

PSYCHOLOGICAL APPROACH IN THE MANAGEMENT OF IRRITABLE BOWEL SYNDROME

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PSYCHOLOGICAL APPROACH IN THE MANAGEMENT OF IRRITABLE BOWEL SYNDROME (Abstract): Irritable bowel syndrome has a worldwide prevalence that affects up to 10-15% adults of all ages, being related with a significant health care and economic involvement. The factors that play a role in the alteration of the brain-gut axis include genetic predisposition, an intestinal infection prior to symptoms onset, or chronic stressful life events. People with IBS should discuss with the gastroenterologist in developing a management plan to address these issues effectively and improve quality of life. An important step for the diagnosis is to look for symptoms and signs that are suggestive for other conditions, like inflammatory bowel disease, or celiac disease. The treatment for IBS includes life style changes, medication, counseling with psychological and behavioral therapies. **Keywords:** IRRITABLE BOWEL SYNDROME, PSYCHOLOGICAL, MANAGEMENT.

INTRODUCTION.

EPIDEMIOLOGICAL DATA

Irritable bowel syndrome (IBS) is a long-term recurrent disorder of gastrointestinal (GI) functioning with disturbances of gut motility. It is characterized by abdominal pain or discomfort, bloating and altered bowel habit (chronic or recurrent diarrhea, constipation, or both – either mixed or in alternation).

IBS has a significant worldwide prevalence that affects up to 10-15% of adults and between 25 and 45 million people in the United States. It involves persons of all ages and about 2 out of 3 IBS patients are females. This functional disease can also severely compromise a person's quality of

life, being the second cause of absenteeism from work after the common cold (1).

Studies have shown that IBS patients have an increased number of outpatient health care visits, diagnostic tests, and even surgeries (2). The symptoms are the consequence of increased sensitivity to gas, food, or stool in the bowel and appear from disturbances in colonic motility. Finally, the bowel tends to be overly reactive to various factors (emotional stress, GI infections, eating, gaseous distension, or menstrual period) which can bring about or amplify the symptoms (3).

ETIOPATHOGENESIS

There are possible genetic factors and

prior adverse life experiences that can predispose to IBS, but the exact cause of it is not completely understood.

Brain-gut interactions

The altered patterns of colonic motility appear to be due to disruptions in the communication between the brain and gut, the interaction being known as the brain-gut axis. These bi-directional interactions respond to any potential disturbance or stressor and are important in maintaining normal bowel function. The factors that may play a role in the alteration of the brain-gut axis include: genetic predisposition, intestinal infection prior to symptom onset, chronic stressful life events, or other psychosocial factors.

PSYCHOLOGICAL FACTORS

Some people with IBS report symptoms such as anxiety, or depressed mood that occur mainly in persons with more severe symptoms and in patients seen in tertiary medical care referral centers. Psychological factors are not a primary cause of IBS, but they may influence how a person seeks to manage and deal with IBS (4).

Emotional distress may be associated with a worsening of IBS symptoms that may induce an anticipatory anxiety due to the severity, unpredictability, and negatively perceived consequences of having an "attack." This may result in continuing symptom occurrence and set up a vicious cycle between emotional distress, symptoms, and personal management strategies.

Many people experience abdominal pain and constipation or diarrhea without any evidence of anxiety, depression, or other psychological symptoms. This response in people with IBS is more pronounced on a recurrent or chronic basis and therefore, they are more likely to experi-

ence worse symptoms when they are exposed to a significant stressor.

Addressing these issues with an empathetic doctor, who can refer the patient for counseling, would improve IBS symptoms and daily function. In patients with IBS there is increased GI response to stress which basically represents anything that can stimulate the GI tract, including: diet, psychological stress, hormonal changes, physical activity that has been shown to increase motility and sensation of the colon to a greater degree in these patients.

Stress disturbs the balance between brain and body, with or without conscious feelings of anxiety, distress, or anger. It can be acute (short term) or chronic (more than three months), ranging from daily hassles to life-threatening events. People presenting IBS should work with their health care providers in developing a management plan to address these issues effectively, in order to decrease symptoms and improve, overall, quality of life (5).

DIAGNOSIS

The first step in making a positive diagnosis of IBS is for the doctor to identify if an individual has the symptoms of IBS. This is best determined by the use of the Rome Criteria, which is a collection of the most common symptoms that typify the disorder. This includes abdominal pain for several months that is associated with two of the following: the pain is relieved by defecation, the pain is associated with an increase or decrease in stool frequency, and/or the pain is associated with the stools becoming harder or softer in consistency (6).

The next important step is to look for signs and symptoms that are suggestive of a condition other than IBS, such as in-

inflammatory bowel disease (IBD), or celiac disease which have been referred to as “alarm signs” or “red flags.” They include: anemia and other abnormal blood tests, blood in the stool, unexplained weight loss, fever, new onset of symptoms at the age of 50 or older, family history of IBD, celiac disease, or colon cancer. When these symptoms and signs occur, they should be brought immediately to the attention of a doctor who may perform colonoscopy, upper endoscopy with small bowel biopsy, abdominal ultrasound and additional tests. Colonoscopy may also be done for younger people, particularly if the “red flags” or the doctor’s judgment lead to the suspicion of other bowel diseases, such as IBD (7). It was noted that lymphocytic or microcytic colitis and nonspecific inflammation only occurred in patients with diarrhea-predominant IBS, and hence it was recommended that colonoscopy, when required, should include random colonic biopsies. Therefore, according to the American College of Gastroenterology guidelines, colonic investigation of diarrhea-predominant IBS and mixed diarrhea and constipation-type IBS subgroups with barium enema or CT colonography is not appropriate because of inability to perform random biopsies (8).

TREATMENT

Getting the IBS improvement means understanding that IBS is a sensory and a complex motility disorder which may have physical and stress-related dimensions.

A strong partnership between a knowledgeable patient and an empathetic doctor can control over symptoms and produces significant improvement for individuals with IBS.

The first line of treatment for IBS in-

cludes general measures such as: establishing an effective patient-physician relationship, obtaining education about IBS, and implementing lifestyle changes, which may be associated with symptoms.

Lifestyle changes

Lifestyle refers in evaluation any dietary or stress-related factors that could lead to symptoms and discuss these with the gastroenterologist. If certain foods set off or worsen symptoms, they must be reduced or avoid, also if the abdominal discomfort or pain occurs after eating, it may be helpful to eat smaller and more frequent meals.

Increased stress may result in the onset or worsening of IBS symptoms and associated non-bowel symptoms such as fatigue or low energy. Proper rest and exercise can help reduce stress levels and positively influence IBS.

Taking into consideration that IBS is also a stress, learning more about the disorder by self-care and communicating effectively with a gastroenterologist can reduce that stress.

Medication

A thorough evaluation by a physician is an important step toward selecting the treatment that is most appropriate for individual circumstances.

If lifestyle changes do not completely relieve IBS symptoms, a number of medications may be helpful. Antispasmodics: otilonium, pinaverium, dicyclomine, hyoscyamine, cimetropium may relieve abdominal pain or discomfort, particularly if the symptoms occur soon after eating. Anti-diarrheal agents: loperamide (Imodium), diphenoxylate (Lomotil) can be effective in preventing and relieving symptoms of diarrhea but may not be as helpful for the pain.

Laxatives (Linaclotide) can help treat symptoms of constipation and should be used under the supervision of a physician. Non-absorbable antibiotic rifaximin is recommended for reduction of IBS symptoms, as well as bloating in non-constipated patients. The use of prebiotics, synbiotics and probiotics that modify the gut microbiota are suggested for overall symptom improvement in IBS patients. Tricyclic antidepressant (TCAs) and selective serotonin reuptake inhibitors (SSRIs) medications are helpful for people with IBS and psychological distress (9). Individuals who have not responded to lifestyle changes and careful use of medications should be evaluated by a physician who specializes in functional GI and motility or stress-related GI disorders.

Counseling

Psychological and behavioral therapies may be indicated and effective in certain individuals.

Cognitive behavioral therapy (CBT) allows the individual to regain personal skills as well as mental techniques to better manage the symptoms (10). Hypnosis is useful to reduce painful discomfort mostly in treatment resistant patients. Psychological therapies like CBT, hypnotherapy, relaxation training is suggested for overall symptom improvement in IBS patients (11). Interpersonal psychotherapy addresses stressful responses to interactions with others. Behavioral therapy or skilled coun-

seling may help with self-understanding and with identifying personal traits or problems that can be dealt with. Talking to a professional allows discussions of personal matters without fear of recrimination or blame (which is what can happen when talking to family, friends, or colleagues) and often helps to mutually develop a program for change. The effectiveness of complementary and alternative medicine therapies such as Chinese herbal therapy, acupuncture, acupressure, mindfulness meditation, and yoga are being evaluated in IBS patients. Acupuncture studies have demonstrated that a positive provider-patient interaction during acupuncture treatment sessions is associated with a beneficial effect in IBS (12).

CONCLUSIONS

IBS is a condition with well-defined clinical features and specific diagnostic criteria.

Worldwide it is estimated that 10-15% of the population has IBS and about 2 out of 3 patients are females.

Stress does not cause IBS, but it can worsen or trigger symptoms because of the connection between the brain and the gut.

IBS can only be diagnosed by a professional doctor and involves the exclusion of other organic diseases by colonoscopy.

Psychological and behavioral therapies are available to manage symptoms for IBS, being indicated and effective in certain individuals.

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NEWS

DIRECT ANTIVIRALS AND COAGULATION TO PATIENTS WITH HEPATITIS C VIRUS

The advent of direct-acting antivirals (DAAs) has been a major breakthrough in hepatology representing the therapeutic standard of care in patients with chronic hepatitis C virus infection over the past few years, providing safe and effective treatments for all patients with chronic HCV infection by increasing the sustained virological response rate to over 95%. A group of researchers from Italy (1) assessed the impact of DAA therapy on the coagulation parameters in viral cirrhosis C and sustained virological response. They investigated 28 patients on DAAs treatment and performed prothrombin-time, thrombin generation with and without thrombomodulin, whole-blood thromboelastometry, as well as the individual procoagulants (II, VIII, XIII, von Willebrand) and anticoagulants, antithrombin and protein-C. Patients had undetectable HCV-RNA at the end-of-treatment and at 12-weeks after end-of-treatment. In conclusion, it has been demonstrated for the first time that AAD treatment in HCV positive patients and cirrhosis leads to improvement in pro- and anticoagulant status; does not substantially alter their balance but makes it more stable and less susceptible to disruption, as assumed before treatment (Tripodi A, D'Ambrosio R, Padovan L, *et al.* Evaluation of coagulation during treatment with directly acting antivirals in patients with hepatitis C virus related cirrhosis. *Liver Int* 2017; 37(9): 1295-1303).

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