Functional Gastrointestinal Disorders (FGID)
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Irritable Bowel Syndrome (IBS)

IBS affects up to 1 in 5 people, the commonest FGID. IBS is a multisystem disorder, affecting not just the gastrointestinal system but could co-exist with chronic fatigue syndrome, fibromyalgia and temporomandibular joint dysfunction.

Non-intestinal features of IBS could include gynaecological symptoms of dysmenorrhoea, dyspareunia, premenstrual tension; urinary symptoms of frequency, urgency, incomplete emptying and nocturia; as well as other symptoms ranging from back pain, poor sleep, fatigue to headaches.

IBS can be triggered by a wide range of causes including gastrointestinal infections, pelvic surgery, psychological stress and trauma, sexual or physical abuse, mood disturbances, anxiety, depression, eating disorders and food intolerance.

Risk factors include female gender, pre-existing life events, severity and duration of diarrhoea and high hypochondriacal anxiety and neurotic scores at time of initial illness.

Diagnostic Criteria

In the last 12 months, at least 12 weeks consecutively of abdominal pain/discomfort and 2 out of 3 of following features:
- relieved with defecation
- onset associated with change of frequency of stool
- onset associated with a change in form of stool

The following symptoms cumulatively support diagnosis of IBS:
- abnormal stool frequency (>3/day or <3/week)
- abnormal stool form
- abnormal stool passage (straining, urgency, incomplete evacuation)
- passage of mucus
- bloating or feeling abdominal distension

The decision for further investigation is judged on a clinical basis. Presence of rectal bleeding, nocturnal pain and weight loss would point towards the need for further investigation.

Treatment

Current strategies of IBS treatment are targeted towards end-organ treatment or central treatment.

End-organ treatment includes exploring dietary triggers, high fibre diet for constipation, antidiarrhoeal drugs for bowel frequency, smooth relaxants for pain relief, hydroxytryptamine (HT3)-receptor antagonists for diarrhoea predominant IBS and HT4-receptor antagonists for constipation predominant IBS.

Central treatment on the other hand, looks into physiological explanation of symptoms, counselling, psychotherapy, hypnotherapy, CBT and antidepressants.

Pain/gas/bloat syndrome

There are patients who suffers with functional bowel disease where abdominal pain and other GI symptoms are a consequence of disordered motility and visceral sensation predominantly affecting midgut and small intestines.

Its symptoms based diagnostic criteria are abdominal pain, not relieved by opening of the bowels, and not associated with frequency or form of stool. Abdominal distension is not restricted to upper abdomen but also includes postprandial fullness, nausea, anorexia and even weight loss.

Treatment is not easy and pain be chronic and severe. Narcotics should always be avoided. Central and end-organ approaches should be combined.

Functional diarrhoea

Normally there's absence of abdominal pain and associated with:

- passage of several stools in rapid succession usually first thing in the morning
- first stool usually formed but later much looser and watery
- urgency of defecation
- anxiety or uncertainty about bowel movements with restriction of movement (travelling etc)
- exhaustion following the 'morning rush'

Features of rectal bleeding, large volume stools, nutritional deficiency and weight loss would call for further investigations. In cases where it is difficult to distinguish between functional diarrhoea and organic causes of diarrhoea, patient cab be admitted to hospital for a formal 3-day analysis of stool weights and faecal fat levels, stool osmolality and creatinine contents.

Reference: Kumar & Clarke Clinical Medicine