The extracolonic manifestations of the irritable bowel syndrome

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People with the irritable bowel syndrome (IBS) account for 30% to 70% of the patients seen by gastroenterologists. They present with various abdominal and extra-abdominal complaints, and they have often been seen by numerous physicians and undergone costly investigations.[1] It is not our intention to review the pathogenesis of IBS or to discuss its colonic features; these have been adequately addressed in earlier reviews.[2,3] Instead, we want to draw to the attention of physicians the numerous extracolonic manifestations of IBS. Awareness of these diverse symptoms may prevent inappropriate referral and investigation.

Many of the symptoms in IBS may be due to a diffuse disorder of smooth muscle or its autonomic regulation.[4,5] Motility of the esophagus[6-8] and small bowel[9-12] may be disturbed and cause a host of symptoms such as globus, reflux and dysphagia. Lower esophageal sphincter pressure has been reported to be significantly decreased in patients with IBS, and there are often nonspecific motor abnormalities in the esophagus.

Chronic and recurrent pain in the right upper quadrant frequently leads to repeated investigation of the gallbladder and biliary tree and possibly to inappropriate surgery. It may be caused by biliary dyskinesia, but more likely it is referred from the small bowel or colon. Balloon distension at trigger sites in the duodenum, jejunum, ileum and right colon has been found to reproduce such pain.[13] In addition to the right upper quadrant, the pain may be referred to the shoulder, the chest, the back, the loin, the perineum and even the thigh.[14]

Women with IBS have frequently complained of dyspareunia and noted that sexual intercourse provokes abdominal pain. The IBS symptoms are often worse during menses, and some women may also have dysmenorrhea. Hysterectomy is not uncommon. Premenstrual tension does not, however, seem to be a feature of IBS.[15-18]

Irritable bladder symptoms such as frequency, urgency, hesitancy, nocturia and incomplete bladder emptying affect 30% to 60% of IBS patients; instability of the detrusor muscle is common in those who have alternating constipation and diarrhea.[19]

The notion that IBS is a diffuse disorder of smooth muscle responsiveness is further supported by the finding that some IBS patients have an exaggerated bronchial smooth muscle response when challenged with methacholine inhalation,[20] although not with histamine inhalation.[21]

Between 40% and 60% of patients with fibromyalgia, characterized by diffuse muscle pain and sleep disturbance, have IBS symptoms.[22] Both IBS and fibromyalgia patients have a high incidence of chronic headache and migraine.[22,23]

IBS patients frequently have the somatic symptoms of depression or anxiety. Even if they do not have a psychiatric disorder they may complain of palpitations, fatigue, poor sleeping, bad breath and a fear of serious illness.[18,24]

The management of extracolonic symptoms is certainly as challenging as that of colonic symptoms but is beyond the scope of this editorial. The principles — explanation, reassurance and judicious investigation — are applicable in both cases. Drug therapy for such symptoms as heartburn, bladder spasms, headache and dysmenorrhea may make sense, but we have found no reports of the efficacy of drugs in managing extracolonic symptoms in IBS patients. Other interventions (often out of desperation in cases of "refractory" IBS) include modifica-

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tion of psychosocial factors, behaviour modification, relaxation exercises, problem solving, cognitive restructuring, assertiveness training and hypnotherapy, but they have yet to be studied.[25,26]

As no diagnostic marker exists for IBS the onus is on the physician to make the diagnosis from the patient's history, the findings at physical examination and the results of a minimum of investigations. The investigations should be limited to those needed to exclude organic disease of sufficient likelihood to cause the symptoms. What is ultimately done varies directly with the physician's confidence in diagnosing functional disease on the basis of the history and the physical findings. The type of management is influenced by the physician's expertise, experience, empathy, anxieties and attitudes, but it also encompasses a realization of the patient's anxieties, concerns and behaviour. An awareness of the extracolonic symptoms of IBS may help to minimize repeated investigations and prevent inappropriate referrals to psychiatrists, neurologists, rheumatologists, urologists, gynecologists or surgeons.

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