- Consider tricyclic antidepressants as second line treatment for abdominal pain or discomfort if laxatives, loperamide, or antispasmodics have not helped. Start treatment at a low dose (5-10 mg equivalent of amitriptyline) taken once at night, and review regularly. The dose can be increased but does not usually need to exceed 30 mg. If this fails, consider treatment with a low dose selective serotonin reuptake inhibitor.
- Psychological interventions (such as cognitive behaviour therapy, hypnotherapy, and psychological therapy) may reduce pain and other symptoms and improve quality of life. Consider such treatments for those who have had symptoms for at least 12 months and have not responded to first line treatments.
- Advise patients that reflexology, acupuncture, and aloe vera have shown no benefit and are therefore not recommended.
- Do not discourage people from trying specific probiotic products for at least four weeks.
- Data from dietary elimination and food challenge studies are limited and sometimes contradictory; however, if diet is considered a major factor in a person's symptoms even after general lifestyle and dietary advice has been followed, consider referral to a dietitian for advice on avoidance of single foods and an exclusion diet.

Overcoming barriers

The emphasis on positive diagnosis, optimal clinical and cost effective management of IBS, and the importance of patient empowerment relating to their condition and self management of their medication should benefit patients with IBS. Implementing these guidelines will require many medical professionals to view IBS in a new light. The principle of a positive diagnosis of IBS will be foreign to many: reducing the amount of fibre in the diet flies in the face of many health messages, and using psychotherapy will be a new concept. However, the guidelines provide clear advice on this condition. The guideline group expects that people with IBS will be treated more effectively without the need for unnecessary investigations and referral. When referral is required, the guidelines indicate the most appropriate interventions.

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Commentary: Controversies in NICE guidance on irritable bowel syndrome

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The NICE guidelines summarise the diagnosis and treatment of irritable bowel syndrome (IBS), but several issues remain contentious.

Can a positive diagnosis of IBS be based on symptom patterns?

The NICE guidelines offer a pragmatic definition of IBS, similar to one published in 2002 by the American College of Gastroenterology Taskforce.[1] However, the utility of these pragmatic definitions is unknown. The Rome criteria for IBS were developed for research purposes and are specific, but there are no adequate validation data documenting their applicability in primary care.[1 2] The NICE guidelines suggest that symptoms that are made worse by eating support a diagnosis of IBS, but as acknowledged in the guidelines, this is based on expert consensus rather than research evidence. Clinicians need to be aware that this symptom may lead to confusion with functional dyspepsia and peptic ulcer disease. Making a positive diagnosis of IBS seems reasonable, but the approach applied still is largely based on expert opinion, not high quality evidence.

Are "red flag" indicators truly useful for predicting organic disease?

Consensus has been reached that patients who present with symptoms of IBS and alarm features ("red flag" indicators) such as rapid weight loss deserve prompt referral for a structural evaluation. However, no consensus exists on exactly what features should constitute an alarm feature.[1-3] In a study of 1434 patients at a referral centre with a clinical diagnosis of IBS, alarm features were reported by 84% of the sample, but the positive predictive value of individual alarm features for identifying organic disease was at most 9%.[3] Age over 60 is considered an alarm feature in the NICE guideline. This differs from US guidelines, which suggested that all those 50 years and older,

regardless of symptoms, deserve screening (such as with colonoscopy) to exclude colon cancer.[4]

Should blood testing be routine in those with typical features of IBS?

Clinicians fear missing organic disease, but how useful are blood tests in patients with classic symptoms of IBS? The American College of Gastroenterology Taskforce concluded from the data that, aside from serological testing for coeliac disease, no evidence existed to support routine blood testing.[1] A UK study of 300 outpatients with IBS found just 1% had an abnormal erythrocyte sedimentation rate or C reactive protein level and detectable organic disease,[5] although the NICE guidelines still recommend routinely checking patients' erythrocyte sedimentation rate and C reactive protein level. The guideline rightly does not recommend hydrogen breath testing to detect possible bacterial overgrowth as no consensus exists on its utility.

Is fibre harmful?

Evidence from randomised controlled trials show that fibre supplements improve constipation in IBS.[1] Overall, the data from these randomised controlled trials are too sparse to conclude that fibre definitely worsens symptoms of IBS despite uncontrolled observations that suggest too much fibre aggravates bloating.[6] The NICE recommendation, based on consensus opinion, is to restrict fibre intake to 12 g daily, although the optimal fibre dose in IBS is not known and may differ by subtype.

Psychopharmacotherapy in IBS: better targeting of drug class and dose?

The NICE guideline recommends treatment with low dose tricyclic antidepressants in resistant cases. Evidence is emerging that standard dose selective serotonin reuptake inhibitors provide overall relief in IBS[7] and tend to be better tolerated than tricyclic antidepressants. Whether tricyclics are more efficacious for IBS in which diarrhoea is predominant (because of their anticholinergic action) and selective serotonin reuptake inhibitors work best in IBS in which constipation is predominant (because of a prokinetic effect) is uncertain but makes pharmacological sense. Optimal dosing remains unclear as head to head dose ranging studies are not available, but in practice a low dose tricyclic (such as nortriptyline 10-25 mg at night) or a full dose selective serotonin reuptake inhibitor is usually prescribed. No data on selective noradrenaline reuptake inhibitors are available, but they might have a role in difficult cases with abdominal pain.

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