

Irritable bowel syndrome: management of expectations and disease

WILLIAM Osler described the 19th century version of irritable bowel syndrome (IBS), then known as mucous colitis, as occurring principally in psychiatrically-disordered young women and accompanied by the passage of mucus with the appearance of frog spawn.¹ Osler's close linkage of psyche and soma in IBS persisted for almost a century and in the 1970s the condition, then labelled spastic colitis, was still seen as having a very substantial psychiatric component, particularly because no gold standard or diagnostic test for the condition was available. Diagnostic progress was made when Adrian Manning elaborated his well-known eponymous diagnostic criteria in Bristol in 1978,² although little aetiological progress was made until the last decade. The 1990s saw the development of the Rome I³ and Rome II⁴ criteria for the diagnosis of IBS and also an explosion of research interest into peripheral and central neuroenteric and neuropsychological mechanisms involved in the control and perception of gut motility and nociception.

Current concepts of the aetiology of IBS need to embrace the interplay between abnormal visceral function, peripheral and central abnormalities of the perception and handling of painful stimuli and the impact of social and psychological factors, all of which may contribute both to illness onset and to the persistence of symptoms. Childhood experiences of abdominal pain and later experiences of physical and sexual abuse may also play a part⁵ while, at the other end of the aetiological spectrum, up to one in five patients with IBS associates the onset of symptoms with an episode of enteric infection.⁶ This work has resulted in the promise of treating IBS with drugs acting on 5HT₃ and 5HT₄ pathways, which seem likely to represent a significant therapeutic gain over the previously widely-used and non-specific antispasmodics. Compounds such as alosetron and cilansetron, which are 5HT₃ antagonists, have been shown to relieve a range of symptoms in diarrhoea-predominant IBS patients,⁷ while the partial 5HT₄ agonist tegaserod has a significant effect on the symptoms and functioning of patients with constipation-predominant IBS.⁸ The full 5HT₄ agonist prucalopride may also be effective in this group of patients.⁹ Interestingly, this research has been accompanied by a parallel increase in interest in non-drug treatments of IBS, including hypnotherapy¹⁰ and cognitive behavioural therapy¹¹ which, although relatively scarce resources in the National Health Service, have the advantage of being applicable to the entire spectrum of IBS patients and also being free of the side effects that have impeded the wider availability of effective drug therapy.

The two IBS articles in this issue of the Journal contain some new information and also emphasise the importance of IBS as a ubiquitous condition with significant consequences for individuals and health services. Both papers comment on the impact of IBS on patients' quality of life, which has been shown in other studies to be substantially impaired, whether measured by generic

instruments, such as the 12- or 36-item short-form health surveys (SF-12 or SF-36), or by disease-specific instruments such as the IBS-quality of life (QoL) measurement or the IBS symptom severity scale.¹² The carefully conducted community study from Birmingham¹³ provides a new estimate for the population prevalence of IBS of around 10%, with the usual female preponderance. It also found that almost half of their patients who had been identified in the community as having IBS had seen either a general practitioner or a specialist in the preceding 6 months, much higher figures than those found in a survey in the south of England 12 years earlier.¹⁴ The Birmingham IBS research group emphasise the negative impact of IBS on quality of life (measured by the SF-12) and on primary care services, as well as raising some interesting methodological issues concerning the accurate estimation of disease prevalence using the Rome II criteria.

The Rome II criteria were also used to select patients for participation in a study from Edinburgh,¹⁵ which compared the characteristics of patients with IBS managed predominantly in either primary or secondary care. On this occasion advertising was used to invite participation in the study. Smith and colleagues also found significant adverse impacts on disease-specific and general measures of quality of life, in this case using the 5-domain EuroQoL (EQ-5D), and, although they were able to identify a small number of factors independently associated with contact with secondary care, they found no evidence that these patients had more severe physical symptoms or greater psychological morbidity. This latter finding contrasts with previous studies reporting higher levels of psychiatric disorder in the secondary care population;^{16,17} an alternative interpretation of the findings of the Edinburgh group is, of course, that some of the primary care patients are still awaiting definitive diagnosis and management whereas those in secondary care have been fully investigated and are being appropriately treated. Unfortunately, most of the information that we have about the characteristics of IBS patients at different points of their therapeutic journeys derives from cross-sectional rather than longitudinal studies, generating associations rather than identifying causal links. Furthermore, given the critical importance of doctor-patient interactions in the diagnosis and management of IBS, surveys of patients, which do not include an account of the variations in physicians' behaviour, can provide only a partial picture of natural history and disease progression.

At a time when significant new therapeutic opportunities are likely to become available for symptom relief in IBS, their place in an overall management strategy must be clearly defined. Many patients consulting with non-specific, yet troublesome, bowel symptoms harbour concerns about the possibility of malignant disease and require an approach in which appropriate investigation is carefully balanced with the need to provide a credible explanation of the symptoms as a basis for reassurance. If this approach

can be backed up by the availability of effective drug therapy that patients can use when symptoms become troublesome, so much the better. However it is important to realise that non-drug interventions, applied to well-selected patients, also have significant symptomatic benefits and have the advantage of shifting the locus of control, so that patients themselves may feel more able to cope and deal with their symptoms.¹⁸ While IBS is not considered to be associated with the development of serious organic disease, it is, as these new studies remind us, a common and troublesome condition that deserves our clinical and research attention. It is also a condition in which the management of expectations is important, and, at our present level of understanding, one in which diagnosis and management should best be approached within a paradigm of care, rather than cure.

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Chlamydia screening in primary care

SEXUAL health in the United Kingdom (UK) has shown little improvement over the past decade. Diagnoses of chlamydia are increasing, teenage pregnancies are not yet down and there are long waits for genitourinary medicine (GUM) clinic appointments.¹ Two articles in this month's Journal and a parliamentary report highlight further problems. A qualitative focus group study by McNulty *et al* found that general practitioners (GPs) are often too busy to screen for chlamydia and feel that they don't know enough.² Similarly, interviews with 71 female street-based commercial sex workers in Bristol revealed that although they do attend general practice, they do not disclose their occupation and they do not receive optimal care.³ Finally, a House of Commons Select Committee recently completed an inquiry into the sexual health of the nation.⁴ They found a 'crisis in sexual health' and little evidence that primary care trusts were ready to take on responsibilities for sexual health commissioning. 'The whole sexual health service seems to be a shambles'.⁵

National screening programme for chlamydia

A major recommendation of the *National strategy for sexual*

health and HIV, published in 2001,⁶ was that chlamydia screening be rolled out more rapidly. What are the implications for primary care and what do GPs need to know? *Chlamydia trachomatis* is a much publicised, common, treatable sexually transmitted infection (STI) that can cause pelvic inflammatory disease but produces few symptoms in up to 70% of women and 50% of men. After one episode of pelvic inflammatory disease, around 15% of women may become infertile, 10% suffer chronic pelvic pain and 10% of subsequent pregnancies may be ectopic, which can be life threatening. Chlamydia costs the National Health Service >£100 million annually, but the human costs are borne disproportionately by women. Screening for chlamydia has been shown to reduce the incidence of pelvic inflammatory disease⁷ and to be cost-effective at prevalences of ≥5%.⁸ Although the national screening programme has not yet focused on primary care, many practices offer opportunistic chlamydia testing.

Which chlamydia tests should GPs use?