Smart Diagnosis & Smart Treatment of IBS

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Simply Screening , *Total Endoscopic Health & Prevention*

With assistance from Albert Einstein, PhD

What is irritable bowel syndrome?

Not everything that can be counted counts, and not everything that counts can be counted. ~Albert Einstein

Irritable bowel syndrome is diagnosed by a description of symptoms, as there is no blood, x-ray, biopsy, or endoscopic test that positively diagnoses the disorder. A group of researchers into this functional bowel disorder went off to Rome some years ago, and in conference developed the "Rome Criteria" for the diagnosis of irritable bowel syndrome.

After much wine and pasta, this is what they came up with:
IBS is a chronic, episodic medical condition characterized by abdominal pain or discomfort associated with altered bowel function (at least two of the three):

- Less than 3 bowel movements per week or greater than three per day
- Hard or lumpy stools, or loose or watery stools
- Straining with a bowel movement, or urgency, or a feeling of incomplete evacuation.

Let's be clear here. If you don't have abdominal pain associated with your strange poops you may have just diarrhea or constipation, not IBS. If you have belly pain but no strange poops, it isn't IBS. Both must travel together. You need to have had the condition chronically (greater than six months), but not continuously. You should have experienced it for at least 12 weeks over any twelve month period. And…you need to have no other bowel disorder. If you have inflammatory bowel disease, like Crohns' disease or ulcerative colitis, you don't have IBS. IBS occurs in the absence of other disorders.

To confuse you further, there are three subgroups of IBS. The folks with D-IBS and C-IBS get, well, loose or constipated poops respectively. Then there's a group of poor souls that are what we call "Alternators", who swing from D-IBS to C-IBS with wild abandon.

Who has IBS?

If I had my life to live over again, I'd be a plumber. ~Albert Einstein

Up to 20% of the US population, when asked in surveys, have the symptoms of IBS; even your author has it (D-IBS, thanks for asking). It is slightly more common in females, but has carried the rap of being a 'girl disease' because in this country women seek out physicians more often for the disorder. To make matters worse, IBS is a much more common disorder than many other common treatable diseases, including: diabetes 3%, asthma 4%, heart disease 8%, and hypertension 11%.

Some days, your doc wishes she had become a plumber rather than a physician.

How should my IBS be treated? Do I need the new drugs?

Insanity: doing the same thing over and over again and expecting different results ~ Albert Einstein

If what you're taking works for you, for heaven's sake, don't change it. Traditional therapies have focused solely on improving symptoms. We've used anti-spasm drugs and low dose anti-depressants

for the pain from a hypersensitive colon clenching down, and anti-diarhheals or laxatives and fiber to combat either a rapidly moving or sluggish gastrointestinal tract.

If it's not been working for you, you're not alone. Over two-thirds of IBS sufferers are dissatisfied with traditional medications for IBS. Two new, smart treatments are available for IBS that affect the bowel serotonin: Lotronex /Alosetron for D- IBS and Zelnorm/Tegaserod for C-IBS.

What research led to the development of the two new medications for IBS?

If we knew what it was we were doing, it would not be called research, would it?
~Albert Einstein

Starting with decades old research in which IBSers and 'normals' (how normal could it be to volunteer for this research?) allowed researchers to insert and inflate rectal balloons to demonstrate that IBSers had reproducibly lower thresholds to pain sensation with balloon distension, we've known that something was up with the specialized nervous system of the gut, aka the enteric nervous system. At that very same time, we demonstrated by immersing hands in ice water or applying electric shocks, all things not approved in the Geneva Convention, that the somatic pain perception of these same IBS folks was the same, and if anything they might be even more stoic than the same normals…folks with IBS weren't wimps .

Recently, we've found with PET scan technology that IBSers brains react more aggressively to pain inflicted in the gut. We then discovered that some folks with D- IBS had higher than average levels of serotonin, a nervous system transmitter chemical, in their blood stream. Constipated folks didn't have lower than normal levels of serotonin…that'd be too easy, but their receptors in the gut were relatively insensitive to the serotonin that was there…analogous to an adult onset diabetic who makes insulin, but the receptors just don't acknowledge it well.

What does serotonin do in the gut?

Everything should be made as simple as possible, but not simpler. ~Albert Einstein

Serotonin is one of the many chemicals that helps the gut to contract properly to produce peristalsis, the 'milking' motion that moves your food from your mouth to your posterior. In addition, it is one of the chemicals in your gut responsible for the transmission of pain sensations up your spinal column to be perceived by your brain.

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Updated 04/06