Supporting community patients with irritable bowel syndrome (IBS)

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Irritable bowel syndrome (IBS) is associated with a significant impairment of quality of life. Due to the nature of its symptoms, the role of the nurse is central to the care of patients who may have IBS. The often embarrassing symptom profile means that patients may rely on nurses to provide psychological and physical support in helping them to improve their symptoms. In this article, the author discusses the management of patients with irritable IBS, including the optimal delivery of care for patients and the role of community nurses in dealing with this chronic condition.

KEYWORDS:
Continence  Irritable bowel syndrome  Chronic conditions

To diagnose IBS safely, it is imperative that alarm, or red-flag symptoms for other gastrointestinal diseases are ruled out (NICE, 2008). These alarm symptoms may indicate other serious gastrointestinal diseases such as colon cancer, coeliac disease, ulcerative colitis or Crohn's disease and need medical assessment. Alarm symptoms include (NICE, 2008):
- Unintentional weight loss
- Rectal bleeding
- Family history of bowel or ovarian cancer
- Change in bowel habit to looser stools for longer than six weeks in persons over 60 years of age.

CLASSIFICATION
There are three acknowledged subtypes of IBS, which are based on the presence of abdominal pain in addition to the dominant bowel symptoms that patients may experience (NICE, 2008):
- Constipation predominant (IBS-C)
- Diarrhoea predominant (IBS-D)
- A mixture of the two (IBS-M).

One-third of patients with IBS are thought to have IBS-C, suffering from chronic abdominal pain, bloating and constipation (Rao et al, 2012).

QUALITY OF LIFE
IBS is associated with a significantly impaired quality of life (Akehurst et al, 2002) (Table 1). Due to the nature of the symptoms, the role of nurses is central to the care of patients with the condition. The embarrassing symptom profile means that patients may rely on nurses to provide psychological and physical support, in helping them to improve their symptoms.

WHAT CAUSES IBS?
The cause of IBS is currently unknown (NICE, 2008). However, common explanations include:
- Visceral hypersensitivity: higher than normal sensation of pain in the internal organs (viscera) can result in more painful bowel movements (Delvaux, 2002)
- Post infective: this involves continued gastrointestinal symptoms following a resolved gastrointestinal infection or course of antibiotics (NICE, 2008)
- Dietary intolerance (NICE, 2008)
- Stress and life events may also cause/exacerbate symptoms of IBS (Table 1) (NICE, 2008).

<table>
<thead>
<tr>
<th>Table 1: Impact of IBS on patient quality of life</th>
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<td>IBS reduces quality of life (Akehurst et al, 2002)</td>
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<td>IBS is a leading cause of work absenteeism (Hulisz, 2004)</td>
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<td>IBS can cause significant disability, affecting patients physically and psychologically (Sainsbury and Ford, 2011)</td>
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<td>IBS can have an emotional impact, with symptoms including depression, frustration, embarrassment and anxiety (Sainsbury and Ford, 2011)</td>
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DIAGNOSIS AND MANAGEMENT

One of the main aims of IBS management is to provide a positive diagnosis to rule out any other gastrointestinal cause of the symptoms (NICE, 2008). Those with 'red flag' indicators should be referred to secondary care for further investigation such as endoscopy (NICE, 2008).

In the absence of alarm symptoms, IBS can be confirmed with some simple investigations to exclude more serious disease such as colon cancer, coeliac disease, ulcerative colitis or Crohn’s disease. These include blood tests such as full blood count (FBC), C-reactive protein (CRP) and coeliac antibodies (tissue transglutaminase [tTG]) (NICE, 2008).

Only 19% of patients are diagnosed at their first consultation and 56% of patients may require up to five consultations before a diagnosis is confirmed (Hungin et al, 2003). IBS can be difficult to diagnose because it can present with inconsistent symptoms that mimic organic disease. Patients may require extensive investigation and consultation before a final diagnosis is reached.

IBS accounts for 20–50% of referrals to gastrointestinal clinics within secondary care, and it is estimated that up to 50% of those diagnosed with IBS are referred to hospital for other tests, such as endoscopy (British Society of Gastroenterology, 2013).

Patients are often fearful that they have conditions such as inflammatory bowel disease (IBD) or cancer. Some studies have shown that this fear is often still present even at the end of consultations, which may contribute to patients returning so often (Thompson et al, 2000). This is why reassurance and explanation from all clinicians is so important (Thompson et al, 2000).

‘Patients are often fearful that they have conditions such as inflammatory bowel disease or cancer’

CURRENT PHARMACOLOGICAL TREATMENT OPTIONS

Most current treatments are aimed at relieving individual symptoms (NICE, 2008). Many of these are targeted at treating either diarrhoea or constipation and have varying levels of success depending on the patient and the nature of their IBS. This can mean that patients often receive multiple treatments for different symptoms (NICE, 2008).

New treatments for IBS can improve patients’ quality of life by targeting specific symptoms including abdominal pain, bloating and constipation. As such, they represent a welcome development in the management of the condition (Table 2).

DIETARY AND LIFESTYLE ADVICE

The chronic nature of IBS requires good basic information about dietary and lifestyle adjustments. Self-management is also stressed.

NICE (2008) provides clear general advice about diet:

- Have regular meals and take time to eat
- Avoid missing meals and long gaps between eating
- Restrict tea and coffee to three cups per day
- Limit high-fibre foods (wholemeal, cereals high in bran, brown rice)
- Those suffering from bloating should try oats and linseed (up to one tablespoon per day).

There is some evidence that probiotics can improve the symptoms of IBS (Nikfar et al, 2008), and NICE guidance recommends that patients try a four-week course. The reasons for probiotic efficacy are unclear, but may relate to a rebalancing of normal gut flora. However, NICE does not specify which particular strain of probiotic should be used (NICE, 2008).

COMPLEMENTARY THERAPIES

As with many chronic illnesses, patients often seek out complementary therapies to help them manage their symptoms. However, in the case of IBS there is little, or no, published evidence for these. Indeed, NICE guidance recommends that acupuncture and reflexology are not to be encouraged (NICE, 2008).

There is good evidence for the role of hypnotherapy, however (Houghton et al, 1996). Specialist gut-directed hypnotherapy uses visualisation and deep relaxation targeted at the bowel. Studies have shown it to be beneficial, not only reducing symptoms, but also improving quality of life (Houghton et al, 1996).

THE ROLE OF COMMUNITY NURSES IN IBS

Nursing support is important in the management of IBS. Many patients feel that their illness is not taken seriously enough by clinicians (British Society of Gastroenterology,
Five-minute test

Answer the following questions about this topic, either to test the new knowledge you have gained or to form part of your ongoing practice development portfolio.

1. What is irritable bowel syndrome (IBS)?
2. Name some of the common symptoms of IBS.
3. What are some of the reasons for the development of IBS?
4. Name some of the potential treatment options for IBS.
5. Why is self-care so important?

2013). Although the condition is not life-threatening and will not shorten life expectancy, it is a lifelong condition that has a serious effect on quality of life (Longstreath and Thompson, 2006).

A strong nurse-patient relationship can help nurses to share clear information with patients, assist them in setting management goals and evaluate adherence to treatment on an ongoing basis (British Society of Gastroenterology, 2013).

As a first-line option, patients with IBS are usually advised to try and treat their symptoms by altering their diet and increasing their fibre intake. However, if the patient has diarrhoea, flatulence or abdominal bloating, a high-fibre diet can actually worsen these symptoms.

In many cases, altering diet is ineffective at relieving patients’ symptoms, and this leads to repeat visits to primary care professionals and referrals to secondary care to complete investigations, exclude other organic diseases and confirm the diagnosis of IBS.

The focus on reducing secondary care referrals has been prompted by increasing waiting times and the move to manage long-term conditions closer to the patient’s home (Department of Health [DH], 2012). There are real opportunities to optimise IBS management here, and gaining a positive diagnosis for IBS in primary care is possible. Primary care professionals, such as community nurses, have the benefit of greater familiarity with the patient and previous consultations to refer to and they can view symptoms in context, rather than in isolation. For example, where patients have developed constipation, community nurses are able to view this change in bowel habit with reference to an individual’s medication history, dietary changes and mobility, etc.

Supporting patients to self-care, using clear, validated patient education materials will lead to a greater acceptance of IBS as a chronic condition. Self-management of long-term conditions such as IBS is acknowledged to be a fundamental part of helping patients live with ongoing symptoms and nurses can take a lead in this, using their relationship with patients to help them manage their condition.

Encouraging patients to self-care

The IBS Network provides dedicated support to people living with IBS in the UK. The Network aims to help them, their families and carers to manage their IBS and achieve an improved quality of life. While the Network’s online resource (http://www.theibsnetwork.org) includes fact-sheets and other information, it has also developed a self-care management programme that members can access online. There is an interactive programme for the management of IBS, which consists of 12 modules that have been adapted for individual study, or which can be used by self-help groups. The self-help module includes:

- Have I got IBS: what is IBS; what else could it be?
- How do I know if it is anything more serious?
- What are the causes of IBS?
- Diet: food allergy, intolerance, food and mood, pre- and probiotics
- Stress: reducing fear and panic, managing anger/despair, psychological therapies
- Medical: when to see a doctor, medical treatments
- Therapies: hypnotherapy, counselling and psychotherapy, nutrition, and herbal therapy
- Symptom management: constipation, diarrhoea, bloating, abdominal pain, symptom tracker, bowel-directed relaxation module.

The course aims to help individuals to understand and self-manage their IBS.

CONCLUSION

Community nurses can play a major role in improving the management of people with IBS in the community setting.

Firstly, it is important to recognise the recommendations from both NICE and the British Society of Gastroenterology, which stipulate that the management of most patients with IBS can take place within a primary care environment and does fall within the community nursing remit (NICE 2008; British Society of Gastroenterology, 2013).

It is also important to enable a positive diagnosis by recognising the chronic nature of IBS and supporting patients to self-manage, answering questions and directing them to self-management resources.
Enhancing IBS services, including providing access to specialist and practice nurses, GPs with a special interest or secondary care gastroenterology services, is also vital, as is developing local pathways in partnership with secondary and primary care services to assist in triaging referrals and help with symptom management.

Ensuring continuity of care, as well as providing advice and support for people with IBS can help them overcome the burden of the condition. Helping patients achieve a better quality of life should be a specific aim of community nurses.

Finally, community nurses should aim to take an active role in the management of IBS patients by developing care pathways, which take into account new treatments.

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