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GASTROENTEROLOGY BOARD REVIEW MANUAL

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The *Hospital Physician Gastroenterology Board Review Manual* is a study guide for fellows and practicing physicians preparing for board examinations in gastroenterology. Each manual reviews a topic essential to the current practice of gastroenterology.

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Irritable Bowel Syndrome and Other Nongastrointestinal Functional Disorders

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Irritable Bowel Syndrome and Other Nongastrointestinal Functional Disorders

Ami D. Sperber, MD, MSPH

INTRODUCTION

The irritable bowel syndrome (IBS) is the best known of the functional gastrointestinal tract disorders, all characterized by chronic or recurrent gastrointestinal tract symptoms not explained by structural abnormalities, infection, or metabolic changes on routine testing.¹ Patients with IBS suffer from chronic abdominal pain, usually in the lower abdomen, with a disturbed bowel pattern. The latter can be constipation, diarrhea, or alternating constipation and diarrhea. Although the range of prevalence rates for IBS in studies conducted throughout the world is broad (2%–25%), in the Western world it is generally agreed that 10% to 20% of adults meet diagnostic criteria for IBS.^{2,3} Approximately 60% to 70% of IBS patients are women,⁴ making it a serious women's health concern.

The burden of IBS on society is substantial. As many as 28% of referrals for gastroenterology consultations are for IBS.⁵ Absenteeism rates from work or school are significantly higher among patients with IBS than healthy individuals.⁴ The cost of health services for patients with IBS is very high.^{6,7} Although the overall impact of IBS in terms of daily physical and emotional functioning, interpersonal relationships, and psychologic distress is probably immeasurable, disease-specific health-related quality-of-life instruments have been developed in an attempt to estimate its individual and societal impact.^{8,9} When associated with other, nongastrointestinal, functional disorders in the same patient, the burden on health care resources and the negative impact on quality of life is often increased.^{10,11}

CASE STUDY

INITIAL PRESENTATION

A 32-year-old woman is referred for consultation. She complains of lower abdominal pain, alternating constipation and diarrhea, and abdominal distention

with flatulence. She has had these symptoms on and off for as long as she can remember. Her appetite is normal, but she limits the food that she eats. Her weight fluctuates without any significant weight loss. She also suffers from heartburn and a feeling of early satiety after some meals.

The patient is single and lives with her mother. She has tried many jobs but is embarrassed that she has to take a lot of time off because of her abdominal pain and that when she is at work she has to go to the bathroom often. Her social life is very limited. She does not sleep well and is tired when she wakes up in the morning.

She has consulted with numerous physicians about these problems over the years and was told that she has IBS. She has undergone multiple diagnostic procedures (Table 1) and tried different treatments. The doctors have told her “there is nothing wrong with her” or that “it’s all in her head” and she has to “learn to live with it.”

• How is IBS diagnosed?

DIAGNOSTIC CRITERIA FOR IBS

There is no specific diagnostic test for IBS nor any pathognomonic sign or symptom. For many years IBS was considered a “diagnosis of exclusion.” This led to the conduct of multiple, unnecessary, and potentially dangerous diagnostic procedures. Over the past 15 years, expert working groups have developed symptom-based, consensus diagnostic criteria for IBS and the other functional gastrointestinal disorders.¹² Known as the Rome criteria (Rome III in its latest version; Table 2), these criteria have contributed to positive developments in the field of functional gastrointestinal disorders. IBS can now be confidently diagnosed on the basis of a cluster of symptoms, a minimal diagnostic work-up,¹³ and the absence of “red flags” (Table 3). Red flags are historical information or findings on diagnostic tests that lead the treating physician to believe that another diagnosis has to be considered. If any red flag is present, the work-up has to be expanded to rule out other possible causes.