Ali Hutton
Registered Dietitian, Juvela (Hero UK Ltd)

Ali worked as a dietitian in the NHS for six years and is now a product manager for Juvela Gluten Free Foods. She also works as a Freelance Dietitian at the Grosvenor Nuffield Hospital in Chester.

For full article references please email info@networkhealthgroup.co.uk

THE DIETETIC MANAGEMENT OF IRRITABLE BOWEL SYNDROME

Irritable Bowel Syndrome (IBS) is a functional bowel disorder in which abdominal discomfort or pain is associated with defaecation, or a change in bowel habit, and with features of disordered defaecation.[1] It affects 10-20% of the UK population[2] and is characterised by symptoms of abdominal pain or discomfort, constipation and/or diarrhoea, bloating and flatulence.[3] In this article, Ali Hutton looks at the important role of the dietitian in IBS management.

Diagnosis of IBS is on the increase, which places a large financial burden on the NHS.[4] It is recommended that referral be made to a dietitian for advice and treatment where diet is considered to be a major factor in a person's symptoms.[5] Also, it has been recognised that early referral to a dietitian may lead to a reduction in future costs of care for people with IBS.[5] Increased involvement in the management of IBS may represent a good opportunity for dietitians for make their mark and defend their profession in an NHS that is under pressure to commission evidence-based and cost-effective services.[6]

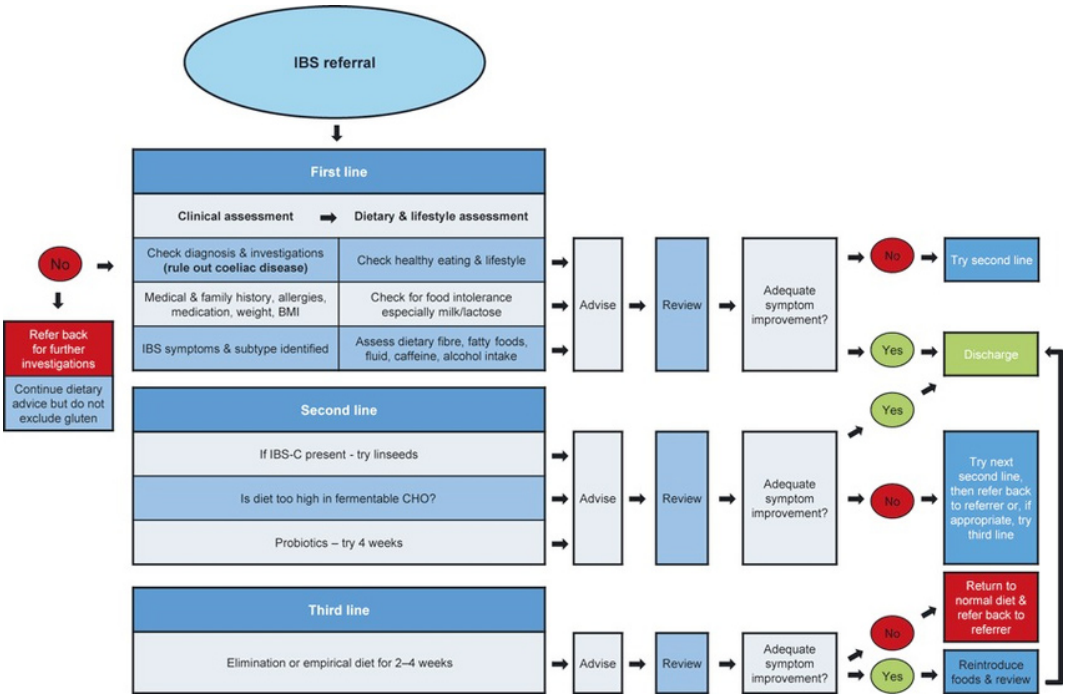
A diagnosis of IBS should be considered only if the person has abdominal pain or discomfort that is either relieved by defaecation, or is associated with altered bowel frequency or stool form[3] and accompanied by two of the following: altered stool passage, abdominal bloating, symptoms worsened by eating and mucus per rectum.[1] In people who meet the IBS diagnostic criteria, a number of blood tests should be done to exclude other diagnoses and they should be assessed and clinically examined for 'red flag' indicators.[3]

GUIDANCE AND PATHWAY

Although gut hypersensitivity, post-infective bowel-dysfunction and a disturbed colonic motility are considered to be possible causes of IBS, its exact aetiology is yet to be established. Because of this, the main aim of treatment tends to be the relief of the most predominant symptom(s). A multitude of treatment options may be considered, including lifestyle intervention, pharmacological treatments, hypnotherapy, physiotherapy, behavioural therapies and dietary manipulation. In 2015, the NICE Irritable bowel syndrome in adults guidance[3] was updated and now recommends that, where diet is considered to be a major factor in a person's symptoms and they are following general lifestyle/dietary advice, they should be referred to a dietitian for advice and treatment, including single food avoidance and exclusion diets.[7] This is based on the assumption that, where people with IBS tend to alter their diet to alleviate symptoms of IBS, they often do so in a self-directed manner or with guidance from inadequately qualified nutritionists, which can lead to the exclusion of individual foods or complete food groups. The guideline recognises that this may lead to inadequate nutrient intakes and ultimately malnutrition.

The IBS Algorithm (Fig 1) from the British Dietetic Association's (BDA) IBS guidelines[8] has given dietitians an evidence-based chronological pathway for the dietary management of adults with IBS. The algorithm encourages the use of clinical assessment,

Figure 1: The IBS Algorithm taken from the BDA's evidence-based guidelines for the dietary management of irritable bowel syndrome in adults[8]



alongside dietary and lifestyle factors, in a three-tiered management approach. First line advice includes evaluation of eating habits and lifestyle, consideration of a food intolerance and assessment of dietary fibre, high-fat foods, fluid, caffeine and alcohol intake. Second line advice includes consideration of the low FODMAP diet, which will be discussed in a little more detail here, as its success has increased the referral of patients with IBS to dietitians for advice and has given dietitians recognition as having an important role to play in the management of IBS. Third line advice involves elimination and empirical diets.

THE LOW FODMAP DIET

FODMAPs (Fermentable Oligosaccharides, Disaccharides, Monosaccharides and Polyols) are short chain carbohydrates, the ingestion of which is believed to increase the delivery of readily fermentable substrate and water to the distal small intestine and proximal colon, resulting in luminal distension and induction of functional gut symptoms.[9] The low FODMAP diet is based on the theory that restricting these fermentable carbohydrates leads to a reduction in symptoms.

Whilst the NICE irritable bowel syndrome in adults guidance[3] gives advice around the balance of good health, dietary fibre, wheat and lactose intolerance, sorbitol, caffeine, prebiotics, probiotics and aloe vera, the aforementioned 2015 update[7] considers the use of the low FODMAP diet in the dietary management of IBS in adults. The guideline now recommends that if a person's IBS symptoms persist whilst following general lifestyle and dietary advice, they should be offered advice on further dietary management, including single food avoidance and exclusion diets (e.g. a low FODMAP diet).

Given the lack of evidence on the long-term adverse effects of following the low FODMAP diet, the potential harms of following the diet without dietetic support were considered by the NICE committee. Nutritional inadequacy or deficiency caused by inappropriate or blanket restriction without suitable food replacements

and modification of faecal microbiota whilst following the low FODMAP diet, were recognised as potential harms. The guideline now recommends that, given the complex nature of the diet, it should only be undertaken under the advice of a healthcare professional with expertise in dietary management. In addition to this, the NICE Costing report for IBS[5] recommends increasing the use of dietitian referrals for people where diet is considered to be a major factor in their IBS symptoms.

IBS MANAGEMENT IN PRIMARY CARE

The British Society of Gastroenterology (BSG) clinical commissioning report for IBS/functional symptoms[10] advises that up to 50% of patients who are diagnosed with IBS by their GP are referred to secondary care for endoscopy and other tests to eliminate more serious illness. This has a cost implication for an already over-stretched NHS. The report identifies a lack of dietary advice before referral to secondary care as a common failing here. It suggests that IBS management in primary care could be improved and savings could be made in both time and money by increasing integration with dietitians.

This recognition from NICE and the BSG offers dietitians an ideal opportunity to promote and defend their profession in an NHS that needs to commission services that are effective and can potentially generate savings. But recognition is not simply enough and dietitians need to demonstrate that they can deliver an effective treatment for IBS that is cost-effective and evidence-based.

THE IMPORTANCE OF PATIENT REPORTS

As IBS remains a symptom-based condition that cannot yet be reliably diagnosed or monitored with biomarkers alone, the patient report is essential to determine the diagnosis, gauge overall disease severity, develop rational treatment plans and assess outcomes.[11] The most commonly employed definition of clinically meaningful improvement in IBS has been a patient's 'yes or no' report.[12] Whilst these definitions are assumed to have face validity, empirical data is needed for each outcome measure to assess the clinical significance of different degrees of change from both the patient's and the physician's perspectives.[12]

Dietitians need to be able to identify and predict what the desired outcome of their intervention will be and to what extent this has been achieved from the viewpoint of both the dietitian and the recipient, both of whom can have quite different perspectives and expectations.[13] Patients should not be given expectations of a 'cure'.[9] Also, it is important to explain that diet may not be the cause of their symptoms and, if this is the case, then other therapeutic approaches may be needed. Explaining this from the onset may help reduce disappointment when dietary changes do not help to relieve symptoms.

CONCLUSION

There is no widely adopted validated method for measuring IBS symptom outcomes in clinical and dietetic practice in primary and secondary care.[14] The BDA Gastroenterology Specialist Group (GSG) formed a group in 2012 to develop such a tool, in line with the BDA Model for Dietetic Outcomes.[13] The GSG has encouraged dietitians to get involved in development of this tool.[14]

In conclusion, increasing their involvement and expanding their role in the management of IBS represents an excellent opportunity for dietitians to promote and defend their practice in an environment where commissioning groups favour effective and financially viable services. In order to do this, they will need to continue to find innovative ways of proving their worth and develop outcome measures to demonstrate their effectiveness in the management of this chronic and increasingly common condition.