LETTERS

Letters to the Editor

Irritable bowel syndrome diagnosis

Aust Prescr 2019;42:84
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I found some of the statements in the article about irritable bowel syndrome confusing.[1]

First, there is the statement that 'irritable bowel syndrome is not a diagnosis of exclusion'. The article then says that the diagnosis is made on symptoms fulfilling the Rome IV diagnostic criteria and the absence of red flags, which include the absence of iron deficiency anaemia and a negative faecal occult blood test. It also recommends testing for urea and electrolytes, C-reactive protein, liver function tests, faecal calprotectin and that testing for coeliac disease should be considered.

The article also states 'the symptoms of irritable bowel syndrome share similarities with inflammatory bowel disease and gastrointestinal malignancies'. This statement suggests that the presence of symptoms alone cannot make a positive diagnosis of irritable bowel syndrome. There are no features that are unique only to irritable bowel syndrome.

Second, there is also the confusing statement 'There is no role for a faecal occult blood test to exclude gastrointestinal malignancy in patients with symptoms of irritable bowel syndrome'. However, the absence of red flags mandates a negative faecal occult blood test (see Box 2 of the article).

How can irritable bowel syndrome be a positive diagnosis when the diagnostic process involves the exclusion of alternative, more sinister diagnoses?

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REFERENCE

1. Basnayake C. Treatment of irritable bowel syndrome. Aust Prescr 2018;41:145-9. https://doi.org/10.18773/austprescr.2018.044

Chamara Basnayake, the author of the article, comments:

The letter highlights the common diagnostic dilemmas in irritable bowel syndrome. As the paper focused on treatment, the nuances and controversies surrounding diagnosis were not detailed.

The diagnosis is made on the basis of symptoms obtained from the patient's history, as described by the Rome criteria, in the absence of red flags. When the symptoms are unclear, or there is an obvious red flag in the history, further testing is recommended.

Diagnostic testing is not required to rule red flags in or out. Box 2 of the article was titled 'Red flags that require further testing or specialist assessment'. It does not include conditions that require ruling out in order to diagnose irritable bowel syndrome. Red flags prompt the doctor to investigate the potential for alternative, more sinister diagnoses.

Faecal occult blood testing has been proven exclusively for screening populations to improve the early detection of colorectal cancer. It is not helpful as a diagnostic tool in people with symptoms. A false-negative faecal occult blood result in symptomatic individuals may inappropriately reassure doctors not to proceed with further investigations.[1]

It is true that there are many similarities in the symptoms of organic and functional gastrointestinal disorders. There is no unique symptom that positively diagnoses irritable bowel syndrome. Similarly, chest pain is not solely a symptom of ischaemic heart disease. An appropriate history should include an assessment of risk factors for organic gastrointestinal conditions, including a family history of gastrointestinal malignancies, or coeliac disease. The use of non-invasive testing is at the discretion of the doctor assessing a patient. If a red flag is identified on non-invasive testing, endoscopies should be arranged.

REFERENCE

1. Friedman A, Chan A, Chin LC, Deen A, Hammerschlag G, Lee M, et al. Use and abuse of faecal occult blood tests in an acute hospital inpatient setting. Intern Med J 2010;40:107-11. https://doi.org/10.1111/j.1445-5994.2009.02149.x

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