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TEA PARTY FORUM!

A welcome tea party forum for new members organized by the IBS support group was held on 29th October 2005 at SAFRA. New and existing members of the IBS support group turned up in anticipation of learning more about the condition that they suffered from. After a welcome speech by Dr Gwee Kok Ann, in which he welcomed the new members in the support group, the speakers for the tea party were introduced. The speakers invited to this forum were Dr Wong Heng Yu, Consultant Gastroenterologist in TTSH and Dr Adrian Wang, Consultant Psychiatrist at Gleneagles Medical Centre.

Dr Wong who was the first speaker spoke about the common misconception that IBS was purely a psychological disorder caused by stress. Using examples from various scientific studies, he stressed (no pun intended) that the current scientific evidence points to IBS being a disorder of signals from the brain to the gut and vice versa. Dr Wong explained that while the brain filters out certain signals from nerves in the gut in individuals without IBS, the brains of IBS patients were more sensitive to signals from the gut and interpreted them as pain and discomfort. Dr Wong also went through various medications that worked on both the brain and gut and could be useful in the treatment of IBS.

Subsequently, Dr Adrian Wang gave a talk about how stress affected our everyday lives. Dr Wang spoke about how stress was good if it was well controlled, however if stress went overboard, then it would predispose us to both physical and mental ill health. Dr Wang also shared about methods to cope with stress, including exercising, asking for help, changing our way of thinking about our work, etc. Dr Wang concluded by describing the various ways in which psychiatrist treated patients with anxiety and depression.

The tea party forum ended with a very lively question and answer session where members of the audience not only cleared up some queries with the doctors but also shared their personal experiences in dealing with IBS.

Upper gastrointestinal symptoms and therapies in elderly out-patients, users of non-selective NSAIDS or coxibs

(*Alimentary Pharmacological Therapy* 2005;22:147-155)

A study done in Italy with a study population of more than 5000 primary care patients aged 65 years and above, found that patients using NSAIDs *(pain killers such as aspirin, diclofenac)* had an increased risk of developing upper gastrointestinal symptoms such as pain, reflux, vomiting and indigestion. 43.7% of patients who were using NSAIDs developed these upper gastrointestinal symptoms, as compared to 32.7% of patients using coxibs *(alternative pain medications such as celebrex)* and 32.1% of patients not using any medication.

A Nationwide Study of Mortality Associated with Hospital Admission Due to Severe Gastrointestinal Events and Those Associated with Nonsteriodal Antiinflammatory Drug Use

(*American Journal of Gastroenterology* 2005;100:1685-1693)

NSAID-Associated Deaths: The Rise and Fall of NSAID-Associated GI Mortality

(*American Journal of Gastroenterology* 2005;100:1694-1695)

A study done using the information from 197 Spanish hospitals which represented 80% of the healthcare resources in Spain showed that use of NSAIDs and low dose daily aspirin was associated with an increase risk of death and adverse drug effects.

It was found that 5.6% of the death rate from hospitalized patients with gastrointestinal complaints was due to NSAID use. 1/3 of the death rate from NSAID use was due to low dose daily aspirin that is prescribed for heart conditions. Overall, the use of NSAIDs including low dose daily aspirin caused a 4 time increased risk of gastrointestinal complications. 90% of the patients who died from NSAID use were above the age of 60 years, 65% of the patients who used NSAIDs had heart disease.

A secondary observation of the study was that it is possible that proton pump inhibitors (e.g. Nexium & Losec) when used with NSAIDs and aspirin, has a greater effect on reducing the adverse effects and death from gastrointestinal complications than using alternative drugs such as coxibs.

Irritable Bowel Syndrome and Surgery: A Multivariable Analysis

(*Gastroenterology* 2004;126:1665-1673)

A study in America which had a study population of 89 thousand patients showed that a higher proportion of patients who had IBS were subjected to various forms of surgery as compared to patients who did not have IBS.

3 times as many IBS patients had gallbladder surgery, 2 times as many IBS patients had appendix operations and surgical removal of the uterus, and 1.5 times as many IBS patients had back surgery as compared to patients without IBS. The authors of the paper suggested that IBS patients were subjected to more surgery because of difficulties in confident diagnosis of IBS and the fact that IBS symptoms could often be mistaken for other forms of abdominal disease.

MAKING SENSE OF IBS AND THE STRESS CONNECTION

To most people and doctors, IBS is a condition that is caused by stress. Even recent medically related publications in the newspapers have emphasized that IBS is a condition that is caused by stress. Is IBS really caused by stress and how does stress contribute to the symptoms of IBS? *There are many mechanisms by which stress has been postulated to exacerbate GI discomfort, and while the exact mechanism by which stress aggravates IBS is unknown, several of the known pathways are summarized here*.

The ideas that stress causes IBS originated from observations that patients with IBS had more anxiety disorders. However studies showed that patients with anxiety disorders did not have increased incidence of IBS. Thus there is no conclusive scientific evidence that stress causes IBS. What is now accepted among leading experts in IBS is that stress can aggravate IBS but does not by itself cause IBS.

Everyone has experienced butterflies in their stomachs when they get excited or stressed. However that is only the tip of the iceberg. Stress, whether it is mental, physical or environmental, causes the secretion of a hormone called CRH by the brain.

CRH affects various aspects of the body's functions. *One of the main functions of CRH is to stimulate the body to produce hormones that*

cause release of glucose into the blood, thus increasing the energy supply to the body that is under stress. CRH has been reported to increase colonic motility, and a recent study has looked at the use of CRH antangonists in the treatment of IBS. In addition to peripheral effects, CRH also induces behavioral changes such as anxiety and depression. Stress-related CRH release in the brainstem also activates the adjacent noradrenergic locus coeruleus. The ascending noradrenergic input modulates the pain perception.

CRH also has an effect on activating certain immune cells called mast cells. *Mast cells are the immune cells responsible for allergic reactions and conditions such as asthma*. Mast cells are also responsible for secreting other substances, including histamine and Substance P. Under conditions of prolonged inflammation, mast cells can form direct connections with the nerves in the intestines and directly affect their function. Substance P and histamine can cause the nerves in the gut to send pain signals to the brain, and the person thus feels 'stomach pain'.

Mast cells are also suggested to cause either constipation of diarrhea by various other mechanisms. Thus under conditions where the nerves are already directly connected to mast cells, stress can indeed induce symptoms of abdominal pain, diarrhoea and constipation. However stress in itself does NOT cause a person to have IBS.

PRACTICAL TIP OF THE DAY

Poor sleep plays an important role in the generation of IBS symptoms. Establishing a regular sleep routine with sufficient sleep may help control your IBS symptoms.

To find out more, visit our website www.ibs-support.com.sg, or write to us at ibssupport@gmail.com or Gleneagles Hospital Annexe Block, 6A Napier Road #05-37, Singapore 258500.