Katie Crocker, Anna Chur-Hansen, Jane Andrews
Irritable bowel syndrome : Reply
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Irritable bowel syndrome

Dear Editor

I read the article 'Interpersonal relationships for patients with irritable bowel syndrome: a qualitative study of GPs perceptions' by Crocker et al (AFP November 2013) with interest but came to the conclusion that the authors may have missed a fundamental tenet of medical practice, namely management (diagnosis and treatment) of the actual physical condition itself, before delving into its psychological manifestations. Eliminate the symptoms of irritable bowel syndrome (IBS) and there is a good chance the psychological issues will fade away. This of course does not mean we should not consider the psychological effects of all acute and chronic diseases on our patients' lives but let's first address the organic conditions where they do exist.

IBS is an umbrella term and its symptoms are common. Most patients don't mention them because they have come to live with them and assume they are 'normal'. So, the first thing we have to do is find the patients. We need to 'ask' about IBS symptoms.

Then we need to identify and treat the obviously organic conditions – inflammatory bowel disorder (IDB), gastrointestinal infections, coeliac disease, lactase deficiency, etc. If these conditions are absent a trial of a FODMAP diet will reduce or even eliminate the symptoms in 75% of the remaining patients.

If we make them feel better they will cope better. To me the axiom 'First do no harm' also means don't miss something we can fix. I am therefore concerned about the authors' statement 'IBS is a common functional gastrointestinal disorder.' This is confusing.

Do they use the term 'functional' to mean IBS is a psychosomatic condition (after all they are psychologists) or do they accept it is a physiological one? Are they having a bet each way? Whichever, I believe good general practitioners need to address the latter before the former.

Dr Craig Lilienthal
Sydney, NSW

Reply

Dear Editor

We thank you for the opportunity to respond to Dr Craig Lilienthal's comments as we feel that he may have misunderstood our paper.

This study was undertaken to explore the attitudes of general practitioners towards dealing with people in whom there was a secure diagnosis of irritable bowel syndrome (IBS). There was no implication that people with gastrointestinal symptoms should not have an appropriate diagnosis made and certainly no suggestion that IBS is a psychosomatic condition.

Dr Lilienthal seems to object to the term 'functional', but this is the accepted terminology for these disorders and so, for precision, it needs to be used. It means the function (motor and sensory) of the gut, rather than the structure, is impaired. Many of these patients have visceral hypersensitivity, and some will also have altered cytokine profiles. Nonetheless, they are classified as functional gastrointestinal disorders. We also wish to correct his assumption that all authors are psychologists (JM Andrews is a clinical gastroenterologist with about 20 years of practical experience).

Dr Lilienthal advises that we should 'eliminate the symptoms of IBS', and if there were a universally successful way to do this, we are sure that we all would. However, there are few substantially effective therapies – this is the current crux of the problem with IBS. In the literature, the two therapies with the best evidence of benefit are psychological therapies, as they help people cope and think differently about their symptoms, and dietary therapy – the Low FODMAP diet – but this is only effective when followed and is not a cure.

We agree entirely that all relevant differential diagnoses need to be reasonably excluded, but this can be done easily with a thorough clinical history and a limited number of simple tests. A diagnosis of IBS is a positive one made on the basis of typical symptoms, in the absence of clinical alarm features in the face of normal simple screening tests. If this approach is followed, the diagnosis is secure, accurate and safe. These people do not need to have colonoscopies and CT scans, nor can the healthcare system fund such unnecessary and defensive practices.

After a diagnosis has been made, we do need to address the psychological issues with which our patients struggle, as the experience of a 'disease' is far more than just what can be seen or measured. We hope Dr Lilienthal agrees and that he is cognisant of these issues in his patients with IBS.

Ms Katie Crocker
Professor Anna Chur-Hansen
Associate Professor Jane Andrews

Letters to the Editor

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Erratum

Harris M, Dennis S, Pillay M. Multimorbidity: negotiating priorities and making progress. Aust Fam Physician 2013;42:850–54.

In the Focus article by Harris, Dennis and Pillay, published in the December 2013 issue of *AFP*, reference 33 (Smith SM, Soubhi H, Fortin M, Hudon C, O'Dowd T. Cochrane Database Syst Rev 2007) was incorrectly labelled as 32 in the Reference section. We apologise for this error.