WEBINAR

CHRONIC ABDOMINAL PAIN: COULD IT BE IRRITABLE BOWEL SYNDROME?

Thursday, 25 June 2020
7.00 – 8.00 pm AEST
CHRONIC ABDOMINAL PAIN: COULD IT BE IRRITABLE BOWEL SYNDROME?

The interdisciplinary discussion will focus on:

- when imaging is appropriate in patients with chronic abdominal pain
- diagnosis of irritable bowel syndrome
- evidence-based dietary and psychological therapies
A CASE: MELISSA IS STRUGGLING WITH ABDOMINAL SYMPTOMS

- Melissa is a 42-year-old woman
- Recent change 9-month history of abdominal pain, usually crampy, usually relieved by using her bowels
- Often has looser stools, 3 or 4 days a week
- Worse in the last 3 months with some stresses at home
- Minimal help from trials of dairy and wheat exclusion
- Her grandmother recently died of bowel cancer, aged 89
- She is really worried about something serious causing this
- She thinks she might need a scan or a colonoscopy
RED FLAGS TO EXCLUDE

- Age over 50 years, no previous colon cancer screening and presence of symptoms
- Recent change in bowel habit in people over 50 years of age
- Evidence of overt gastrointestinal bleeding (ie, melaena or haematochezia)
- Nocturnal pain or passage of stools
- Unintentional weight loss
- Family history of colorectal cancer or inflammatory bowel disease
- Palpable abdominal mass or lymphadenopathy
- Evidence of iron deficiency anaemia on blood testing
- Positive test for faecal occult blood

ROLE OF IMAGING

- Diagnostic imaging is rarely indicated as an initial investigation of chronic abdominal pain
  - may be indicated as an initial investigation of:
    - right upper quadrant pain
    - renal pain
    - suspected Crohn disease
    - and to rule out abdominal vascular disease.

- CT is rarely indicated for patients with chronic undifferentiated abdominal pain

- When indicated, the modality depends on presentation, including:
  - the site of pain
  - history
  - findings of physical examination
  - results of pathology tests (if indicated).
**INVESTIGATION BASED ON CLINICAL FEATURE**

<table>
<thead>
<tr>
<th>Presenting feature</th>
<th>Initial imaging</th>
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<tbody>
<tr>
<td>Right upper quadrant/biliary</td>
<td>Ultrasound</td>
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<tr>
<td>Dyspepsia</td>
<td>Not indicated: endoscopy if red flags</td>
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<tr>
<td>Renal/loin pain</td>
<td>Ultrasound or unenhanced CT</td>
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<td>Bowel obstruction (non-acute)</td>
<td>Plain abdominal X-ray</td>
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<tr>
<td>Pelvic/suprapubic/ iliac fossa origin</td>
<td>Young adult: ultrasound</td>
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<td></td>
<td>Older patient: CT or ultrasound</td>
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<tr>
<td>Suspected abdominal aortic aneurysm</td>
<td>Urgent referral and ultrasound or CT</td>
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<tr>
<td>Suspected functional GI disorders</td>
<td>Not indicated: colonoscopy if red flags</td>
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IRRITABLE BOWEL DISORDER – DIAGNOSIS

Rome IV diagnostic criteria

Recurrent abdominal pain; ≥ 1 day per week in the past 3 months associated with two or more of the following criteria:

- related to defecation
- associated with a change in frequency of stool
- associated with a change in form (appearance) of stool

\[a\] Criteria fulfilled for the last 3 months with symptom onset at least 6 months before diagnosis.

Lacy et al, Gastroenterology 2016; 150: 1393-1407.e5.
THE BRAIN-GUT-BACTERIA AXIS

Big brain
► Neurotransmitter release
► Hormone release
► Instructs the bowel how to function

Autonomic nervous system
► Sends messages from the “big brain”
► Tells the gut to speed up / slow down
► Tells the gut how sensitive it should / shouldn’t be

The immune system
► Changes the sensitivity of the gut

Bacteria
► Release hormones
► Directly act on the gut surface to change function
► Release neurotransmitters

“Gut” brain
► Responsible for the day-to-day function of the bowel
► Only organ of the body that can function without the “big brain”
WHAT CAUSES FUNCTIONAL GI DISORDERS?

Risk factors
- Genetics
- Gut bacteria
- Pelvic floor problems

Trigger factors
- Psychosocial stressors
- Mood
- Infection
- Inflammation
- Surgery

Changes in bowel function

Symptoms
- Diet
- Medications

Ongoing factors
- Stress
- Psychological trauma
- Early life events

Symptom-related anxiety

Adapted from Mayer et al. Am J Physiology 2001
## INVESTIGATIONS

<table>
<thead>
<tr>
<th>Limited investigations</th>
<th>Not recommended</th>
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</thead>
<tbody>
<tr>
<td>- Full blood count</td>
<td>- Ultrasound</td>
</tr>
<tr>
<td>- CRP</td>
<td>- Sigmoidoscopy</td>
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<tr>
<td>- ESR</td>
<td>- Colonoscopy</td>
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<tr>
<td>- Coeliac serology</td>
<td>- Double-contrast barium enema</td>
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<tr>
<td>- Iron studies</td>
<td>- Thyroid function tests</td>
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<tr>
<td>- Albumin</td>
<td>- Hydrogen breathing tests</td>
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<tr>
<td>- Faecal calprotectin</td>
<td>- Stool tests for pathogens</td>
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<td>- Stool microscopy, culture and sensitivity</td>
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<td>- Parasite if overseas travel</td>
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<tr>
<td>- Bowel cancer screening</td>
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Radiologic imaging is not required in patients fulfilling Rome IV criteria and red flags are not present.
MANAGEMENT OPTIONS

- **Dietary therapies**
  - low FODMAP diet
  - general dietary advice
  - fibre and probiotics

- **Psychological therapies**
  - cognitive behavioural therapy
  - hypnotherapy

- **Medicines**
  - antispasmodics
  - antidepressants
  - complementary medicines

Basanayke. Aust Prescr 2018;41:145-9
DIETARY THERAPY – LOW FODMAP DIET

Low fermentable oligosaccharides, disaccharides, monosaccharides and polyols (FODMAP)

- Significantly reduces IBS symptoms compared to a regular Australian diet
- Symptoms of pain and bloating respond better
- Current recommendations are for a qualified dietitian to supervise the diet

- Phase 1 – FODMAP intake is restricted for 2–6 weeks
- Phase 2 – Low FODMAP diet is continued.
- Phase 3 – Well-tolerated FODMAPs are reintroduced

Basanayke. Aust Prescr 2018;41:145-9
Halmos E, Gibson PR. J Gastroenterol Hepatol 2019;34:1134-1142.
DIETARY THERAPIES

- **Probiotics**
  - efficacy varies and is dependent on the bacterial strains used

- **Fibre**
  - getting enough fibre is a common problem
  - dietitian will provide advice on how to increase fibre naturally through low FODMAP foods
  - if necessary, dietitian will provide advice about suitable fibre supplements
  - choose low FODMAP and low-fermentable fibre options (eg oat bran, rice bran, linseeds/ flaxseeds/ kiwi fruit)

- **General dietary advice**
  - eating smaller frequent meals, avoiding trigger foods, and avoiding excess alcohol and caffeine.

Basanayke. Aust Prescr 2018;41:145-9
PSYCHOLOGICAL THERAPIES

Psychological therapies are effective in reducing IBS symptoms and psychological distress and increasing quality of life

- Gut-focused hypnotherapy – directly affects visceral sensitivity and gastrointestinal motility and improves symptoms over the long term.
- Cognitive behavioural therapy – global effect with most evidence
MEDICINES

- Antispasmodics – targets pain only; modest effects with adverse effects

- Antidepressants – work by manipulating visceral hypersensitivity and abnormal central pain sensitisation
  - tricyclics – recommended for patients with diarrhea
  - serotonin reuptake inhibitors – comorbid depression

- Motility agents

- Complementary medicines – peppermint oil, iberogast
RESOURCES

Patients

- [https://www.monashfodmap.com](https://www.monashfodmap.com)
  - Low FODMAP Diet App,
  - Low FODMAP Diet Booklet,
  - Online training
  - FODMAP Dietitians Directory

- [https://www.gesa.org.au](https://www.gesa.org.au)
  - Health information factsheets

Health professionals

  - Diagnostic Online Tool for GPs

- [https://www.gesa.org.au](https://www.gesa.org.au)
  - Resources/clinical guidelines

  - Resources and tools