Presentation of Irritable Bowel Syndrome in Medical Outpatient Department of a Tertiary Care Hospital

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To study the presentation of irritable bowel syndrome (IBS) in medical outpatient department of a tertiary care hospital and to compare it with the available western data. Seventy five patients suffering from IBS presenting to outpatient department of Mayo Hospital, Lahore were studied during the period from January 2002 to December 2002. The patients presenting in OPD with the complaints of altered bowel habits were included in the study according to Rome's Criteria or Manning's Criteria. Necessary investigations were done to confirm the diagnosis. The western data is not applicable to our community due to different life style and food habits.
Key words: Irritable bowel syndrome, constipation, diarrhoea

Irritable Bowel Syndrome (IBS) is a common illnes[1,2]. The symptoms suggestive of IBS are widely prevalent in our community. The patient may be presenting with abdominal pain, constipation, diarrhoea or constipation alternating with diarrhoea. There can be tenesmus, urgency, rectal dissatisfaction and passage of mucus in stools. Some times the abdominal pain can be so distressing as to simulate serious abdominal conditions appendicitis[12], cholecystitis or pancreatitis. Abdominal distension, increased borborygmi and passage of large amount of flatus disturb the patient all the time[4].

It is not a serious illness. It is not causing increased mortality, but the presence of distressing symptoms cause a lot of discomfort and disturbance.

Most of the data available on this subject regarding age, sex, psychosocial predisposition and symptomatology is available from the western world. Not much work has been done on this subject in Pakistan. The western data may not be applicable to our community due to different food habits, different life style and different climatic conditions. In this part of the world incidence of bacterial and viral gut infections, amoebiasis, tuberculosis and parasitic infections is more than western world. The bowel infections may lead to IBS or IBS may co-exist with more sinister diagnosis. Some times the symptoms of IBS may be exacerbated by organic gastrointestinal condition[5]. In our community there is a lot of quackery. There is a trend for hakeem medication and herbal medication. Self medication is common which all disturb the bowel habits and make the picture more confusing especially in malignancy prone old age group where frequent use of laxatives change the disease pattern. In such perplexing situation the patients of IBS are some times over diagnosed which may miss the underlying organic illness or they may be underdiagnosed and have to undergo a chain of unnecessary investigations causing a lot of discomfort and economical burden[6,7,8,9,10]. So there is a dire need to make our own strategy to solve this common problem.

Material and methods

This is an observational, non interventional, cross sectional study of 75 patients. The patients presenting in medical OPD of Mayo Hospital, Lahore were studied.

Inclusion criteria

The patients included in the study were evaluated according to universally accepted Rome and Manning Criteria.

Manning Criteria[10]

1. Looser stools at onset of pain.
2. More frequent bowel movements at onset of pain.
3. Pain eased after bowel movement.
4. Visible abdominal distension.
5. Passage of mucus.
6. Feeling of incomplete evacuation.

Rome Criteria[12]

At least 12 weeks, which need not to be consecutive in the preceding 12 months of abdominal discomfort or pain that has two of three features.

i. Relieved with defecation and/or
ii. Onset associated with a change in frequency of stool and/or
iii. Onset associated with a change in form (appearance of stools).

The following symptoms suggest the diagnosis of IBS.

- Abnormal stools frequency.
- Abnormal stool form (lumpy hard, or loose/watery stool).
- Abnormal stool passage (straining urgency or feeling of incomplete evacuation).
- Bloating or feeling of abdominal distension.

Exclusion Criteria

a. Frequent nocturnal symptoms.
b. Absence of history of relapses and remission.
c. Watery stools–where stool volume is more than 200ml/day.
d. Persistent weight loss or vomiting.
e. Presence of fever, anaemia, rectal bleeding, abdominal guarding or mass.
f. Endoscopic abnormality

The patients included in the study were having inappropriately well appearance. A complete medical history was taken with special emphasis on laxative use, hakeem medication and self medication. Any history of fever, weight loss or mass formation was noted.

In the physical examination presence of lymphadenopathy, visible peristalsis, rectal fissures or abscesses, abdominal mass, oral ulcers, evidence of mal-absorption of fat or other nutrients was noticed. Appropriate investigations were done which included CBC, ESR, Hb%, RBC morphology, B Sugar and B urea; stool for ova, cyst, parasites, leucocytes, fat, blood and occult blood, thyroid function test, Endoscopy and biopsy, barium meal follow through and CT abdomen was advised when needed.

Results and observations

Seventy five patients were studied during January 2002 and December 2002. Male patients were 50 and 25 were female patients. The age distribution was as follows.

Table 1. Age distribution (n=75)

Age in years	Male	Female
10-15 years	03	-
16-20 years	02	-
21-30 years	17	02
31-40 years	13	-
41-50 years	10	18
51-60 years	05	05

The female patients usually presented in their late forties. The main complaints were as follows.

Table 2. Chief complaints

Complaints	No.
Predominant diarrhoea symptoms	17
Predominant constipation symptoms	48
Diarrhoea alternating with constipation	10

Table 3. The associated symptoms

Symptoms	Male	Female
Feeling of bloatness	10	03
Frequent passage of flatus	30	10
Heaviness in abdomen	02	03
Uneasy feeling in abdomen	02	02
Heaviness of head	04	04
Frequent belching	09	07
Pain before defecation	15	07
Pain after defecation	04	03
Sense of suffocation	04	03
Increased intestinal sounds	10	07

Discussion

In this study we concluded that the patients are much bothered about their symptoms and they want to get rid of these as soon as possible. The patients go on changing their physician as they are not easily satisfied. They took a lot of herbal medicines and hakeems medication before presenting to outpatient department. They were prescribed frequently different antibiotics and anti-amoebic treatment without making any definite diagnosis or without asking for proper investigations.

Most of our patients were male contrary to available western data. Dietary modification was not easily adaptable nor easily accepted. Dietary modification when strictly observed was not very effective.

The altered bowel habits were not related with their physical activity. There is no definite relation to any specific economic group. Usually IBS is not associated with other functional disorders. That is again contrary to western data[12].

Predominant diarrhoea IBS may sometimes be aggravated by psychological upset, otherwise no definite relation was observed. Predominant constipation group belonged to old age. Before making a diagnosis of IBS, important conditions to be kept in mind are alactasia, mal-absorption, drug toxicity, laxative abuse, visceral autonomic neuropathy, hypo or hyperthyroidism, inflammatory bowel disease, food allergies, colonic or pancreatic malignancy, chronic pancreatitis, giardiasis, amoebiasis and psychiatric disorders.

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