



## Overview of Irritable Bowel Syndrome

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The diagnosis and treatment of irritable bowel syndrome, also known as IBS, has come a long way in the last 20 years. Once considered a “diagnosis of exclusion” now can be approached in a positive manner. Our improved, though limited understanding of the disease process, coupled with the advances in therapy have led to a far better quality of life for individuals with this disorder. Despite this progress, a significant percentage of people with IBS never seek the advice of a physician. Many simply choose to live with their symptoms relying on home remedies for relief. National gastroenterological organizations are now attempting to popularize this disorder so that affected men and women can be treated properly.

IBS is primarily defined by symptoms since there are no specific anatomical or biochemical markers. The symptoms are likely related to alternations in muscular activity, a heightened awareness of pressure or volume changes within the gut (visceral hypersensitivity), immunological or inflammatory factors and even a response to gut infection.

Criteria for the diagnosis of IBS have been revised several times since the initial description at a conference in Rome in

1989. Known as the Rome Criteria, a positive diagnosis can be made in greater than 90 percent of cases. The most recent revision known as the Rome III guidelines is noted in the insert.

IBS has now been subtyped based on predominant

stool pattern into three groups:  
D-IBS – predominant diarrhea  
C-IBS – primary constipation  
M-IBS – a mixture – alternating diarrhea and constipation

This subtyping has allowed a much more specific approach to therapy. If medications are used they should be aimed at controlling the predominant symptoms e.g., antispasmodics for diarrhea, etc. Other important therapeutic modalities include reassurance that no organic disease exists (e.g., fear of cancer), dietary advice (avoidance of trigger foods), establishment of a good physician-patient relationship and psychological treatments if deemed necessary.

The patient must be convinced that a firm diagnosis has been made. Furthermore, an understanding that treatment, rather than being specific in every case, may require trial and error. Maintaining a caring doctor-

patient relationship through this journey will lead to a successful outcome in most cases.

### Revised Rome III Diagnostic Criteria\* for the definition of IBS include the following (3):

Recurrent abdominal pain or discomfort\*\* at least 3 days per month in the last 3 months associated with 2 or more of the following:

- Improvement with defecation
- Onset associated with a change in frequency of stool
- Onset associated with a change in form (appearance) of stool

\* Criteria 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

### Supporting symptoms for the diagnosis of IBS (not part of diagnostic criteria):

- Abnormal stool frequency (greater than 3 bowel movements/day or less than 3 bowel movements/week)
- Abnormal stool form
- Abnormal stool passage (straining, urgency or feeling of incomplete evacuation)
- Passage of mucous
- Bloating or feeling of abdominal distention



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