American Gastroenterological Association Medical Position Statement: Irritable Bowel Syndrome

This document presents the official recommendations for the American Gastroenterological Association (AGA) on irritable bowel syndrome. It was approved by the AGA Patient Care Committee on October 5, 1996, and by the AGA Governing Board on November 10, 1996.

The following guidelines were developed to assist the physician in the diagnosis and management of patients with irritable bowel syndrome (IBS). They emanate from a comprehensive review of the medical literature pertaining to IBS. The IBS is a combination of chronic or recurrent gastrointestinal symptoms not explained by structural or biochemical abnormalities, which is attributed to the intestines and associated with symptoms of pain and disturbed defecation and/or symptoms of bloatedness and distension.

Diagnosis

Symptom-Based Criteria

A diagnosis is based on identifying positive symptoms consistent with the condition (Table 1), and excluding in a cost-effective manner other conditions with similar clinical presentations.

Evaluation

A physical examination and the following studies are recommended for routine evaluation: complete blood count; sedimentation rate; chemistries; stool for ova, parasites, and blood; and flexible sigmoidoscopy or colonoscopy or barium enema with sigmoidoscopy if older than 50 years. Other diagnostic studies should be minimal and will depend on the symptom subtype. For example, in patients with diarrhea-predominant symptoms, a small bowel radiograph to rule out Crohn’s disease, or lactose/dextrose H₂ breath test, and if negative, a therapeutic trial of olperamide. For patients with constipation-predominant symptoms, a therapeutic trial of fiber supplement may be all that is required. For patients with pain as the predominant symptom, a plain abdominal radiograph during an acute episode to exclude bowel obstruction and other abdominal pathology, and if negative, a therapeutic trial of an antispasmodic may be indicated. The evaluation strategy may be modified by other factors, such as the duration and severity of symptoms, changes in symptom type or severity over time, and demographic or psychosocial factors.

Treatment can then be started and the patient’s condition reevaluated in 3–6 weeks. If treatment is unsuccessful, or if further evaluation seems needed, additional studies based on symptom subtype can be performed at that time. Some tests may require referral to a major medical center.

Treatment

The treatment strategy is based on the nature and severity of the symptoms, the degree of physiological disturbance and functional impairment, and the presence of psychosocial difficulties affecting the course of the illness. Patients with mild symptoms usually respond to education and reassurance and simple treatments not
Table 1. Rome Diagnostic Criteria for Irritable Bowel Syndrome

At least 3 months of continuous or recurrent symptoms of the following:
Abdominal pain or discomfort
- Relieved with defecation, or
- Associated with a change in frequency of stool, or
- Associated with a change in consistency of stool
Two or more of the following, at least on one-fourth of occasions or days:
- Abdominal pain or discomfort
  - Relieved with defecation, or
  - Associated with a change in frequency of stool, or
  - Associated with a change in consistency of stool
- Altered stool frequency (for research purposes altered may be defined as more than three bowel movements each day or less than three bowel movements each week), or
- Altered stool form (lumpy/hard or loose/watery stool), or
- Altered stool passage (straining, urgency, or feeling of incomplete evacuation), or
- Passage of mucus, or
- Bloating or feeling of abdominal distention

Psychotropic medication. Antidepressants are recommended for severe or refractory symptoms of pain, and may be helpful for less severe symptoms. They have neuromodulatory and analgesic properties independent of their psychotropic effect, and these effects may occur sooner and in lower dosages than is the case when these drugs are used for treatment of depression. Most studies have evaluated treatment with tricyclic antidepressants (e.g., amitriptyline and desipramine), rather than SSRIs (e.g., fluoxetine, paroxetine, sertraline) in patients with IBS, and no comparative studies have been performed. However, the selective serotonin reuptake inhibitors are now in common use because of their low side effect profile and better safety than the tricyclic antidepressants. Anecdotal evidence suggests that they may be as effective as the trichloroacetic acids.

Anxiolytics are generally not recommended because of weak treatment effects, a potential for physical dependence, and interaction with other drugs and alcohol.

References


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