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Irritable bowel syndrome – doctor`s and patient`s trauma

Key words:

irritable bowel syndrome,
doctor,
patient

Abstract

Introduction: Irritable bowel syndrome represents chronic, functional bowel disorder, without organic substrate, which manifests with abdominal pain, bloating and diarrhea and/or constipation. Diagnosing irritable bowel syndrome includes anamnesis, physical examination and depending on indications, endoscopic exam as well. Therapy includes medications and psychotherapy, during exacerbations.

Case report: Female patient 26 year old, pays a visit to outpatient clinic, due to frequent stools in last couple of weeks. She has 2-4 stools a day, without mucilage or blood in the stool. She feels bloated and experiences abdominal discomfort, which subsides after emptying stool contents. She denies other symptoms and has been perfectly healthy up till now. After the examination we came up with working diagnosis - IBS and the patient was presented with the treatment plan. She disagrees with it and asks for specialist referral. From the first referral, to hospitalization, to making final diagnosis, a year has passed and the final diagnosis has been the same as the diagnosis made by the family medicine specialist.

Conclusion: In order for primary care doctors to be health system gate keepers, it takes sufficient time for them to spend with a patient (reduce the number of patients seen daily), greater work autonomy and adequate health legislations, which is possible through systemic changes, as a result of a dialogue of all relevant participants in the health care system.

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Introduction

Irritable bowel syndrome is a chronic, functional disorder of the large intestine, without organic substrate and is manifested with abdominal pain, bloating and bowel emptying disorder. It is becoming an increasing public health issue, especially in Western countries, with the prevalence of 8-20%. In 50% of patients it appears before 35 years of age and almost 2/3 of the diseased are women. Despite its high prevalence, only 30% of the patients seek doctors` help.

Pathogenesis of the diseases is very complex and still insufficiently researched. Most oftenly mentioned causes are: bowel motility disorder, visceral oversensitivity, psychosocial disorders, genetic predisposition and immunologic mechanisms.

Two, most frequently described forms of irritable bowel syndrome are:

1. IBS with prevalence of constipation, where periods of constipation are interchanging with periods of normal stool emptying. The stool usually contains mucilage. The pain is colicky like and rarely dull and continuous.
2. IBS with the prevalence of diarrhea, is characterized by sudden diarrheas, especially right after awakeninig, during and right after meals, especially after fast consumption of food. Urgency and incontinence of defecation is followed by an intense pain.

Diagnosing IBS is based on anamnesis, physical examination and endoscopic exam, depending on indications (proctosygmoidoscopy, in patients older than 40, who previosly haven`t had IBS symptoms).

Roma III criteria have positive predictive value of 98% in diagnosing IBS. They include reccurent abdominal pain that lasts at least 3 days a month, during last 3 months, together with at least two symptoms:

- Recurrence of pain is connected with changes in stool emptying frequency
- Pain subsides after defecation

During diagnosing proces it is necessary to exclude "alarm symptoms" which would include organic diseases (blood in the stool, anaemia, fever, loss of body weight, diarrhea and pain so strong that it awakes a patient).

Differential diagnosis includes:

- Intestinal lesions caused by medications (laxatives, antacids with magnesium)
- Intestinal diverticulosis
- Psychiatric disorders
- Parasitic infections
- Inflammatory bowel diseases (ulcerative colitis, Crohn`s disease)
- Mal absorption syndrome (chronic pancreatitis, coeliac disease)
- Metabolic disorders (diabetes, thyrotoxicosis)
- Bacterial infections
- Colon cancer

Therapy includes combination of psychotherapy and short time use of medications during the periods of exacerbations (antidiarrhoeics, spasmolytics, laxatives, sedatives).

Case report

Anamnesis: Female patient 26 year old, pays a visit to a family physician, due to frequent daily stools in last couple of weeks. She has 2-4 liquidy stools, a day, on average, acompanied by bloating and abdominal discomfort. Her discomfort diminishes significantly after stool emptying. She hasn`t noticed any changes in her stool (colour, blood, mucilage). She denies fever, urunary problems, her apetite is good and she hasn`t noticed any weight loss. She sleeps well at night and has no pain or stools then. She noticed that her problems were significantly lesser while being on vacation. She was recommended an antdiarrhoic drug, by a pharmacist and it helped her, but only while taking the drug. She is a mother of two, non smoker and up till now she had no health problems. She denies hereditary diseases, is currently unemployed and lives with her family.

Physical examination: Alert, oriented, afebrile, eupnoic, has no movement problems, communicates normally, stronger osteomuscular build, normal skin colour, no rashes, oedema or periferial lymphadenopathy. Her head is normal configuration, female type of crinosity, eyes are symetrical, irises round, symetric and react to light and accomodation. Nostrils are free, Valleix points non tender. Throat is not soar, tongue is wet. Her neck is cilindric, movable, thyroid gland is not enlarged. Chest of normal configuration, with normal respiratory sounds. Regular heart rate rhythm, no murmurs. BP 100/70 mm Hg, pO2 98%. Abdomen is soft, flat, non tender to palpation. Extremities are smooth, no varicous veins. Cranial nerves are intact. Posture is normal, Romberg is absent.

Lab results: ESR 5, FBC Er 4.59, Hgb 137, HCT 0.416, Le 4.3, Gr 59.9%, Ly 28.8%, Tr 237, glucose 5.0, TSH 1.45.

Abdominal ultrasonography: The liver is normal in size and overall echogenicity, no focal lasiones. Gallbladder is of normal wall thickness and no evidence of intraluminal echogenicity. Hepatic ductuses are of normal diameter. Pancreas is normal in appearance. Big, abdominal blood vessels show no signs of thrombosis or dissection. Kidneys and spleen are normal in appearance. Urinary bladder is normal in appearance and filled with clear urin. Bowels are distended and peristaltic movements are pronounced. There is no free fluid in abdomen, pleura or pericardium.

Ultrasonographic findings of the thyroid gland are normal.

Workig diagnosis: Irritable bowel syndrome
Treatment plan: Inform the patient about the nature of the disease, recommend life style changes, include the use of antidiarrhoeics, SSRIs and benzodiazepines, with regular follow up appointments. The patient didn`t approve of the treatment plan. She was of the opinion that her disease was more serious and she didn`t need psychiatric medications, so she requested specialist refferal.
First internist`s consultation: Dg: Functio laesa intestini alia; Th: probiotic, anidiarrhoeic.
Patient was reffered to gastroenterologist.
First gastroenterologist`s consultation: Dg: Functio laesa intestini alia; Th: probiotic, antidiarrhoic.
Pacient was suggested to examine her coproculture (parasites, protozoae, fungi, Helicobacter pylori stool antigen), complete lab. results, thyroid hormones.
Second gastroenterologist`s consultation: Dg: Idem; Th: Idem
Patient was advised to perform FBC, amylase (s) and lipase (s), fecal calprotectin.
Third gastroenterologist`s consultation: Dg: Idem; Th: Idem.
Patient was advised to bring the findings of HBP Ag, FBC, gastroscopic findings with biopsy.
Abdominal ultrasonography: Heterogenous mass, 5 cm of diameter, in left paraumbilical region.
Fourth gastroenterologist`s consultation: Dg: Abdomen in obs; Th: Idem.
The patient was scheduled for abdominal CT scan.
Second internist`s consultation: Dg: Abdomen in obs; Th: Idem.
Internist also agreed to abdominal CT scan.
Hospitalization:
Colonoscopy: Colitis chronica (medium activity)
Gastroscopy: Gastroduodenitis, GERB gr A
CT scan: normal; Lab results: normal.
Final diagnosis: Colon irritabile, Syndroma psychoorganicum.
The importance of life style changes was emphasized to the patient. She was given SSRI and benzodiazepine (with the advice for follow up appointment when these drugs might be discontinued), salycilates and probiotics for 21 days.

Discussion

Irritable bowel syndrome may appear in one in five people, at some point of their lives. It can affect their life quality and use of health services[1,2,3].

Treatment costs for IBS are significant. Treatment of only one patient with IBS costs 6800 USD, a year, in the USA[3,4].

IBS patients take up a lot of time in family medicine clinics and more often than not they are cause of frustration for their doctors, mostly because of patients` unrealistic expectations, connection between the disease and psychosocial factors and chronic caracter of the disease[1]. In the internet era, when information are available online, most patients can`t interpret the information they find properly due to their lack of medical knowledge. It`s questionable whether the information are trustworthy and how they can be interpreted in the context of patient`s health problems. The greatest fear of IBS patients is that they might have colon cancer. Thus, they frequently pay visits to family medicine clinics, use referal services, visit emergency rooms and refuse psychotherapy. According to the current Patients` rights protection law, a patient is entitled to second opinion, concerning his health problems. Family doctor has to write a referral letter, if the patient insists, whether the doctor finds it justifiable or not. Current law also entitles a patient to ask for the opinion of another specialist if he wasn`t satisfied with the opinion of the first consultant[5].

Primary care physicians are responsible for rational spending of health resources and unjustifiable referals, due to patients` guaranteed health rights, are a great problem[5] Referal justification is measured by returned specialist report. Patients avoid using medications, ask for repeated diagnostic procedures, even before scheduled follow up visit and thus, work efficacy is diminished and health resources are irrationally spent[5].

The patient in the case report was properly diagnosed during her first visit to the family doctor. Cost of the visit, including lab results and ultrasonographic exam, was 30€. From the first patient`s request for referal to making final diagnosis, which was suggested from the very start by family physician, a year has passed and health costs rose to 3000 €.

Who is responsible for irrational resources spending, lost time, patient`s state of health, remains unknown.

Family physician must be very knowledgable in order to treat great spectrum of diseases he incounters in everyday practice. The question is why are they often refered to as "referral writers"? Are patient`s unrealistic requests and health system the only ones to blame?

The patient from the case report was referred to the consultant with the diagnosis *Irritable bowel syndrome*. Family physician was of the opinion that according to curent AGA (American Gastroenterologist Association) guidelines further diagnostic procedures were not necessary. The consulting physician didn`t share this opinion and ordered an abundance of diagnostic procedures. Would the turn of the events be identical if financial control, by Health insurance fund, was as rigorous at higher health levels as in primary care, is anybody`s guess. A solution to the problem could be introduction of "internal referrals", as is the case in European Union. Internal referral letter is provided by the consultant for the diagnostic procedure he requires. This would make physi-

cians from primary and secondary level equals and it would enable to establish whose responsibility is irrational spending and who would be sanctioned[6].

Will the family physicians earn their well deserved place in the health system and when will it happen is hard to say. Until then, all that`s left is for us to do our jobs responsibly, expand our clinical skills through continuous medical education and improve communication with our patients[7,8].

Conclusion

In order for primary care physicians to be health system gate keepers, they need more time with their patients (less daily visits), greater autonomy, compared to secondary health level, and adequate health legislations, which is possible only through systemic changes, as a result of a dialogue of all relevant participants in the health care system.

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Синдром иритабилног колона – траума лекара и пацијента

Кључне речи:
иритабилни колон,
љекар,
пацијент

Сажетак

Увод. Синдром иритабилног колона - ИБС (*Irritable bowel syndome*) представља хронични функционални поремећај рада дебелог црijева без органског узрока, који се карактерише боловима у стомаку, надутошћу и поремећајем пражњења црijева. Дијагноза синдрома иритабилног колона поставља се на основу анамнезе, физикалног прегледа и у зависности од индикације ендоскопским прегледом. Терапија подразумјева комбинацију психотерапије и медикаментне терапије у периодима егзацербације.

Приказ случаја. Пацијенткиња старости 26 година, јавља се у амбуланту због учесталих столица у последњих пар недјеља. У просјеку дневно има двије до четири течније столице без присуства слузи и крви, надута је и осјећа нелагоду у стомаку која попушта након нужде. Друге тегобе негира. До сада здрава. Након учињеног прегледа поставља се радна дијагноза ИБС и пацијенткињи предочава план лијечења. Наилази се на отпор и захтијева упутница специјалисти. Од издавања прве консултантске упутнице до хоспитализације и постављања коначне дијагнозе, која је идентична дијагнози постављеној приликом првог прегледа љекара специјалисте породичне медицине, прошло је годину дана.

Закључак. Да би љекари примарне здравствене заштите чували *улазна врата* здравственог система, неопходно им је вријеме за пацијента (смањење броја прегледа), значајно већа аутономија и адекватна здравствена легислатива, што је могуће само кроз системске промјене, као резултат дијалога свих релевантних фактора у систему здравствене заштите.

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