Management of Irritable Bowel Syndrome (IBS)

NHS Tayside

You must provide:

- A positive diagnosis of IBS (See Assessment and Diagnosis Pathway)
- An explanation of possible contributing factors i.e. stress, lifestyle, diet, recent illness
- Clarification of and possible treatment outcomes - it is unlikely symptoms will be controlled by pharmacological treatment alone, **they MUST be used in conjunction with dietary/lifestyle advice including psychological strategies when indicated.**

All patients should be issued with 1st line dietary advice. You can access 1st line IBS dietary advice here www.bda.uk.com/foodfacts/IBSfoodfacts.pdf

Do not issue Low FODMAP advice - this requires support and guidance from a Specialist Dietitian. If further support is required consider a referral to the Nutrition and Dietetic Service

1st line Treatment	Rationale
Establish regular balanced meals; where possible cook from fresh reducing intake of processed foods	Poor dietary structure and reliance on processed foods may contribute to symptoms due resistant starch
Cut down on fatty foods; limit large portions of high-fat foods, particularly those with limited nutritional value i.e. high-fat fast food	Fat delayed gastric emptying Poor transport of gases = worsening bloating/reflux Increased intestinal permeability = accelerated transit in large bowel
Limit intake of spicy foods	Possibility of capsaicin causing burning sensation and accelerated gut transit time. Need to consider other ingredients high in FODMAPs i.e. onion, garlic, pulses
Dietary fibre: spread intake over meals and snacks each day as tolerated: ➢ Fruit and veg 2-3 portions of each ➢ Aim for 3 portions of wholegrains ➢ 1-2 portions of nuts/seeds/legumes	Not enough = constipation Too much = increased gas production & diarrhoea *Patient should be advised to decrease or gradually increase for a 4 week trial depending on symptoms*
Fluid: aim for 1.5-2 litres of fluid per day - Mostly water	Maintain hydration Promotes normal gut function and helps to prevent constipation
Reduce intake of alcohol; at least 2 alcohol free days per week and no more than 1 standard drink a day e.g. ➢ A small bottle of low strength beer ➢ A small glass of wine ➢ A small measure of spirit ➢ Or exclude for 4 week trial	Oesophageal sphincters relax = more reflux Increased gastric acid secretion and peristalsis Mucosal inflammation Reduced water and sodium absorption = change in intestinal permeability
Limit intake of caffeine-containing drink/food a day e.g. ➢ Max 2 mugs of tea or coffee (not strong) ➢ or switch to decaffeinated varieties ➢ or exclude for 4 week trial	Increases stress hormones Increased gastric acid secretion Increased colonic motor activity
Avoid all sweeteners ending in OL plus isomalt	May help to control loose stools, wind/bloating symptoms
Reduce intake of fizzy drinks	May help to control wind/bloating
Take time when eating and chew food thoroughly; avoid eating late at night; eat at table	Eating quickly and less chewing may = poorer absorption, increased air consumption Late night eating = impact on digestion
Advise on correct toileting position and good habits	Delaying using toilet/ not responding to your bowel's natural pattern = worsening IBS symptoms Poor toileting positioning = affect constipation
Take regular exercise as tolerated Take time to relax	Can help control stress & anxiety Correlation with gut/brain axis = impact on symptoms.

Pharmacological Treatment if required

Choice of single or combination of medications is based on the nature and severity of predominant symptoms.
Medicines are second line to dietary and non-medicine approaches overleaf

1st line pharmacological treatment to consider

If pain predominant consider Antispasmodic	If IBS-Diarrhoea (D) predominant consider antimotility	If IBS-Constipation (C) predominant consider laxative
Mebeverine 135mg tablets three times a day PRN – preferably taken 20 minutes before meals *Review after 1 month if no improvement discontinue.* *There is unlikely to be any benefit in changing to an alternative antispasmodic*	**Loperamide** 2mg capsules 2-4 a day. Max. 16mg daily PRN *Using codeine long-term for loose stool risks dependency and tolerance*	**Macrogol (Laxido)** 1 sachet once or twice daily in 125ml water increased or decreased as required **Ispaghula Husk** 1 sachet twice daily in at least 300ml of water *(Should only be prescribe if unable to increase intake of dietary fibre –* **CAUTION** *may contribute to bloating and wind)* **Avoid Lactulose**
	Advise how to adjust dose according to clinical response. The aim is to produce a soft, well formed stool (Bristol stool form scale type 4)	

If no improvement in symptoms and not already done so, consider a referral to Nutrition and Dietetics

2nd line pharmacological treatment (TCA and SSRI off label for IBS)

If pain and IBS-D predominant consider TCA	If pain and IBS-C predominant consider SSRIs
Amitriptyline 10mg once daily at night *Review after 1 week and if needed up-titrate dose slowly* **to a maximum 50mg once daily** *Review ongoing requirement monthly and once stabilised every 6 months*	**Fluoxetine** 20mg once daily OR **Citalopram** 10mg-20mg once daily *Review monthly and once stabilised every 6 months*

If IBS-C treatment with laxative +/- antispasmodic for 3-6 months with a poor response consider: *(only licensed for adults with moderate to severe IBS)*

Linaclotide 290mcg once daily (at least 30 minutes before a meal)
Review after 1 month to check for initial response
Good response = continue and once stabilised review in 6 months (clinical trial data is limited to 6 months).
No/Poor response = stop if no improvement in symptoms (consider TCA/SSRIs if not already tried)

CAUTION

- Advise patients to seek medical advice if diarrhoea is severe or persists for > 1 week, or if signs of lower GI bleeding occur.
- Use with caution in elderly & patients at risk of dehydration, dizziness, hypotension, hypokalaemia, reduced mobility, lower GI bleeding and patients prone to a disturbance of water or electrolyte imbalance/control.
- Use with caution in patients on concurrent PPIs, laxatives, NSAIDs, oral contraceptives or levothyroxine (or other oral medicines with a narrow therapeutic index, as their efficacy maybe reduced).

NB: IBS – C where possible, avoid medicines which can cause constipation e.g. opioids, antimuscarinics

Produced by IBS Prescribing Working Group
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