IBSnet
THE FUNCTIONAL BOWEL NETWORK

- ✓ *Platform to bring together medical professionals dedicated to functional bowel disease (CH and AU)*
- ✓ *Know-how exchange about research ideas, practice and knowledge*
- ✓ *Excellent interdisciplinary networking opportunities*
- ✓ *Homepage of SwissNGM (official country representative of the European Society of Neurogastroenterology and Motility (ESNM))*

Find us here: ***www.IBSnet.ch***

IBS – How can we reduce the time to diagnosis?

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Path to diagnosis

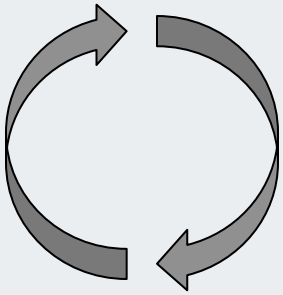
Direct way

The usual suspects...

Organic disease: cancer...

High clinical relevance

Diagnostic „roundabouts“



?

Functional disease

High prevalence

Epidemiology IBS

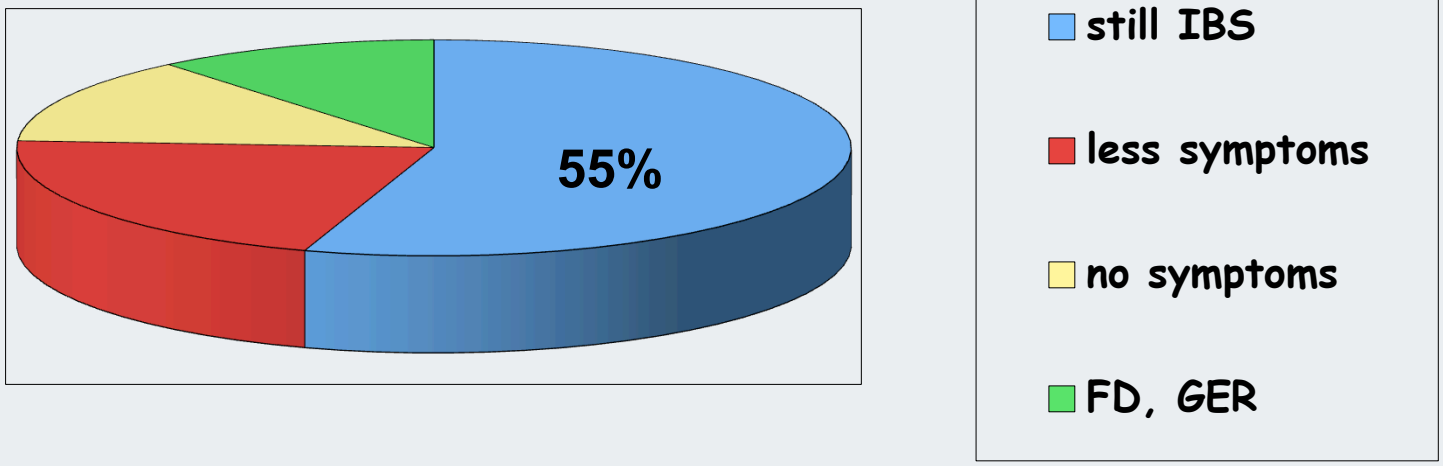
- Frequent chronic GI-disease
- Incidence 2-70 / 1000 patient years
- Prevalence variable depending on criteria of diagnosis
  → 7% pooled
- IBS-D and IBS-M > IBS-C, change of sub-groups frequent
- W:M = approx. 1.5-2:1, most frequent during 3. decade, with age less distinctive gender differences
- High percentage of psychiatric comorbidity (e.g. somatoform disorders (15-48%) and/or anxiety disorders, depression)
- Clearly reduced quality of life, high costs

Am J Gastroenterology 2009; 104:S1 – S35
Layer P et al. S3-Leitlinie, Z Gastroenterol 2011; 49: 237–293

Natural History of Disease

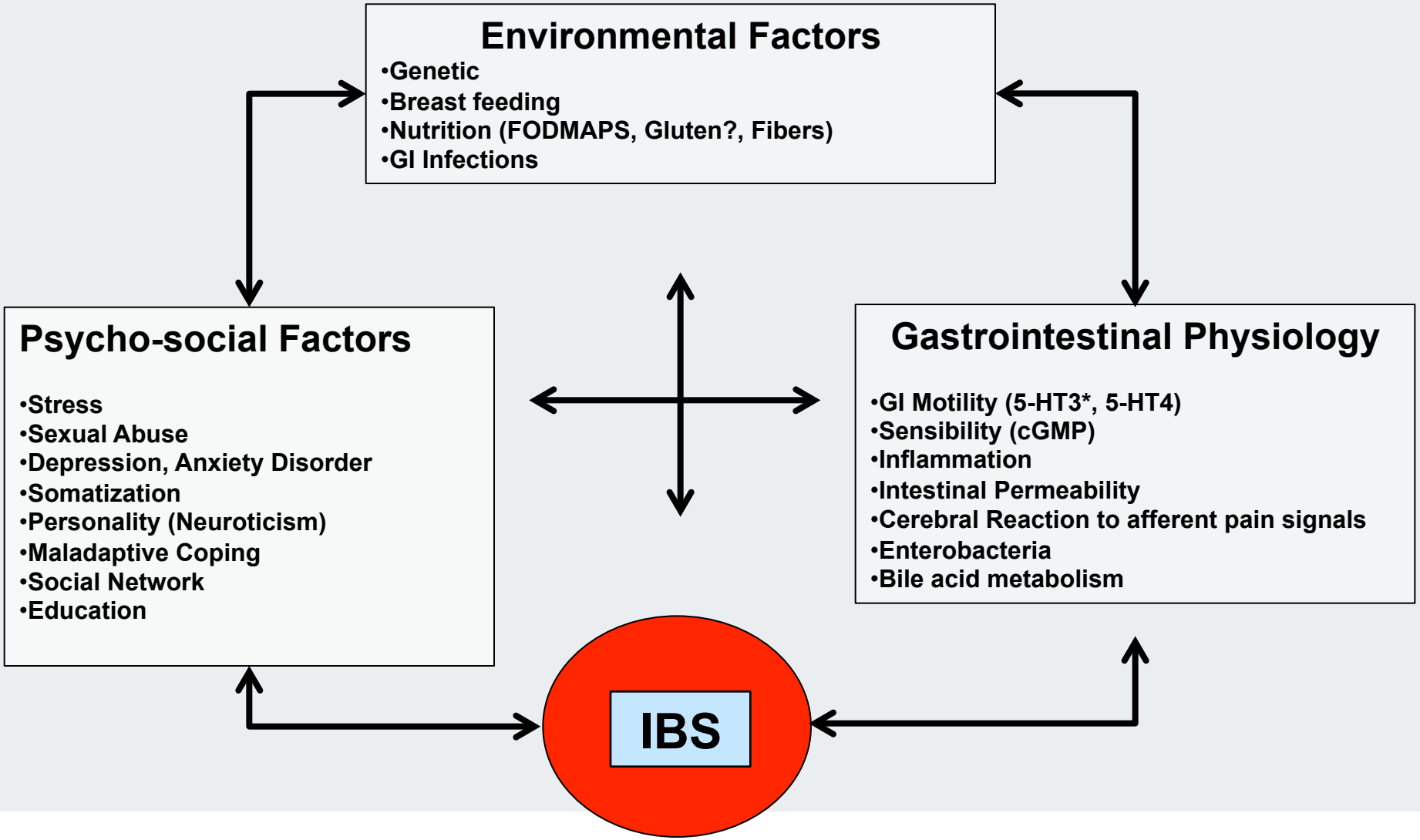
- After diagnosis waxing/waning symptoms over several years
- Change of symptoms possible over time
  - e.g. changes of stool consistency

Prognosis after 7 years?



Spiller R. Gut 2007;56:1770-98
Agreus L. Am J Gastroenterol 2001;96:2905-14

Pathogenesis IBS



Modified fromr: Sayuk GS, Gyawali CP, Irritable Bowel Syndrome: Modern Concepts and Management Options, The American Journal of Medicine (2015)

IBS-Definition

C1. Irritable Bowel Syndrome

*Diagnostic criterion**

Recurrent abdominal pain or discomfort** at least 3 days/month in the last 3 months associated with *two or more* of the following:

1. Improvement with defecation
2. Onset associated with a change in frequency of stool
3. Onset associated with a change in form (appearance) of stool

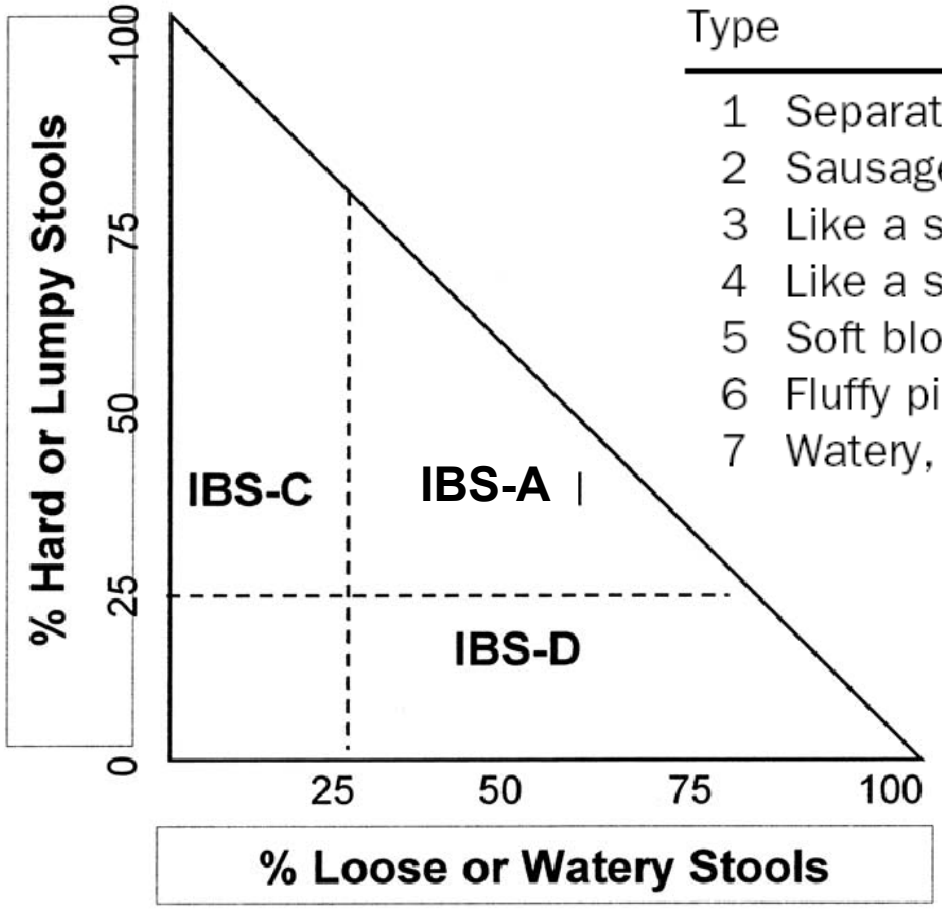
* Criterion fulfilled for the last 3 months with symptom onset at least 6 months prior to diagnosis

** "Discomfort" means an uncomfortable sensation not described as pain.

In pathophysiology research and clinical trials, a pain/discomfort frequency of at least 2 days a week during screening evaluation is recommended for subject eligibility.

Rome III; Gastroenterology 2006; 130:1480-91

IBS-Subtypes Rome III



Type	Description
1	Separate hard lumps like nuts (difficult to pass)
2	Sausage shaped but lumpy
3	Like a sausage but with cracks on its surface
4	Like a sausage or snake, smooth and soft
5	Soft blobs with clear-cut edges (passed easily)
6	Fluffy pieces with ragged edges, a mushy stool
7	Watery, no solid pieces, entirely liquid

The Bristol Stool Form Scale

Rome III; Gastroenterology 2006; 130:1480-91

Diagnostic IBS

ACG Taskforce 2009:

- *„No diagnosis of exclusion; Diagnosis is not recommended in case of missing alarm symptoms and in young patients“*
- *„The probability to find an organic disease, when lacking alarm symptoms, is equally as high as in the common population“*

DGVS 2011:

- „Still: Important differential diagnoses have to be excluded“

Statement 3-1-1

Für die Diagnosestellung sollen grundsätzlich 2 Komponenten erfüllt sein:

a) Anamnese, Muster und Ausmaß der Beschwerden sind mit einem Reizdarmsyndrom vereinbar.

b) Die „Sicherung“ des Reizdarmsyndroms erfordert den – symptomabhängig gezielten – Ausschluss relevanter Differenzialdiagnosen (insbesondere bei Vorliegen von Alarmsymptomen)

[Evidenzgrad B, Empfehlungsstärke ↑ ↑, starker Konsens]

ACG Referenz, Monografie Drossman, S3 Guideline DGVS 2011, Z Gastroenterol

Organic disease symptom (+) for IBS

ORGANIC DISEASE	IBS PATIENTS (%)	GENERAL POPULATION (%)
Inflammatory bowel disease	**0.51-0.98**	**0.3-1.2**
Colorectal cancer	**0-0.51**	**0-6 (varies with age)**
Celiac disease	**4.7**	**0.25-0.5**
Gastrointestinal infection	**0-1.5**	**NA**
Thyroid dysfunction	**6**	**5-9**

Cash B et al. Am J Gastroenterol 2002; 97:2812-19.

1. Visit (patients not managed beforehand)

- Patient History
- Exam
- Laboratory
- Abdominal Ultrasound

The plan for further procedures of clarification has to be adjusted to the individual results of the patient (consider personal history, physical exam, lab values)

Patient History

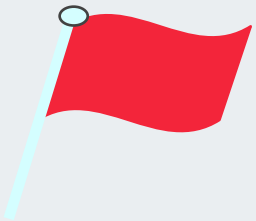
- *Duration of Symptoms?*
- *Frequency of Symptoms?*
- *Change of Stool habits?*
- *Improvement with Defecation?*
- Medication?
- Symptoms stress related?
- Travel history?
- (History of) Inlectious Disease?
- Intake of Antibiotics?
- Allergies?
- Food Intolerance?

Adaptiert aus: AGA Medical Position Statement. Gastroenterology 2002; 123:2105-7, S3 Guideline DGVS 2011, Z Gastroenterol.,
Dres. Pohl, Fried, Rogler, Gubler, Guldenschuh, Biedermann

Medication to look for

- Opioids (Fentanyl, Morphine, Tramal, Codeine, …)
- Tricycle antidepressant (Amitriptyline)
- SSRI
- Oral iron supplement
- Anti-epileptic drugs (Chlorpromazine, etc.)
- Chemotherapy (Sorafenib, Cladribine, ...)
- Antihypertensive (calcium channel inhibitor)
- Antibiotics
- Bile-acid binders
- Ondansetrone
- And many many more…

Red Flags



Anamnesis

- Beginning of symptoms >50 years
- Weight loss
- Family history for colorectal carcinoma / IBD / ovarian carcinoma
- Blood per rectum
- Nightly symptoms

Indications

- Fever
- Abnormity in status
- Pos. FOBT

Laboratory

- Anemia
- Leukocytosis
- CRP
- Abnormal chemistry

1. Laboratory Examination / Diagnostic IBS

All IBS patients
Age-depending Colorectal Cancer Prevention

IBS-D
Calprotectine
Celiac serology)
Colon biopsies

IBS-M
Calprotectine
Celiac serology
Stool Diary

IBS-C
Therapy-refractory: Functional Diagnostics (anorectal manometry, MRI defecography)
(celiac serology)

TSH
(always, no hard evidence)

Pancreatic elastasis Stool
(6.1% of IBS-D, IBS-A)

Parasitology Stool (3x)
(for IBS-D, IBS-A, travel history, no evidence)

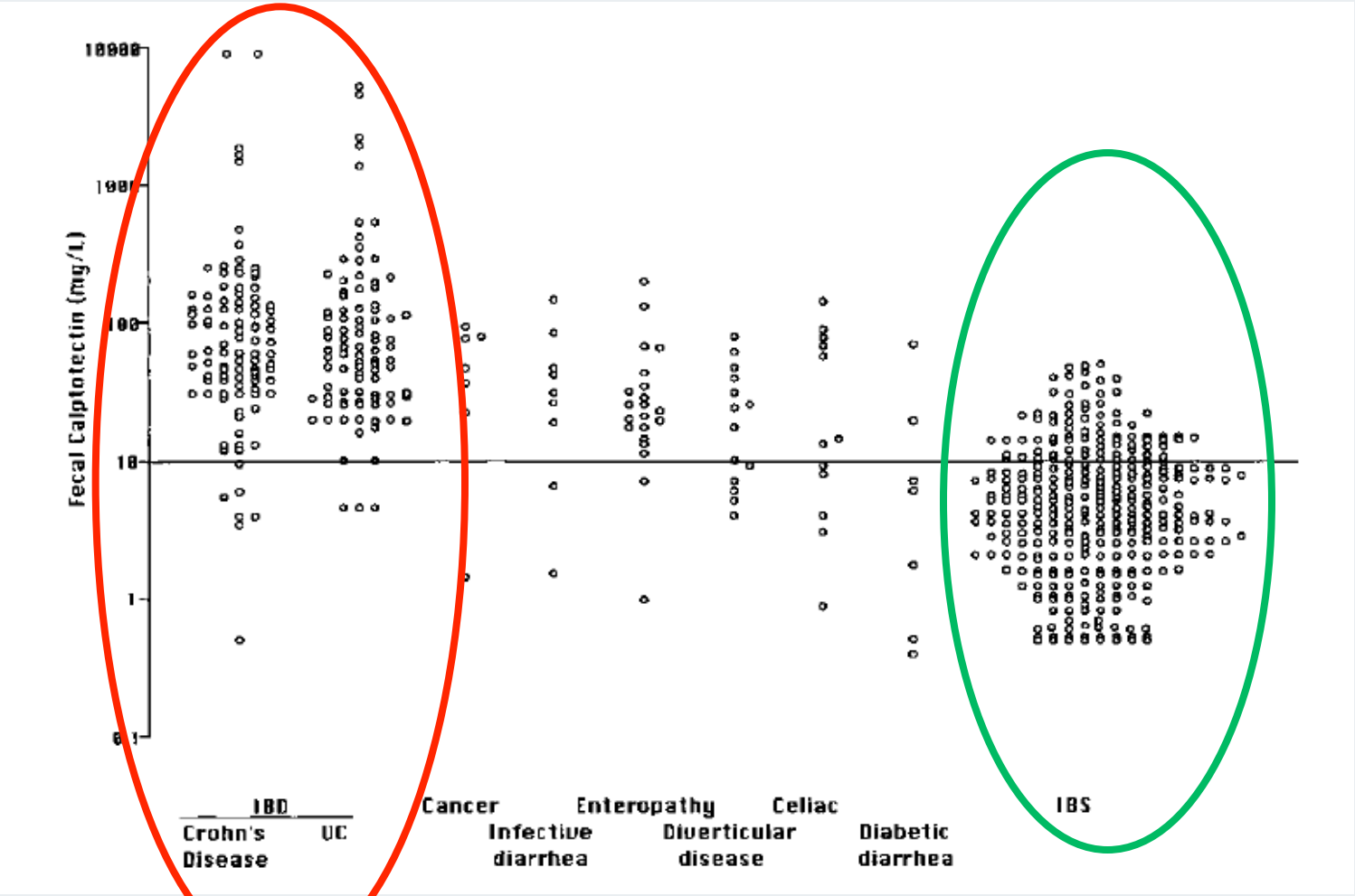
(Lactase deficiency)
(LCT-13910, for IBS-D, IBS-A)

(Bile acid malabsorption (IBS-D, IBS-A)
Testing complex, we provide empirical therapy)

Kumar S. J Gastroenterol Hepat. 2012 Sep 18
Chey W.D. JAMA 2015 Mar 15
Ford AC. Arch intern Med 2009; 169(7)
Macaigne G. Am J Gastroenterol; 2014 109(9) 1461-1470

Hamm LR, Am J Gastroenterol. 1999 May;94(5):1279-82.
Sanders et al. Lancet 2001; 358:1504
Langhorst J. Am J Gastroenterol 2008;103: 162-9
Tibble et al. Gastroenterology 2002 Aug;123(2):450-60
Shin A. Clin Gastroenterol Hepatol 2013;11(10):1270-1275

Fecal Calprotectin



Tibble JA et al. Gastroenterology 2002;123:450–460

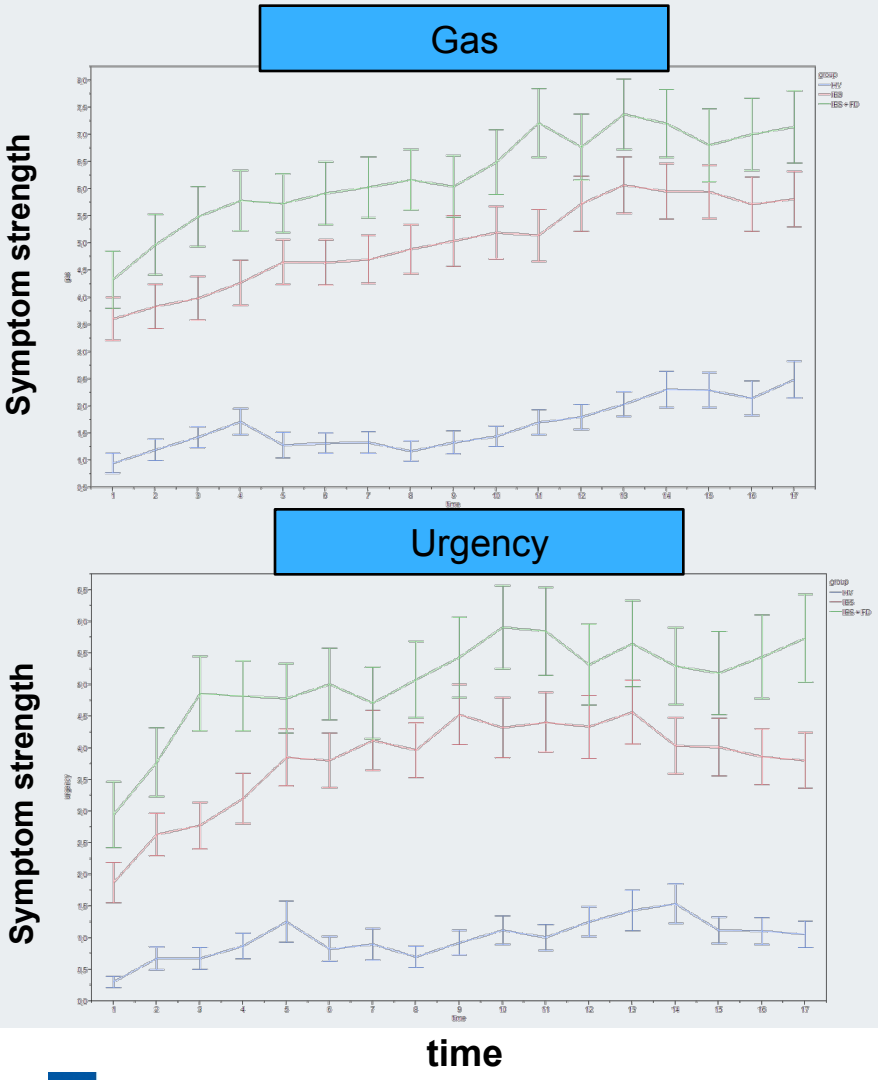
2. Visit (referral)

IN WOMEN GYNECOLOGICAL EXAM NECESSARY

- Gynecological council with endovaginal ultrasound (no recommended age limit)
  - DD Ovarian-CA, Endometriosis, Ovarian Cyst, Pelvic Inflammatory Disease

Layer P, Z Gastroenterol 2011; 49: 237–293
BSG, NICE guidelines 2009

Nutrient Challenge testing



	group	FD_17	FD_20	FD_21
time	**<.0001**	**<.0001**	**.016**	**.0032**
FD	**<.0001**	**0.001**	**<.0001**	**.001**
FD*time	*.066*	*.064*	.55	.29

	group	FD_17	FD_20	FD_21
time	**<.0001**	**<.0001**	**<.0001**	**<.0001**
FD	**<.0001**	**.0019**	**<.0001**	**.0062**
FD*time	**.019**	.24	**.027**	**.0495**

UniversitätsSpital Zürich

Pohl, van Oudenhove ...Simren, UEGW 2015

Not recommended tests

Stool Flora Analysis

- Not validated
- At the moment no prediction possible

Measurement of Visceral Hypersensitivity

- No routine procedure

Blood Biomarker

- approved in USS (IBS-D versus IBD)

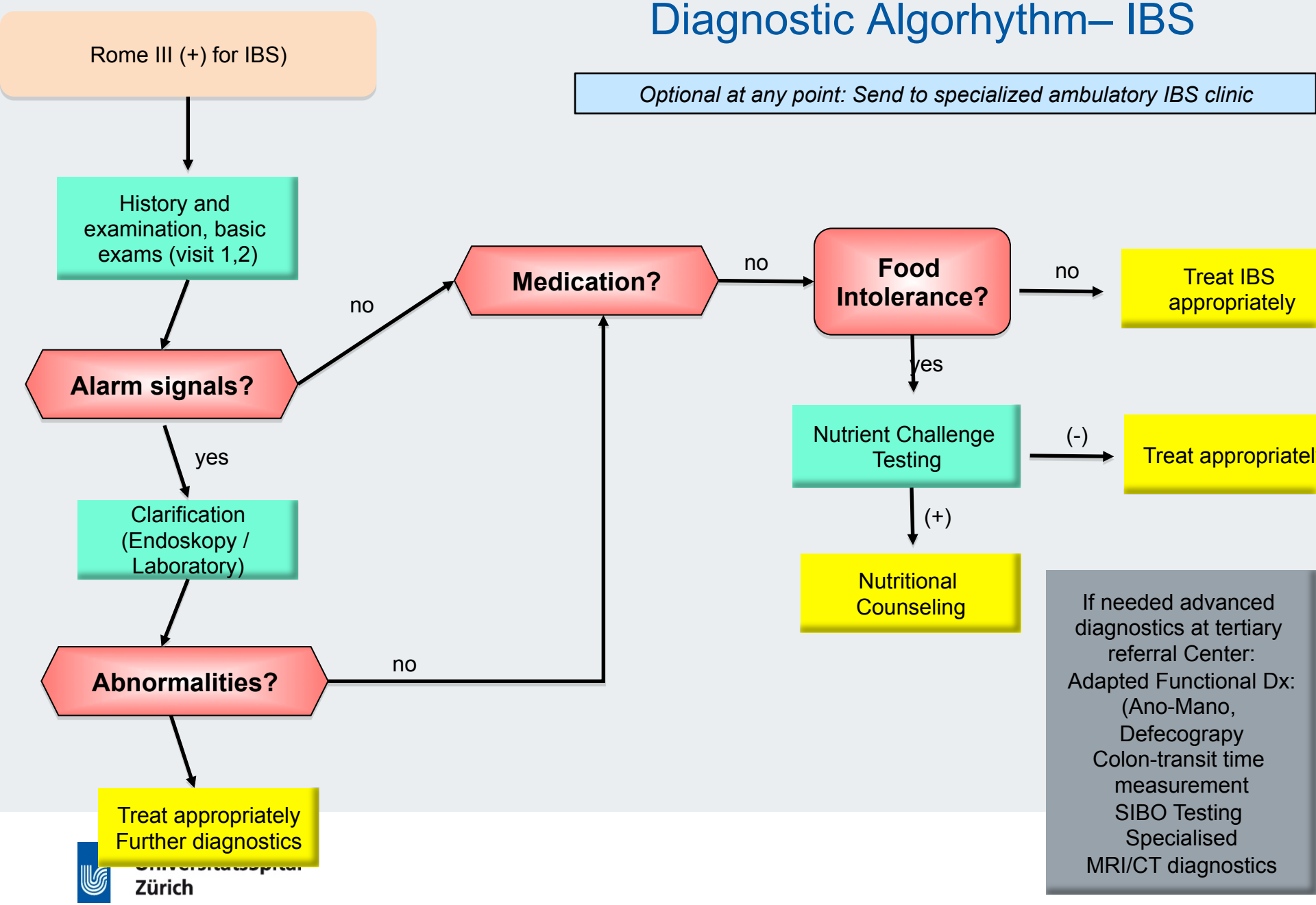
Food Intolerance / Allergies

- Fructose Breath Test
- IgG Food Allergens

Tests with names you cannot spell or that sound made up

Layer P et al. S3-Leitlinie IBS. Z Gastroenterol 2011; 49: 237–293

Diagnostic Algorhythm– IBS



Zürich

General IBS diagnosis advice

Diagnosis with appropriate, following patient information

- Do not stigmatize the patient as “psychologic” or “mental”

No unneeded diagnostic measurements

- Analysis of stool flora
- IgG Titer of food allergens

No further diagnostic measurements for established diagnosis of IBS

- Do not repeat endoscopy
- Restrict to appropriate therapy of patients

Thank you for your attention