Supporting community patients with irritable bowel syndrome (IBS)

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Irritable bowel syndrome (IBS) is a chronic, relapsing and often life-long disorder affecting 10.5% of the UK population (Wilson et al, 2004). It is twice as common in women as in men, and most commonly presents in people aged between 20 and 30 years (National Institute for Care and Health Excellence [NICE], 2008). In the UK, IBS is estimated to cost the NHS over £200 million per year (Akehurst et al, 2002), and represents a major proportion of the gastrointestinal cases in both primary and secondary care (Thompson et al, 2000). As IBS is very common, cost-effective management of the condition is important.

The diagnostic criteria for IBS include any person who exhibits the following symptoms for more than six months (NICE, 2008):
- Abdominal pain or discomfort
- Bloating
- Change in bowel habit.

To diagnose IBS safely, it is imperative that alarm, or red-flag symptoms for other gastrointestinal diseases are ruled out (NICE, 2008). These alarm symptoms may indicate other serious gastrointestinal diseases such as colon cancer, coeliac disease, ulcerative colitis or Crohn’s disease and need medical assessment. Alarm symptoms include (NICE, 2008):
- Unintentional weight loss
- Rectal bleeding
- Family history of bowel or ovarian cancer
- Change in bowel habit to looser stools for longer than six weeks in persons over 60 years of age.

There are three acknowledged subtypes of IBS, which are based on the presence of abdominal pain in addition to the dominant bowel symptoms that patients may experience (NICE, 2008):
- Constipation predominant (IBS-C)
- Diarrhoea predominant (IBS-D)
- A mixture of the two (IBS-M).

One-third of patients with IBS are thought to have IBS-C, suffering from chronic abdominal pain, bloating and constipation (Rao et al, 2012).

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- Continence
- Irritable bowel syndrome
- Chronic conditions

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DIAGNOSIS AND MANAGEMENT

One of the main aims of IBS management is to provide a positive diagnosis to rule out any other gastrointestinal cause of the symptoms (NICE, 2008). Those with ‘red flag’ indicators should be referred to secondary care for further investigation such as endoscopy (NICE, 2008).

In the absence of alarm symptoms, IBS can be confirmed with some simple investigations to exclude more serious disease such as colon cancer, coeliac disease, ulcerative colitis or Crohn’s disease. These include blood tests such as full blood count (FBC), C-reactive protein (CRP) and coeliac antibodies (tissue transglutaminase [tTG]) (NICE, 2008).

Only 19% of patients are diagnosed at their first consultation and 56% of patients may require up to five consultations before a diagnosis is confirmed (Hungin et al, 2003). IBS can be difficult to diagnose because it can present with inconsistent symptoms that mimic organic disease. Patients may require extensive investigation and consultation before a final diagnosis is reached.

IBS accounts for 20–50% of referrals to gastrointestinal clinics within secondary care, and it is estimated that up to 50% of those diagnosed with IBS are referred to hospital for other tests, such as endoscopy (British Society of Gastroenterology, 2013).

Patients are often fearful that they have conditions such as inflammatory bowel disease (IBD) or cancer. Some studies have shown that this fear is often still present even at the end of consultations, which may contribute to patients returning so often (Thompson et al, 2000). This is why reassurance and explanation from all clinicians is so important (Thompson et al, 2000).

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CURRENT PHARMACOLOGICAL TREATMENT OPTIONS

Most current treatments are aimed at relieving individual symptoms (NICE, 2008). Many of these are targeted at treating either diarrhoea or constipation and have varying levels of success depending on the patient and the nature of their IBS. This can mean that patients often receive multiple treatments for different symptoms (NICE, 2008).

New treatments for IBS can improve patients’ quality of life by targeting specific symptoms including abdominal pain, bloating and constipation. As such, they represent a welcome development in the management of the condition (Table 2).

DIETARY AND LIFESTYLE ADVICE

The chronic nature of IBS requires good basic information about dietary and lifestyle adjustments. Self-management is also stressed.

NICE (2008) provides clear general advice about diet:

- Have regular meals and take time to eat
- Avoid missing meals and long gaps between eating
- Restrict tea and coffee to three cups per day
- Limit high-fibre foods (wholemeal, cereals high in bran, brown rice)
- Those suffering from bloating should try oats and linseed (up to one tablespoon per day).

There is some evidence that probiotics can improve the symptoms of IBS (Nikfar et al, 2008), and NICE guidance recommends that patients try a four-week course. The reasons for probiotic efficacy are unclear, but may relate to a rebalancing of normal gut flora. However, NICE does not specify which particular strain of probiotic should be used (NICE, 2008).

COMPLEMENTARY THERAPIES

As with many chronic illnesses, patients often seek out complementary therapies to help them manage their symptoms. However, in the case of IBS there is little, or no, published evidence for these. Indeed, NICE guidance recommends that acupuncture and reflexology are not to be encouraged (NICE, 2008).

There is good evidence for the role of hypnotherapy, however (Houghton et al, 1996). Specialist gut-directed hypnotherapy uses visualisation and deep relaxation targeted at the bowel. Studies have shown it to be beneficial, not only reducing symptoms, but also improving quality of life (Houghton et al, 1996).

THE ROLE OF COMMUNITY NURSES IN IBS

Nursing support is important in the management of IBS. Many patients feel that their illness is not taken seriously enough by clinicians (British Society of Gastroenterology,
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by increasing waiting times and care referrals has been prompted the diagnosis of IBS. Other organic diseases and confirm complete investigations, exclude and referrals to secondary care to visits to primary care professionals, such as community nurses, have the benefit of greater familiarity with the patient and previous consultations to refer to and they can view symptoms in context, rather than in isolation. For example, where patients have developed constipation, community nurses are able to view this change in bowel habit with reference to an individual’s medication history, dietary changes and mobility, etc.

Supporting patients to self-care, using clear, validated patient education materials will lead to a greater acceptance of IBS as a chronic condition. Self-management of long-term conditions such as IBS is acknowledged to be a fundamental part of helping patients live with ongoing symptoms and nurses can take a lead in this, using their relationship with patients to help them manage their condition.

Encouraging patients to self-care
The IBS Network provides dedicated support to people living with IBS in the UK. The Network aims to help them, their families and carers to manage their IBS and achieve an improved quality of life. While the Network’s online resource (http://www.theibsnetwork.org) includes fact-sheets and other information, it has also developed a self-care management programme that members can access online. There is an interactive programme for the management of IBS, which consists of 12 modules that have been adapted for individual study, or which can be used by self-help groups. The self-help module includes:
- Have I got IBS: what is IBS; what else could it be?
- How do I know if it is anything more serious?
- What are the causes of IBS?
- Diet: food allergy, intolerance, food and mood, pre- and probiotics
- Stress: reducing fear and panic, managing anger/depress, psychological therapies
- Medical: when to see a doctor, medical treatments
- Therapies: hypnotherapy, counselling and psychotherapy, nutrition, and herbal therapy
- Symptom management: constipation, diarrhoea, bloating, abdominal pain, symptom tracker, bowel-directed relaxation module.

The course aims to help individuals to understand and self-manage their IBS.

CONCLUSION
Community nurses can play a major role in improving the management of people with IBS in the community setting.

Firstly, it is important to recognise the recommendations from both NICE and the British Society of Gastroenterology, which stipulate that the management of most patients with IBS can take place within a primary care environment and does fall within the community nursing remit (NICE 2008; British Society of Gastroenterology, 2013).

It is also important to enable a positive diagnosis by recognising the chronic nature of IBS and supporting patients to self-manage, answering questions and directing them to self-management resources.
Enhancing IBS services, including providing access to specialist and practice nurses, GPs with a special interest or secondary care gastroenterology services, is also vital, as is developing local pathways in partnership with secondary and primary care services to assist in triaging referrals and help with symptom management.

Ensuring continuity of care, as well as providing advice and support for people with IBS can help them overcome the burden of the condition. Helping patients achieve a better quality of life should be a specific aim of community nurses.

Finally, community nurses should aim to take an active role in the management of IBS patients by developing care pathways, which take into account new treatments.

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REFERENCES


NICE (2008) Irritable Bowel Syndrome in Adults. NICE, London


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