

Irritable bowel syndrome: alternative therapeutic management

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SUMMARY

Irritable bowel syndrome is common, ill-understood and often difficult to treat. Conventional pharmacological approaches have not yet provided adequate solutions, and understandably, patients have looked outside orthodox medicine to find relief. There is a paucity of verifiable data in respect to the alternative and complementary therapies that have been embarked upon, but worthwhile studies have been performed, and it is possible to draw some conclusions based on scientific grounds. Dietary manipulation and exclusion diets can help but value from any dietary addition has yet to be confirmed. Hypnotherapy and psychotherapy (whether individual or group) are valuable in selected patients. Relaxation therapy and biofeedback techniques are probably helpful but reliable data is still awaited. Cognitive behavioural therapy is useful for some patients, but acupuncture does not seem to be effective.

Key words: Irritable bowel syndrome, acupuncture, hypnotherapy, alternative therapy complementary therapy

INTRODUCTION

Irritable bowel syndrome (IBS) is a very common medical problem, affecting between 5% and 13% of Western populations; it is approximately twice as common in women as in men.¹ Although not responsible for death or catastrophic complications, it has a major impact on the quality of life in affected individuals, and more than 40% report marked avoidance of activities. In North America IBS is second only to the common cold as a cause for taking time off work. IBS is, accordingly,

the commonest gastrointestinal disorder seen both by general practitioners and by gastroenterologists. If combined with the other related functional disorders such as non-ulcer dyspepsia² IBS accounts for about 40% of all new gastrointestinal referrals. The current treatment for IBS is sub-optimal. The sheer breadth of therapeutic options to be considered indicates that none is yet approaching an ideal, and it is clear that there are no curative measures. Most expert authors stress the importance of a full explanation of the nature of the condition, and confident reassurance of the patient. This is evidently less than straightforward when those same experts are unable to define the condition, form an unequivocal positive diagnosis, explain its pathogenesis, or provide effective therapy. Nonetheless it is most unusual for a confident IBS diagnosis to prove erroneous with the passage of time, and the overall prognosis is good.¹

Active management typically commences with advice on dietary manipulation, and there is reasonably good evidence of the benefit of high fibre diets and/or fibre supplements for patients with predominant constipation associated with their IBS, and for some patients with the alternating varieties in which constipation is sometime a feature. Fibre, however, is usually ineffective in those without constipation, and will often aggravate sensations of bloating and distension. Other dietary measures can be effective for some individuals and there is an extensive list of foods that are fairly frequently implicated as adverse factors. Lactose intolerance is sufficiently well-defined and important enough to be considered this a condition in its own right, and around 10% of Caucasian patients with apparent IBS will respond to limitation of mild intake on this basis,¹ but there are many other patients with IBS who find that milk and milk products are associated with a worsening of symptoms. Wheat products are also frequently implicated. Piecing together the other most commonly identified foods has enabled the enthusiasts in this area to provide IBS diets and formal

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exclusion diet strategies that are clearly of help to some patients.³ Unfortunately the rigour of both therapist and patient has to be considerable to achieve the best possible results.

Over the years, numerous pharmacological agents have been considered for IBS, and until very recently there has been no good reason to disagree with Klein's view that there was little if anything to offer that was better than placebo in this notoriously placebo-responsive condition.⁴ Simple drugs such as anti-diarrhoeal agents and "anti-spasmodics" for pain are generally ineffective.¹ Nonetheless, there is consistent benefit to be had from the use of antidepressants (both conventional tricyclic types and the more selective serotonin specific agents),¹ and recent advances in our understanding of the parallel serotonergic circuits in the gastrointestinal innervation are beginning to yield worthwhile therapeutic gains. It is clear that modulation of both 5HT₃ and 5HT₄ receptor subtypes can be helpful for selected patients.^{5,6} There are, however, problems with unexpected toxicity, or anxieties that this may occur, and the incremental benefit over the placebo response for both alosetron and tegaserod is probably only in the order of 15%.

A place for alternative and complementary therapies therefore exists and is likely to remain for some time – if not indefinitely.

Food-based interventions

The list of foods and food-derived compounds suggested to be therapeutic in IBS is lengthy and includes aloe vera, rhubarb, peppermint, ginger, and a variety of other herbal remedies. Unfortunately although the scientific literature is replete with studies addressing (with variable success) the value of eliminating different food-stuffs there are no reliable data in respect of therapeutic additions, with the exception of peppermint, for which there is good evidence that it is ineffective in IBS.⁷ The case for food additions must therefore remain an open one for the time-being. It is probable that as more is understood of the (potentially abnormal) gut flora in IBS there will be formal evaluations of a variety of agents employed as prebiotics.

Relaxation therapy

Working from the premise that IBS is heavily influenced by "stress" (however this is defined), it has been logical to examine whether non-pharmacological strategies might be effective. The usual method is to teach the patient to avoid stressful situations as best possible and

to provide a relaxation audiotape for regular listening. There are only three studies to support this, and each of them has its limitations in terms of size, power and appropriate control group.⁸⁻¹⁰ The apparent logic, simplicity, safety and low cost of this approach permit one's cautious endorsement.

Biofeedback

Biofeedback techniques provide patients with some measure of visceral function permitting them to begin to link this with disturbed perception. There has, as yet, been no published study of any specific biofeedback technique for IBS itself. However there is an interesting self-directed, computer-based approach being pioneered at the Royal Free Hospital in London for which the anecdotal outcomes are good.¹¹ Patients with idiopathic constipation form a group with considerable overlap with those with IBS, and this group also shows a response statistically better than in placebo controls when exposed to anorectally-oriented biofeedback supervised by (mainly) nurse practitioners.¹² It is probable that the time spent with the practitioner and the emphasis on normal physiology play an important part in the good results. A study specific to IBS in which relaxation, thermal biofeedback, and cognitive therapy together were compared to an attention-placebo control (pseudo-meditation) showed no additional benefit, strongly implying that overall gain was from the level of attention and support.¹³

Hypnotherapy

The hypnotic trance can be induced in most subjects, and it has been used with therapeutic intent on patients with IBS. It is assumed that gut-directed hypnotherapy can modify gut motility and/or visceral sensation and thus lead to relief of symptoms. Typically patients are taught how to induce a form of self-hypnosis for continued treatment outside sessions with the therapist. It has proved significantly more effective than comparable therapist contact time spent discussing emotional problems and stress.¹⁴ There is however a substantial need for therapist time which has led to another group examining group hypnotherapy and finding similar (but not adequately controlled) results for individual and group interventions.¹⁵ Following a pilot study of a specially devised audiotape encompassing explanation, reassurance, and the beginnings of autohypnosis, which appeared to show an advantage over conventional measures, we compared this tape with formal individual hypnotherapy.¹⁰ Patients with resistant IBS who had been symptomatic for a median of 60 months were selected. Randomisation was to 6 sessions of individual hypnotherapy or the tape; standard

symptom scores and psychological questionnaires were employed to assess the outcomes. Compliance was good, and symptom scores improved in 76% of the hypnotherapy patients compared to 59% of the tape patients (NS). There was a greater reduction in median score in the hypnotherapy than in the tape patients ($p < 0.05$), but an independent assessor considered 52% in each group improved. Interestingly, those who were initially more anxious were both more compliant and more likely to respond. We felt that the ease and economy of tape use recommended it as an option in IBS, reserving hypnotherapy for failures.

Cognitive Behavioural Therapy

The rationale behind cognitive behavioural therapy (CBT) is that IBS is in part a response to adverse life events, and that altered interpretation of unacceptable visceral sensations can be achieved once it is recognized that they are reactive to those life events. Fundamental to its implementation is the concept that the patient takes some responsibility for the illness and its management. There are only two small studies in IBS, but the results have been encouraging, with reductions in abdominal pain, diarrhoea, constipation, belching, and nausea for up to 3 months.^{16,17}

Psychotherapy

As with cognitive behavioural therapy there is an assumption in considering psychotherapy that IBS is, in part, the result of important life events and especially those relating to other individuals, perhaps with a background of insecurity. Recognition of this (insight) by the patient is integral to its efficacy. Three trials of psychotherapy for resistant IBS have been positive, with benefits accruing to over 60% of individuals, particularly in respect of abdominal pain and altered bowel habit.¹⁸⁻²⁰ As with hypnotherapy the commitment in time for both patient and therapist is substantial. Interestingly, female patients and those with overt psychiatric symptoms seem to do better with psychotherapy.

Acupuncture

Acupuncture has become a popularly promoted therapy for IBS in complementary circles, but until recently there has been no clear scientific evidence for or against. Acupuncture has been shown to outperform placebo in a number of conditions but IBS was not included in a NIH review of conditions for which benefit could be demonstrated. With appropriate caution and universal use of new needles, acupuncture is not obviously harmful, and success rates of around 70% are anticipated by its

protagonists.

A controlled trial was therefore devised. This employed sham acupuncture in comparison to traditional Chinese methodology. After an assessment by the gastroenterologist, a “diagnosis” and a treatment plan were devised by a first acupuncturist. The patient was then randomized to real or sham treatment by a second acupuncturist who was the only one of the study team to know the allocation. Active patients were treated according to the meridian-based technique in which there is manipulation or removal of blocking of the “Qi”. Typically 4 to 6 needles are needed to achieve “deqi” which takes from a few moments to up to about 25 minutes. No deqi was sought (or achieved) in sham treatments in which needles were placed at random (non-meridian) points. This cycle was repeated at each of 6 weekly visits. The prior expectation was that 70% of actively treated patients would respond compared to an estimated 30% response rate for placebo therapy. The primary end-point was a symptom score reduction of at least 3 points for which the study had 60% power to detect 30% difference (ie 30 to 60%). Various secondary end-points including quality of life score, and change in anxiety and depression state were also measured. There was good balancing for confounding factors and compliance was excellent. There was a symptom score fall of greater than 3 points in 41% of actively treated patients compared to 31% of the sham group (NS) with a slightly greater fall in the mean symptom score (from 13.5 to 11.6 compared to 13.1 to 11.2; $p < 0.05$), but achievement of reduction in symptom score was commoner in the sham group, and other parameters revealed no differences between the two arms of the study. It has therefore been concluded that acupuncture is ineffective in the majority of patients with IBS and that seeking new resources to incorporate acupuncture into the medical care of these patients is not justifiable.²¹

CONCLUSIONS

Until the aetiology and pathogenesis of irritable bowel syndrome is more completely understood there will continue to be the potential for a range of interpretations of patients' symptoms and a wide range of recommendations in respect of their treatment. Prompt diagnosis and explanation of the low risks and good prognosis associated with the condition will continue to be important. It is always worth considering dietary manipulation, but with the recognition that short of very exacting exclusion diets this will usually be a modest modification of intake and with similarly modest benefit. Increasing die-

tary fibre is valuable for only a minority of constipated IBS patients. There is scientific support for gain from the establishment of a good interpersonal relationship between the therapist and the patient, whatever the principal discipline of that therapist. There is limited support for use of relaxation techniques and it is probable that forms of biofeedback will help some patients. Hypnotherapy and psychotherapy are valuable for selected patients, but it does not appear that acupuncture has a role.

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