastroenterology, Wythenshawe Hospital, Education and Research Centre, Manchester, United Kingdom

*At the 7<sup>th</sup> International Symposium on Functional Gastrointestinal Disorders, held in April 2007 by IFFGD, we talked to Peter Whorwell, MD about treatment options that are available to patients with IBS. At the time of the interview, the IBS drug Zelnorm had just been withdrawn from the market. With limited IBS-targeted drugs available to treat IBS we asked Dr. Whorwell about how he approaches treatment of his IBS patients. For over two decades, Dr. Whorwell has been studying functional gastrointestinal disorders. He directs the South Manchester Functional Bowel Service where he cares for a large number of patients including about 1,000 new patients with IBS per year.*

## **What changes have you seen in medical delivery for people with IBS over the past decade?**

Of the changes I have seen over the past 10 years I have to say there has been an increase in interest in this patient population among medical colleagues. When I started out I was nearly the only person in the UK interested in irritable bowel syndrome (IBS). But I still think that the average physician and gastroenterologist see IBS as a bit of a nuisance rather than anything important, which is contrary to my view.

## **What can you tell people who don't know where to go for help? How do they best find adequate care?**

I think finding adequate care is very difficult, because how do you find that out? In my country it's done usually through the media or word of mouth. A lot of my referrals are word of mouth. So many doctors are not particularly interested and it appalls me that I'll see patients on a regular basis that might have seen 10 gastroenterologists before me and they'll say, "You're the first guy who has listened." I don't know how we turn that around. I suspect that if we had more effective treatments it would be helpful. I think what happens is IBS is perceived by many in the medical profession as untreatable; doctors aren't very good with patients they can't treat. They start to blame the patient.

My view is, to be a good IBS doctor you have to be good at caring for patient needs while not being able to provide a cure. My practice is now exclusively functional gastrointestinal disorders and of that about 70% is IBS. I see about 1,000 new patients a year with IBS and if I didn't improve them, I'd go crazy and stop doing it.

I would say we help at least 90% of people who come to us. Setting the goals and expectations is important. I typically say, "OK, this condition is not curable. That is what you've been told over and over again. But we can help you, hopefully with your symptoms, but we can also help you cope with your symptoms." So I think we're helping in a supportive way and hopefully with actual symptom reduction. But we see ourselves as a caring group.

## **What is the care that you offer to your patients?**

I think the first interview is the key. I spend as long as the patient wants on that interview. They come in and talk and I just sit there and don't say a word. It's usually getting a lot of anger off their chest about previous physicians, and then they begin to talk about their illness. I just listen and then spend as long as they want explaining their illness and trying to give them some insight into their illness. I'm sure the key to all this is if I spend time with them in the beginning I don't have to spend as much time with them long-term. I am there for them still, but the follow-up appointment becomes very short. Whereas, if I only spend 15 minutes and never get beyond a certain point, each subsequent 15 minute interview never gets beyond that point. So they never get anywhere. The investment is at the beginning. And the patients are so grateful for someone who just sits there, quietly, and listens. The nicest thing patients say to me at the end of the interview is, you're the first doctor who listened to me, the first doctor who didn't talk down to me, and the first doctor who talked on my level.

## **TREATMENTS**

### **With the many underlying factors that contribute to IBS and the challenges of developing effective treatments, what tools do clinicians have at hand now to treat their patients with IBS?**

*Listening, teaching, partnering* – As I said before, the first interview is crucial; spending time listening to the patients, addressing concerns, and entering into a therapeutic partnership. They understand how we're going to work to help them. We're not going to cure them. Our clinical team all has the same philosophy. Communication skills come first when we take on a new member of staff.

I think the key to managing IBS is tailoring the treatment to the patient. That's a problem for doctors in general. They like to have a straight-forward patient who they can give a straight-forward prescription to and get them out the door again. But IBS isn't like that. Patients come in different guises: constipation, diarrhea, incontinence, bloating. A lot of patients will put their non-colonic symptoms top of the list: back ache, feeling tired, feeling sick, nausea, and gynecological symptoms. So the doctor needs to go through all these symptoms and find out which are important for the patient.

Patients usually are reluctant to tell me more than 2 or 3 symptoms; they are used to doctors turning off as soon as they mention more than a few. Nonetheless, often I will have drawn out 7 or 8 symptoms from a patient and I'll ask, "If I can only get rid of one of those symptoms, which one will it be?" That will give me a feel for where we need to go. And then, depending on their primary symptom, we'll work with that first.

**Diarrhea** – So if it’s diarrhea, OK loperamide, let’s try that. And if they say, “Oh I’ve tried it and it hasn’t helped” I’ll ask if they’ve tried it in a big enough dose? Or others will say, “I’ve tried it and it constipates me” so I’ll ask if they’ve tried a tiny dose? And so we adjust the dose. Or I’ll ask if they’ve tried it in a pre-emptive way – that is, before doing an activity, take the loperamide.

**Constipation** – For constipation, I’ll ask how they take laxatives. If they say, “Now and again” I’ll ask if they’ve ever tried taking them all the time. And that is absolutely crucial: you should take a small dose all the time. They will often ask, “What about damaging my bowel?” There is no evidence that laxatives (taken as prescribed) damage the bowel.

So those 2 extremes of bowel habit, diarrhea and constipation, one can usually get a bit of a handle on it. That’s the first step.

**Pain** – Then for the pain we go through all the various antispasmodics. We’ll explore what things bring on the pain; are there things they’re doing wrong dietetically that might be making their symptoms worse.

**Diet, food, and eating** – Just about every patient with IBS says eating makes their symptoms worse. And of course they then think its food and ask for a diet sheet. This is an area that really takes some education because eating – chewing, tasting – can set this off before one has even swallowed the food. In that case it’s not the food – it’s the process of eating. It releases a whole lot of hormones, which then stimulate the gut. The possibility that the process of eating sets off the symptoms and not food itself is a hard thing to accept, because you’ve got to eat. This is very important for doctors to explain.

#### Tip

When it is the process of eating and not the food that sets off symptoms, it may help to eat more frequent and smaller meals. For example, divide your daily food intake into 5 small meals rather than 3 large meals.

We then talk about the common foods that cause problems. In the U.K., fiber tops the list – a high fiber diet is a disaster for a lot of patients. And then chocolate and coffee; they’re the 3 main offenders.

So we start with fiber, the worst one. Leave fiber out of your diet for 3 months, every single bit, not a trace of *cereal* fiber. You can have other forms of fiber such as soluble fiber in fruits in vegetables, but no bran and that sort of insoluble fiber. Do that for 3 months, and then see what happens. If nothing happens, we’ll have to go to plan B.

One should never try a treatment for more than a reasonable period of time. Patients with IBS come to me on vast quantities of treatments, because they’ve been afraid to give any of them up. They think in case it’s doing a bit of good they’d better not stop it. We have a completely different philosophy: if it doesn’t work, dump it. So then we say, if the fiber doesn’t work resume it and try not eating chocolate for 3 months. If that doesn’t work then try not drinking coffee. If you think a particular food upsets

you, try not eating it for a few weeks, or preferably 12 weeks, and see if you improve. For example, fat can set symptoms off – try a low fat diet. Most importantly do it scientifically; do it one at a time so that if you do improve you’ll know which one is the problem food.

We spend a lot of time talking about how to manage diet and see if we can get some improvement. And I would say, as a doctor who sees other people’s failures all day long, I can get at least one-half of my patients improved, as opposed to better, with some form of simple dietary manipulation. The idea is to just play with diet, but it must be done scientifically. It’s not something to go at in a rush. As a doctor I’m going to help my patients to get better – it’s going to take months, not days. And we’ll work at it together.

These are things that can be done, that are at hand. So many of my patients have been to see doctors who say, “You’ve got IBS, there’s nothing I can do for you.” They’ve heard this over and over again. Or, “You’ve got IBS, its all in your head. Go and pull yourself together.” Not helpful to say the least. Yet, with these simple maneuvers I’ve described, we can help.

**Medications** – Once we’ve gone through the diet, we then think about medications. I’ve already mentioned laxatives and antidiarrheals. We have quite a few antispasmodics in the U.K. so we’ll run the gamut of those and see if we can find an antispasmodic that helps. Again, these may be most helpful used in a pre-emptive way. If a meal causes pain, take the antispasmodic beforehand. The drug is more likely to work before the pain happens; once the pain has kicked in it may be harder to control. So that’s another approach we adopt.

If nothing we’ve talked about so far has helped, and by this time we’re at the 2<sup>nd</sup> visit probably, then obviously we have to move forward.

**Antidepressants** – My next port of call would be the antidepressants. This is a can of worms. It has to be explained and approached with sensitivity, because so many patients have been told they’re depressed or they’re “crazy.” Part of my interview, and I emphasize this, is to explain this is *not* a psychological illness. I believe psychological factors can make it worse, but I minimize that at the beginning. If later the patient has not done well with our initial approach, then I gently suggest an antidepressant, not because I think they are depressed, but to help reduce pain and other symptoms.

#### Why use an antidepressant if not for depression?

There are two types of antidepressants: the modern selective serotonin reuptake inhibitors (SSRIs) (e.g., Prozac, Zoloft), and the old fashion tricyclic antidepressants. I don’t use the SSRIs. We exclusively use the tricyclics. There is an understandable resistance because an antidepressant implies depression and they are *not* depressed. I explain to the patient, “Look, I’m going to use an old fashion antidepressant; if I thought you were depressed I’d use a modern SSRI because they are much better for treating depression. I’m going to use it at one-tenth the dose that I would use if I were treating depression.” I explain I will try it very gently with them and if this has not worked for them in 3 months I agree to never mention the word ‘antidepressant’ again.

### **What is it doing? How does an antidepressant work for IBS symptoms?**

It's unlikely at the low dose we use that they work by an activity related to depression. I believe these drugs have some activity that we have yet to know fully about. They work well and there's a pharmacological message there. But, again, these are not cure-alls. I would say 50% of our patients are helped by them. That's not bad when you consider that prior treatment attempts for these patients were abject failures, and now we're helping that group.

### **What about side effects?**

There are minimal problems with side effects at the doses we use. The antidepressant we use is called nortriptyline. And there is one called amitriptyline that has a few more side effects. Nortriptyline, at the dose we use, has virtually no side effects. The way we get around this is to start sometimes at 5 mg, whereas the dosage to treat depression would be 100 and 150 mg – 20 and 30 times higher. We start very gently at the beginning. If we started at the dosage for treating depression, the patient would stop it on the second day. At that higher dose they'll get a dry mouth, feel lethargic, become constipated, and they'll feel terrible. When we start at a low dose and just build it up a little – perhaps 5, 10, and 15 mg – that's enough to help the majority of patients.

If they're troubled by side effects, the three most likely ones are sleepiness, so take it at night; dry mouth, can't do a thing about that; and constipation. For a patient with diarrhea this is not a problem, and if they're a patient with constipation we'll give them a little bit of a laxative. That's not a problem, they don't damage the bowel; we'll just give a small dose of laxative to compensate for the effect of the tricyclic. For those few who will get side effects, the main one will be drowsiness. So then we advise taking it at night and that's usually not a problem. At the end of 3 months if they're not better, we'll stop. If a patient wants to try a higher dose, we'll work with that. But we will not go on and on with it if it's not helping.

### **What do you try next if an antidepressant doesn't help?**

**Hypnotherapy** – In my unit we would next try hypnosis. One of our problems at the moment with our hypnosis unit is we have a massive waiting list. We get referrals from all over the U.K. Before we had such a waiting list it used to be we began treatment with the usual measures, hypnosis, and then antidepressants for the hypnosis failures. Now we try the usual measures, antidepressants, and hypnosis for the antidepressant failures. If a patient doesn't respond to an antidepressant or only partly responds to an antidepressant then we will go for the hypnotherapy program.

Now, because we are so well known, people seek us out for hypnosis. When we first started doing hypnosis, patients were hesitant to try it. It's not like stage hypnosis; this is a technique for helping the mind control the gut. We start with a tutorial about the workings of the gut. Hypnosis is not a psychological treatment in that sense of the word; we're not probing their mind. We are teaching a technique to help the mind, the brain, to control the gut. We explain the link between the two – the brain and the gut are linked and constantly influencing each

other – and what we are doing is opening up that link and teaching the patient a way to take better control of their gut. Then, if they like the idea, we send them into the program. This takes 12 sessions so it's a big investment in time and effort. Before they start we explain all the misconceptions about control. Some hypnotists regress the mind back to childhood. We do *not* go there. We are a forward looking unit; we are not interested in one thing that has happened in their past. This is a big problem because a lot of other hypnotists love going back and digging up all sorts of past issues. We don't do that sort of thing.

### **Aren't there only a few hypnotherapists qualified to treat functional GI disorders?**

Yes, I think this is a big problem. We've made a market in this field for hypnosis. In my country there are a lot of hypnotists that claim to be trained by me and I've never even heard of them. It does have to be focused on the gut. It's a special technique that I developed years ago. All these other hypnotists have been trained to regress people and dig up all kinds of problems. This is the trouble with finding a hypnotist in the Yellow pages, for example. Hypnosis has so much baggage with it. There is so much misconception that the mainstream medical profession and the purchasers of healthcare are terribly skeptical of it. We've got this powerful technique that helps 70% of patients and yet, after 25 years, we're still the only National Health Service unit in the U.K. In the U.S. Olafur Palsson, PsyD at UNC in Chapel Hill, NC has a hypnosis treatment unit.

One other thing about hypnosis that everybody needs to know – people come to my door thinking that I'm going to cure them. It's so important to put it in perspective. Hypnosis only helps about 70% of people. That's good certainly, but if you turn it around that's still 30 of every 100 that we fail with. And at 1,000 a year that's quite a lot of patients. So what we have, and what I think any department that sets up a hypnotherapy unit should have, is a safety net. These people are really hurting. We're the last chance for them and if we fail we've got to provide a safety net. We have what's called our respite program. This is where people go into chronic, supportive care by a specialist nurse. We never let them go, unless they want to go, but we continue caring for them. Because otherwise, they are really lost.

*View videos of Dr. Whorwell talking about these issues at the Video Corner in our online Learning Center at:*  
[www.aboutibs.org/site/learning-center/video-corner](http://www.aboutibs.org/site/learning-center/video-corner).

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