Chapter 1

What Is IBS? Classifying the Condition

In This Chapter

- Getting some basic facts
- Recognising your symptoms
- Linking mind and body

IBS is a reality for many people. Up to 11 per cent of the British population have IBS symptoms, and no single definitive cure is in sight. That's quite a double whammy.

But we have some good news: We know a whole lot more about IBS today than we did even five or ten years ago. And although no miracle drug exists that can cure IBS, we do have a lot of treatment options that can provide relief if you're willing to take some time to figure out what works for you.

In this chapter, we paint a picture of IBS with a broad brush. We give an overview of what having IBS is like, look at the typical symptoms, and find out how doctors define IBS. We also talk briefly about other medical problems that frequently occur alongside IBS. We explain which diseases can sometimes be mistaken for IBS, and we strip away the confusion surrounding the role that psychology plays in the condition by asking whether IBS is 'all in the mind'. Many of the issues we touch on in this chapter we cover in depth in later chapters.

Tackling IBS head-on

Even though around 6 million people in the UK have IBS, many won't even mention it to their doctors. The reason is partly embarrassment and partly a perception that nobody can help. But a lot of confusion also exists about

what is normal and when you need medical help. People with IBS often remark (at least at first) that they just assumed their gut was having an off day or two and that things would settle down. That may sound odd when you are running to the toilet dozens of times a day or rolling about in agony, but it's surprising what we tell ourselves about ways our bodies behave. Perhaps you have a desperate optimism that things will get better and you won't need to have any nasty tests or treatments, or get a diagnosis that you don't want.

If you have mentioned your symptoms to your GP, she may told you not to worry – but that's easier said than done when you have pain and your bowels are acting like they're inhabited by alien beings. Perhaps your doctor told you to increase the fibre in your diet, which made you feel even worse. Or maybe your doctor prescribed some medications that didn't work. These experiences can affect your attitude towards your condition, perhaps making you feel that you don't really have a medical condition that can be treated or that your situation is hopeless and nobody can help.

The end result of these influences – embarrassment, helplessness, and denial – is that a majority of people with IBS suffer in silence. But IBS is a real condition, with very real symptoms – as you know all too well – and many treatments and therapies can make a difference. To get on top of your condition you need to believe that it exists and know that you are able to do something about it.

As we discuss later in this book, doctors (especially GPs) are often limited in the medications that they can prescribe, and even more limited in the time they can spend with each patient. This means that your doctor may not be able to give you the best tools available to manage your condition and counsel you in depth about diet, exercise, stress reduction, and how to handle the emotional impact of IBS. Throughout this book, however, we give you those tools and offer a wealth of information about IBS that may just change your life.

Considering a Condition That You Can't Put Your Finger On

IBS is a *functional* condition. That means IBS doesn't cause structural damage to your body the way that a disease does, but it changes the way your body operates or functions. Your doctor can't see the results of IBS on a scan or order a lab test to get a quick diagnosis. To diagnose IBS, your doctor rules out a whole list of other possible bowel conditions and diseases first, such as food allergies and intolerances, or bowel cancer. All this uncertainty makes IBS seem unreal to some people, who may wonder whether the condition is 'all in your head'.

But although IBS may be invisible to others, its symptoms certainly make their presence felt. You know IBS couldn't be more real when your symptoms impinge on your daily life. Having to urgently go to the bathroom may wake you up in the morning. Or you may get up feeling fine but be gripped by painful gas and bloating as soon as you eat your first bite of breakfast. If you have constipation, you may have incredible discomfort, and even though you always feel a certain pressure that makes you think your bowels are about to move, nothing much seems to happen to alleviate your discomfort.

You can't put your finger on a lump or bump that is IBS, or show your friends and colleagues a picture of it (although they may get a feel for the condition if they look at the images at `www.aboutibs.org/site/about-ibs/art-of-ibs/gallery` that people with IBS have sent to the International Foundation for Functional Gastrointestinal Disorders to express their condition). However, you can certainly pinpoint the disruption that IBS causes to your life, and the misery of your symptoms.

Searching for Evidence

The medical world these days looks for evidence about every aspect of disease. Rather than the old-fashioned 'doctor knows best' approach to treating conditions, people want solid statistics and scientific principles – *evidence-based medicine*. What proof is there, doctors now constantly ask, that diseases first described hundreds of years ago actually exist and that treatments long recommended really work?

Asking questions, debunking myths, and setting the facts straight is healthy and often worthwhile. Take stomach ulcers, for example: For many years, doctors thought ulcers were the result of excessive acid eating away at the lining of the stomach. But in new, more powerful tests scientists discovered that a bacterial infection causes ulcers. Ulcer treatments changed overnight: Instead of giving powerful drugs to suppress the production of stomach acid, doctors swapped to offering a short course of antibiotics. In this way science can provide new evidence which makes doctors completely rethink a disease. This is beginning to happen in IBS, as researchers are demonstrating changes in the levels of serotonin (a neurotransmitter or chemical signal) in the gut (Chapter 17 has more on the latest avenues of research). These new findings may one day provide some insight into the cause.

But if, so far, doctors haven't been able to put a finger on the cause of IBS, where's the evidence that the condition is real? Unfortunately, evidence-based medicine is fairly thin on the ground in the realms of IBS. The most powerful evidence for the existence of the condition used to be the sheer numbers of people describing a similar group of symptoms – one in ten of the population have trouble with abdominal pain, bloating, changes in bowel

habits, and flatulence. Laboratory tests were normal and researchers couldn't find any strange pathological specimens, but arguing that 6 million people imagine their problems is difficult.

But now 21st-century medicine is providing harder evidence that something is amiss in IBS. One group of researchers suggest that in at least some people with IBS, an inflammation exists that hasn't been detected before. Meanwhile, other researchers have evidence of excessive numbers of bacteria in the small intestine in people with IBS; these bacteria may ferment food to generate methane gas, which in turn can alter the *motility,* or movement, of the bowel. Yet more scientists report disruptions in the interaction between the gut and the brain in people with IBS.

Meeting the Rome Criteria

As we explain in Chapter 7, your doctor only *officially* diagnoses IBS after she rules out all other conditions such infections, cancer or food allergy. Therefore, most doctors depend on looking at the pattern of symptoms to define the disease.

Rome seems to have a special place in its heart for IBS. In 1988, the 13th International Congress of Gastroenterology was held in Rome. The congress developed the Rome Diagnostic Criteria for IBS, published in 1990. In 1999, the Rome Foundation revised this list of symptoms and signs that guide a doctor to the diagnosis of IBS to form the Rome II criteria, which provide a more detailed and accurate definition of IBS. Yet further revisions, based on new evidence, led to the Rome III criteria, which are even more precise about symptoms, especially of pain.

If you think figuring out whether or not you have IBS is hard, you're in good company. It took ten multinational working teams collaborating for more than four years to arrive at a consensus for the following symptom-based diagnostic standards.

The Rome III Diagnostic Criteria presume 'the absence of a structural or biochemical explanation for the symptoms', and describe IBS as consisting of recurrent abdominal pain or discomfort on at least three days per month in the past three months associated with two or more of the following:

- Improvement with defecation
- Onset associated with a change in frequency of stool
- Onset associated with a change in form (appearance) of stool

These criteria must have been fulfilled for the past three months with symptom onset at least six months before diagnosis.

In the definition, 'discomfort' means an uncomfortable sensation not described as pain. The Rome III committee also advised that 'in order for subjects to be eligible to take part in pathophysiology research and clinical trials in IBS, they should have a pain/discomfort frequency of at least two days a week'.

Some doctors try to sub-classify IBS according to what sort of bowel habit is predominant. Researchers use a guide known as the *Bristol Stool Form Scale.* Devised by gastroenterologists in Bristol, this guide (which comes with handy pictures!) classifies stools into seven types, according to their appearance as seen in the watery depths of the toilet. Type 1 consists of separate hard lumps ('like nuts', the guide says) – this sort of stool has spent a long time in the colon and is hard to pass. At the other end of the scale, type 6 stools are 'fluffy pieces with ragged edges, a mushy stool' and type 7 stool is 'watery, with no solid pieces'.

About a third of people with IBS have mostly diarrhoea (type 5, 6, or 7 stools). They have *diarrhoea-predominant IBS,* (sometimes called IBS-D). Another third have *constipation-predominant IBS,* (IBS-C) (type 1 or 2 stools). The remainder have a *mixed bowel habit,* with both loose and hard stools (IBS-M). Some people, called *alternators,* can't seem to make their minds up and switch subtype frequently.

Most of the published data on the incidence, prevalence, and natural history of IBS do not distinguish between different subtypes of IBS. This may be especially important when it comes to trials of different drugs, because some drugs work better for diarrhoea-predominant IBS and others for constipation-predominant IBS.

Spotting Primary Symptoms

IBS has a way of interfering with your quality of life – your home life, work, sleep, social life, travel, diet, and sex. IBS also creates a financial burden, costing you directly for medical expenses and indirectly for time off work or school and lost productivity. The costs of decreased quality of life are immeasurable. We discuss these various issues in detail in Part IV of this book.

In the following sections, we describe the various symptoms of IBS and talk about the spectrum of severity that people with IBS can experience. IBS has several major symptoms, and not everyone with IBS has all these symptoms. Some people have a predominant symptom, such as diarrhoea, constipation, or pain 30 minutes to two hours after eating.

The symptoms of IBS that most people experience are:

- **Abdominal cramps:** These cramps can be achy or colicky and tend to occur in the lower abdomen. They are sometimes relieved by a bowel movement or passing gas. If they start up in a public place, you probably automatically try to put a clamp on them for fear of passing gas or having a messy accident. That reaction only adds to the pain.

  

  Many women with IBS, both with constipation-predominant IBS and diarrhoea-predominant IBS, report abdominal cramping and pain which they say is comparable to child birth. Although seemingly unbearable pain is rare, it's very frightening and can result in trips to the accident and emergency department at the hospital.
- **Bloating:** Seventy-five per cent of people with IBS regularly undo their belt to accommodate bloat. Bloating comes and goes so fast that you may know you can't wear anything tight around your waist – low-rider jeans were just made for people with IBS.
- **Constipation:** Chronic constipation is often characterised by straining and pain and a feeling of not fully evacuating the bowel. Although you may have a bowel movement only three or fewer times per week, we know you probably spend much of your time contemplating the relief it brings. When the evasive bowel movement comes, the stool is often hard and lumpy, and your relief is rarely absolute.
- **Diarrhoea:** Diarrhoea may be the most distressing symptom of IBS. Running to the bathroom, especially at work or in public, can be embarrassing. The anxiety of worrying about finding a toilet and getting there in time only adds to the problem. Everyone has the odd anxious moment when the trigger from the brain makes the bowels churn. For people with IBS, that moment may occur many times a day.
- **Alternating constipation and diarrhoea:** Having alternating diarrhoea and constipation may not seem so bad in theory. But when your days of running to the bathroom constantly are replaced by broken promises of a bowel movement, you end up with another kind of misery. Whereas a bowel movement can relieve the pain and cramping of gas build-up, constipation makes you feel like an uncomfortable beached whale.

Recognising Other Common Symptoms

As well as the main symptoms of IBS, some people with IBS also experience the following:

- **Diarrhoea after eating or after waking in the morning:** IBS is particularly harsh when the mere act of eating causes your symptoms. For many people with IBS, the stomach, intestinal juices, sphincters, and

muscles go into overdrive when you chew and swallow. For other people, the very act of opening your eyes first thing in the morning stimulates your metabolism and triggers the urge to go. Standing up adds to the process as gravity drops your intestinal contents to their inevitable end.

- **Excessive gas:** Having gas and burping or passing gas is not life-threatening. Most gas is odourless, consisting of oxygen (from swallowing air), nitrogen, hydrogen, and sometimes methane (which is what students light at parties). The noxious odour we associate with flatulence is produced by sulphur-based compounds, such as hydrogen sulphide and methyl mercaptan.
- **Incomplete bowel movements:** When you have an incomplete bowel movement, you have the sensation that there's more to come. When you experience that sensation, you may or may not actually have more stool to pass. The feeling is strange and makes you *too* aware of your bowels. It's difficult to know what causes the sensation, but it may be due to mucus in the intestines.

A severe form of the sensation of an incomplete bowel movement is called *tenesmus,* where the constant feeling of the need to go is painful and involves cramping and involuntary straining efforts. Tenesmus is not associated with IBS but is a symptom of inflammatory bowel disease.

Another cause of incomplete evacuation is a *faecolith,* a hard intestinal mass formed from faeces. If a faecolith partially blocks the rectum, it can cause symptoms of alternating constipation, diarrhoea, pain, and an obvious feeling of incomplete evacuation.

- **Mucus in the stool:** Don't be alarmed if you see mucus in the toilet. Mucus that coats the stool comes from an irritated intestinal lining from all the cramping, gas, and bloating. The mucus is actually trying to coat the intestines and protect them from the irritation.
- **Nausea:** Feeling queasy is pretty easy when your stomach and intestines are bloated and pressing up into your diaphragm. The gut–brain axis (which we describe in Chapter 2) is highly tuned – nerves that detect distension of the intestines send signals into areas of the brain, including those that specialise in nausea, so fullness in your digestive system can make you want to gag.

Looking at Less Frequent Symptoms

In this section we mention some other IBS symptoms, some of which occur in the colon and others in the stomach and oesophagus. These symptoms are rarer than the others we discuss in this chapter.

The following symptoms may occur in the large intestine:

- Pain under the left ribs that is not relieved by a bowel movement
- Bloating that subsides at night but comes back the next day
- Stabbing pains in the rectum, called *proctalgia fugax*

The following symptoms may occur in the stomach:

- Stomach pain that can be confused with ulcers
- Inability to eat a large meal due to pressure from bloating

The following symptoms occur in the oesophagus:

- A sensation like having a golf ball in your throat, which does not interfere with swallowing (called *globus hystericus*)
- Heartburn, which is burning pain often felt behind the breastbone
- Painful swallowing, which is called *odynophagia*

IBS does not cause food to become lodged in the oesophagus. This problem is called *dysphagia.* If you experience dysphagia, get checked out by your doctor because it can be a symptom of narrowing of the oesophagus due to cancer, or due to scarring from the inflammatory bowel disease, Crohn's disease.

Dealing With Mild Cases

IBS symptoms come in various shades of mild, moderate, and severe. Some fortunate people with IBS have only mild symptoms and just an occasional flare-up when the triggers turn into explosions (see Chapter 4 to find out what your triggers may be). The majority of people with IBS are lucky enough to be in this group, and if you are, you may never see a doctor about your symptoms. Perhaps you picked up this book just to see whether having three bowel movements a day was abnormal. Rather than make you read the whole book to find out, we can tell you right now – you're probably just fine.

Morning movements

Many people have two or three bowel movements in the morning, which is perfectly normal. The excitement of getting up, the pressures of gravity, having breakfast, and maybe drinking one too many cups of coffee may be enough to give you an extra bowel movement or two.

But, as we mention in the previous section 'Recognising Other Common Symptoms', the rise and shine time can trigger IBS in some people. The stress of getting ready for your work day can increase your urgency to visit the bathroom. And a few extra trips to the bathroom in the morning can make you run late and further increase your stress, thus increasing your symptoms.

If we've just described your morning, here's a simple solution: Set the alarm 30 minutes earlier, and allow your bowels to get moving. You have a more relaxed preparation time and perhaps reduce bowel stress. If you have more time before running out the door, you may spend less time running to the bathroom.

Three a day

Having three bowel movements a day, especially if they come shortly after meals, is not a symptom of IBS. In fact, it's just what the doctor ordered. Some doctors believe that a single bowel movement a day is normal, but others – especially those who practise medicine that deals with dietary supplements and natural remedies – think otherwise.

Think of your body this way: When something goes in, something else must come out to make room for it. So when you push a meal down at one end of the gut, it makes perfect sense that your body goes into action to move things out at the other end. Perhaps you're wondering why we don't just absorb more of our food to avoid the need to excrete the waste. But, as we discuss in Chapter 2, the waste we produce isn't just left-over food particles. Instead, as nutrients are removed from the gut contents, so their place is taken by millions of friendly bacteria which live in the intestines. Along with dead cells which are constantly shed from the lining of the gut, these bacteria account for a large proportion of the stool that you pass.

Even though having more than three bowel movements a day is one criterion for IBS, it's only *part* of the whole picture. If you don't have pain and bloating as well, you probably don't have IBS – your symptoms may be due entirely to what you eat.

Linking Other Problems to IBS

A whole host of problems may relate to your IBS. In other words, if you have IBS, you have a greater chance of having these other conditions. We talk more about these problems in Chapter 5, but here is a list of possibilities:

- Back and groin pain
- Depression
- Fatigue
- Frequent urination
- Insomnia
- Painful periods
- Pain during intercourse

If you're experiencing one or more of these problems, your doctor may treat each as if it does not relate to IBS. We encourage you to ask your doctor about the possible connection so that you won't be treated for symptoms instead of addressing IBS.

Separating IBS from IBD

As we explain in Chapter 7, IBS is a diagnosis of exclusion. That means your doctor has to rule out the really bad guys before settling on a diagnosis of IBS. Some of the worst bad guys in this story are Crohn's disease and ulcerative colitis. Together, these are called *inflammatory bowel disease* (IBD) and they affect about 1 in 1,000 people. IBD causes damage to the gastrointestinal tract that shows up on an X-ray, through a endoscope (a flexible tube that doctors pass into the bowel to examine it internally) or even on blood tests.

The symptoms of IBS can mirror a mild case of an IBD. For that reason, diagnosing abdominal pain and diarrhoea based on symptoms alone can be difficult. However, moderate to severe IBD has many associated symptoms such as fever and a bloody discharge or actual bleeding from the bowels, which quickly set it apart from IBS (where fever and bleeding don't occur).

In general, Crohn's disease and ulcerative colitis affect two different areas of the bowel. Crohn's mostly attacks the small intestine (although it can cause problems at any point from mouth to anus) while ulcerative colitis attacks the large intestine.

Bleeding from the bowel always need proper investigation, so make an urgent appointment to see your GP if you notice small amounts of bright red blood on the toilet paper after opening your bowels. But if you are losing anything greater than a smear of blood, put down this book and call your doctor immediately, or go to your nearest Hospital Emergency Department. You don't have IBS but may have a more dangerous condition such as a cancer or stomach ulcer, and you could lose a lot of blood.

Knowing That IBS Isn't Just Imaginary

It's hard to think of any condition known to medicine where mind and body remain coldly and cleanly separated and where the illness can be said to be either all in the body or all in the mind. Mind-related conditions such as anxiety and depression cause real physical signs such as a fast pulse, sluggish bowels, or weigh loss, and body-related conditions such as an arthritic joint or an in-growing toenail can cause mind symptoms, including low mood, irritability, and tiredness. The mind and body are inextricably linked and the more we find out about ourselves the more intricate these links appear to be.

The latest research on IBS focuses heavily on the relationship between the brain and the gut, known as the *brain–gut axis,* and the influence the brain has on the function of the intestines via the special nervous system of the intestine (we explain this in Chapter 2). IBS is no more 'all in the mind' than it's 'all in the gut'.

We suspect that people who worry that they are somehow imagining their IBS – perhaps thinking that they may be fussing unnecessarily over something that is really quite normal – aren't looking for an analysis of the anatomy of the nervous system. Instead, they need warm reassurance that their condition is both real and can be treated, that their symptoms are valid and not trivial, and that their despair is not a madness. They are asking for help – not dismissal. Most doctors are aware that their patients fear being branded time-wasters, whingers, or lunatics, and try hard to show their concern and belief in the problem. If your GP seems to think that your IBS is all in your mind, then maybe it's time to find a new one. This book is full of information and therapeutic ideas that should convince even the most hardened sceptic to take IBS seriously.

Science is helping to dismiss the 'all in the mind' myth as it churns out research that is slowly pin-pointing abnormalities in the gut. Meanwhile, several important international research groups are working hard to tell anyone who'll listen that IBS is not a psychological or psychiatric disorder. Even though test results may be normal, stress is an important factor, and no obvious damage to the tissues can be found, IBS is a very real bodily affliction.