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Friends and Colleagues,

Say goodbye to cold weather, winter blues, and the stress from kids home from school because of bad weather. Spring has arrived bringing sunny days, flowers, and the chance to enjoy the outdoors again!

Each season, around the school year, our practice sees patients suffering from a common condition called Irritable Bowel Syndrome (IBS). Spring and summer is the time to recover and workout ways to cope with symptoms. This functional gastrointestinal disorder not only causes recurrent abdominal pain, it can be associated with emotional stress and impaired health-related quality of life. In this issue we discuss the predominant symptoms and causes, nutritional recommendations for treating, and the important role that psychosocial factors play in clinical outcome.

Here in our practice, pediatric physicians, dieticians, and psychologists use a team approach in treating this problem; and we are always available to help you and your patients.

Regards,

Youhanna S. Al-Tawil, MD
Medical Director

SPECIAL ANNOUNCEMENT!

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Irritable Bowel Syndrome

Youhanna S. Al-Tawil, MD

IBS is the most common diagnosis made by gastroenterologists in the United States accounting for 12% of visits to primary care providers and an annual estimate of $8 billion in direct costs and $25 billion in indirect costs. While IBS affects three times as many women as men, only an estimated 25% of persons seek medical care; and studies suggest that those who seek care are more likely to have behavioral and psychiatric problems.

IBS is a condition of recurrent abdominal pain or discomfort at least 3 days/month in the last 3 months and associated with improvement of discomfort with defecation, onset associated with a change in frequency of stool, and/or a change in form (appearance) of stool at least 25% of the time. The diagnosis of a functional bowel disorder always presumes the absence of a structural or biochemical explanation for the symptoms.

There are four subtypes based on predominant symptoms: IBS with constipation (IBS-C), IBS with diarrhea (IBS-D), IBS with pain (IBS-P), and IBS mixed (IBS-M). Patients with IBS-C experience hard stools more than 25% of the time and loose stools less than 25% of the time, while patients with IBS-D experience loose stools more than 25% of the time and hard stools less than 25% of the time. Some patients may also have IBS with alternating diarrhea and constipation (IBS-M). This change in frequency and form of stool found with IBS-C, IBS-D, or IBS-M can be noted in the symptom-based criteria (Rome III) for IBS diagnosis.

In approximately 48-60% of patients, psychological comorbidities can include: depression, anxiety, abuse, somatic attribution and hypochondria. Central pain processing disorders include fibromyalgia, chronic fatigue syndrome and chronic pelvic pain. Other somatic complaints associated with IBS include: headache, fatigue, myalgias, dyspareunia, menstrual pain, sysuria, and dizziness/syncope.

Screening studies are recommended when certain historical information is present. Alarm symptoms, or red flags, requiring pediatric GI referrals include evidence of gastrointestinal bleeding such as occult blood in the stool, rectal bleeding, or anemia; anorexia or weight loss; fever; persistent diarrhea causing dehydration; severe constipation or fecal impaction; a family history of gastrointestinal cancer, inflammatory bowel disease, or celiac sprue. In general, if alarm signs or red flags are not present, and screening from the referring physician is negative, further testing is not needed.

TREATMENT

A treatment strategy is based on the nature and severity of symptoms, characteristics and degree of functional impairment, and the presence of psychosocial difficulties affecting the course of the illness. Mild symptoms usually respond to education, reassurance, and simple treatments not requiring prescription medications. Moderate symptoms require pharmacological treatments, and severe symptoms frequently require referrals for psychological treatments and support.

Where constipation is predominant (IBS-C), consumption of fiber may alleviate constipation and related symptoms such as abdominal pain and tenesmus. Constipation can safely be treated with osmotic laxatives such as nonabsorbable carbohydrates, milk of magnesia, magnesium citrate, or a polyethylene glycol solution. Polyethylene glycol can be easily titrated by the patient under the supervision of the physician, allowing adjustment in dose as symptoms can fluctuate. Lubiprostone is a chloride channel activator indicated for IBS-C in women and adults with idiopathic constipation.

In patients where diarrhea is predominant (IBS-D), a trial with a lactose free diet and avoiding food that make symptoms worse is recommended. Classic antidiarrheal agents such as loperamide and diphenoxylate may help decrease the frequency of bowel movements and improve the consistency of stool. Loperaminde may be useful in some IBS-D patients to manage diarrhea by improving stool frequency and consistency, stool urgency, and fecal incontinence, but not specifically abdominal pain. Alosetron hydrochloride is a 5HT3 receptor antagonist that is currently available under a restricted use program and approved only for women with severe IBS-D who failed conventional therapy. The most widely used antidepressants in IBS are tricyclic antidepressants (TCAs) and selective serotonin reuptake inhibitors as they reduce pain and improve global IBS symptoms. Their analgesic and anxiolytic effect is thought to improve GI motility and function. Treatment must be preceded by screening EKG because of potential long QTc syndrome and cardiac arrhythmia. Doses are usually lower than those used for mood elevation.

In IBS-M and IBS pain predominant (IBS-P), antispasmodics such as hyoscyamine, dicyclomine, have been used to help relieve abdominal pain or discomfort attributed to intestinal smooth-muscle spasm and an exaggerated motility response of the small bowel and colon. They are considered to provide short-term relief. Another treatment of diarrhea and pain/discomfort is based on antagonism of the 5-HT3 receptors. Tricyclic antidepressants (TCAs) are often used at low doses, because their major impact in IBS may be more associated with analgesic and motility effects rather than treatment of psychological symptoms.

PSYCHOLOGICAL TREATMENT

Psychological treatment can be considered when IBS symptoms are moderate to severe, when patients have failed to respond to medical treatments, or when there is evidence that stress or psychological factors are contributing to GI symptom exacerbations. The physician has an important role in clearly communicating why a referral for psychological treatment is recommended. If not done properly, patients may not accept the referral and feel abandoned by their physician. Psychological treatment may initially be expensive because it requires multiple, long sessions, but the benefits over time may reduce clinical visits and healthcare costs.

Reducing IBS Symptoms with Nutritional Tips

Ashley Rogers, MS,RD,LDN

Managing a diet for Irritable Bowel Syndrome (IBS) can help relieve the symptoms of discomfort. Tolerance to specific foods is very individualized, therefore keeping a food diary can help pinpoint any specific foods or food groups that can make IBS symptoms worse. It is helpful to avoid foods that cause gas or flatulence, including: cabbage, broccoli, cauliflower, brussel sprouts, corn, onion, fatty meats, whole milk and cheeses, caffeine, coffee, and carbonated beverages.

A high fiber diet helps; fiber will keep the colon mildly distended and prevent spasms that can often cause abdominal pain. Good sources of fiber include: fruits, vegetables, whole grain breads, pastas, cereals, and dried beans. Slowly increasing the amount of fiber by 2-3 grams each day can decrease the risk of gas and bloating. Other tips to reduce IBS symptoms include: drinking plenty of fluids to help the body break down and digest foods easier; physical activity to help relieve stress and keep the intestines contracting regularly; and eating smaller, more frequent meals. IBS symptoms are not the same for everyone, but exercising, managing stress, drinking plenty of fluids, and eating a well-balanced diet is important to reduce the discomfort associated with IBS.

Irritable Bowel Syndrome in Children

Kate Christian, LCSW

The two most important psychological issues to address when working with a child who has been diagnosed with Irritable Bowel Syndrome (IBS) are stress management and anxiety. Stress aggravates the gastrointestinal system and makes IBS symptoms worse. Teaching children basic stress management skills helps them feel more calm and in control. I often teach children basic relaxation techniques such as deep breathing, guided imagery, and progressive muscle relaxation. Having fifteen to twenty minutes a day where children can do something they enjoy is also important in managing stress. Planning ahead and learning time management skills can prevent children from becoming overwhelmed by the demands of school and extracurricular activities.

Anxiety can trigger IBS symptoms so it is important to come up with strategies to help children with IBS manage their fears. Children often have anxiety about not having access to a bathroom or using the bathroom in front of their peers. Having a letter to the school from a child's medical provider, requesting unlimited private bathroom access, can help alleviate this concern. If a child is in a new situation help him or her locate the bathroom—sometimes just knowing where it is can help children be less nervous about urgently needing to use it. Parents are key in encouraging open communication about any worries their child may have so they can help them problem-solve. If a child with IBS has anxiety that is difficult to manage, it might be helpful to refer him or her to a counselor or behavioral therapist.

Meet our New Providers

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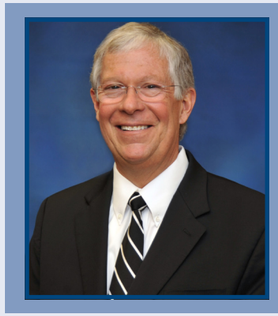

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