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Editorial

Functional Gastrointestinal Disorders or Irritable Bowel Syndrome

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The term Irritable Bowel Syndrome (IBS) has overwhelmed medical sensibleness. The label relates to a common chronic gastrointestinal illness with no detectable pathological or biochemical abnormality. It does not have a pessimistic prognosis either. Therefore it is basically a benign disease. However, IBS causes great distress to the sufferers.

As the disease was first described in the West and as its most obvious symptoms were disturbances in bowel movements, the term most commonly used has been the Irritable Bowel Syndrome. That name is too confined in its impact on popular medical imagination. It makes many physicians and knowledgeable patients believe that, the disease only affects the large intestine. It is liberating, therefore, to hear it renamed Functional Gastrointestinal disorders (FGID).

This change of term moves it from the confines of the large bowel to the entire luminal tract. It would bring into its gambit clinical syndromes such as inexplicable belching, abdominal bloating, intractable psychogenic vomiting and unexplained abdominal pain – all of which are often over investigated and/or passed over to some poorly defined condition such as “gastritis” “chronic cholecystitis” or “chronic appendicitis.” Unfortunately, this has given impetus to ignorant surgeons to cut out innocent appendices and gall bladders. Further, as these functional conditions are often superadded on clearly defined somatic diseases such as inflammatory bowel disease, physicians often mistakenly prescribe or enhance medication to get rid of undiagnosed functional symptoms.

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As it causes so much confusion and causes wrong diagnoses to be made, FGID needs a strong definition by criteria that are as robust as one can get. It is impossible to obtain anything close to the sensitivity or specificity of elevated enzymes in acute liver damage, because FGID is a disease with no defined biochemical abnormality. Further, FGID has a wide array of manifestations from bowel disturbances to intractable abdominal pain. There is a strong psychological component.[1,2] That and increased hypersensitivity of the bowel (visceral hypersensitivity)[3] seem the only well-defined characteristics. Other issues such as motility disorders, immune mechanisms[4,] microflora5 and dietary factors[6] seem to be more conjectural.

The sensible course therefore was to exclude other diseases but the process of exclusion could become one of interminable definition and depth. A P Manning made the brilliant suggestion in 1978 that, clinical symptoms could be weighed and used to come to a positive diagnosis. Kruis in 1984 developed his own scoring system which was considerably simpler. Based on this background three compilations of Rome criteria for FGID were established – named after a gathering of experts in that city. Clinicians never use these in practice but they are a Western prerequisite for publishing any paper on FGID as the powers that be in the West have decided that, there should be some uniformity in diagnosis.

This demand for a prerequisite is fair enough. One cannot talk of a single disease or report on it when the definition is rather vague. However, experts gathering in a city and sorting out this over a table does not appear to solve the problem for reasons I will elucidate below. The only way of getting to a

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proper diagnostic questionnaire or instrument is by doing field studies on the disease. However, field studies have their own looming problems.

The first problem is that of finding a gold standard for the diagnosis. At present there is none. Trained gastroenterologists often fail to make the diagnosis. For instance, many of them ascribe abdominal pain to *Helicobacter pylori gastritis*, which is a ubiquitous infection in Indian adults; it seems to present with dramatic mucosal erythema in some but not in all those with the infection. The results of anti-*Helicobacter pylori* therapy in such patients has been proven to be ineffective.

The way out of this would be to have two or more experienced gastroenterologists independently make the diagnosis and conduct such simple tests as are necessary and follow up patients for a period of at least a year to see if the process has changed. Such studies would have to be made in tertiary care hospitals. Trial questionnaires could then be run on these people to establish a proper diagnostic score or instrument. The diagnostic score of such an instrument could then be applied in the community to test for sensitivity and specificity.

The second problem with the Rome scoring is that it begins with preformed ideas of how these symptoms should be clumped together. The fact that IBS has often been the name for a host of symptoms underlines this fact. That is putting the cart before the horse. It should start with the collection of patient symptoms as and when these patients present at an early point of medical attention and then link them together into symptom syndromes. For instance, many patients have complaints of bloating after a meal, which often deprives them of an appetite. This is most often referred to as “early satiety,” which probably is the most succinct definition for it. It may be the result of visceral hypersensitivity. “Bowel dissatisfaction” often describes the lower intestinal symptoms rather than “diarrhoea” or “constipation”. These can only be elucidated by asking patients about their symptoms rather than presuming their nature. The symptom of stool frequency may not be associated with increase in stool water and “hyperdefaecation” may be the right term.

Further, study after study has shown that, the state of the mind is often the basis of bowel disturbance or singularly associated with it, none of the criteria give any relevance to asking questions that point to mental dysfunction. This is a very major flaw. Many psychiatric conditions are diagnosed and graded using questionnaires. Therefore, it follows that a condition like FGID should use symptoms such as poor sleep, low mood or energy levels and life events in their criteria. There is evidence that this combination of somatic symptoms and psychological assessments is beneficial in making the diagnosis[7]

The group that needs to make such a diagnosis most often are primary care physicians. They are the ones to encounter patients with this problem most frequently and in the first instance. This is one place where such a diagnosis has rarely been entertained especially in India, where the medical curriculum requires all knowledge to be based on well-defined pathological processes. Therefore primary care physicians and medical students need both to be informed about such diseases and taught to make such a positive diagnosis. However, to make such a diagnosis we need much more well established criteria than Rome IV, which is only something that requires research and certainly, even there, defective criteria will continue to be defective agents for research.

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