Transcript Details
This is a transcript of an educational program accessible on the ReachMD network. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/clinical-topics/symptoms-diagnosis/understanding-the-difference-between-ibd-ibs/11172/

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Understanding the Difference Between IBD & IBS

Announcer:
Welcome to Crohn's & Colitis Perspectives on ReachMD, produced in collaboration with the Crohn's & Colitis Foundation.

Dr. Caudle:
If I were to ask you to explain the difference between inflammatory bowel disease and irritable bowel syndrome, what would your answer be? It can be easy for many of us to get those two mixed up or to think that they're interchangeable because they sound so similar and can often to be difficult to distinguish symptoms a patient presents with. But the reality is that these two are two very different conditions that require different treatment approaches, which is what we'll be exploring today. Coming to you from the ReachMD studios in Fort Washington, Pennsylvania, this is Crohns and Colitis Foundation Perspectives. I'm Dr. Jennifer Caudle, and joining me today is Dr. Neil Nandi. Dr. Nandi is an Associate Professor of Medicine, and he's also an Academic Gastroenterologist and the Director of the Center for Inflammatory Bowel Disease at Drexel Medicine in Philadelphia. Dr. Nandi, thanks so much for being here today.

Dr. Nandi: Thanks for having me. I appreciate it.

Dr. Caudle:
So, to start us off, Dr. Nandi, can you share with our audience a basic overview of what irritable bowel syndrome, or IBS, is?

Dr. Nandi:
So, we believe that irritable bowel syndrome is caused by a disorder of the gut-brain access. We believe that a disordered or imbalanced microbiome in the intestine interacts with our nervous system through the gut, up into our central nervous system, and that we may have, increased hypersensitivity, so that patients who have IBS are very sensitive to abdominal distention, gas, bloat, they may be prone, to diarrhea, constipation, or alternating symptoms of diarrhea and constipation. In truth, irritable bowel syndrome is very poorly understood. It seems to be kind of a bucket and, the current hypotheses in 2019 probably alert us that certain patients have one factor creating their specific type of IBS more than another. For example, patients with, IBS diarrhea, they may be more prone to IBS-D because of increased transit, or muscular contractions in the intestine versus someone with IBS constipation. Likewise diet and other factors kind of complicate, uh, everyone's individual type of irritable bowel syndrome. The Rome Foundation has developed specific criteria and they define irritable bowel syndrome as any type of abdominal discomfort that's been present for at least one day a week, every week, for the last three months, and this discomfort might be associated with a change in the bowels in terms of consistency in terms of frequency and that the discomfort itself is relieved with having a bowel movement or passage of gas. So, this is a good start but, again, many illnesses can mimic IBS so we really have to rule out other pathologic diseases before we can settle upon a diagnosis of IBS alone.

Dr. Caudle:
You know, that, that makes a lot of sense and I appreciate you going through that. Now let's shift gears a little bit. What about inflammatory bowel disease, or IBD? What are the characteristics for this disease?

Dr. Nandi:
So, IBD is often times, in the lay public, confused with IBS, but they're very, very different, when, they both have similar symptoms abdominal discomfort, they may have diarrhea or no diarrhea, but when you take a camera and look inside, the intestine of a patient with IBD, it's angry, red, ulcerated, sometimes bleeding, whereas the camera the colonoscopy mucosa in a patient with IBS, it looks healthy and normal. In inflammatory bowel disease, it's the immune system – our actual white blood cells, that are responding to some type of a trigger to attack the lining of the gut, and that results in the ulcerations, inflammation, it prevents us from absorbing our nutrition,

and you can become malnourished. Furthermore, IBD no matter which type you have, Crohns or ulcerative colitis, can have other complications that are associated, such as superinfections with C. difficile, an infectious organism we're all too familiar with, but the primary difference is in IBD we see ulcerated or angry, inflamed, intestinal lining as opposed to irritable bowel syndrome.

Dr. Caudle:
And, when it comes to diagnosing these two diseases, are there different signs and symptoms for each that we should be aware of? And, is there a difference in who gets either disease?

Dr. Nandi:
Indeed. So, when we look at inflammatory bowel disease and irritable bowel syndrome, they're oftentimes confused for one another, more often in the lay public, but IBD is very different from IBS. To make things a little bit complicated though, about 30-40% of our IBD patients will have overlapping, concomitant IBS. So, how do we distinguish, as you asked? History. It's all in the history. When we look at our IBD patients, their inflammation in the gut doesn't take a break. It's a 24-hour process. So, patients with inflammatory bowel disease – the abdominal pain, loose stools, their symptoms will persist through the night, meaning that it will wake them up from sleep. So, abdominal pain that wakes you up from sleep and urgency to go to the bathroom in the middle of the night to have a bowel movement – those are, what we call nocturnal symptoms that are not present in our patients with IBS who can sleep calmly through the night. So, that's a a big thing. The other thing that we look for, when you have a pathologic illness like Crohns or ulcerative colitis, is the toll that it takes in the body. So, you're looking for constitutional signs or symptoms – fever, chills, the presence of night sweats, which all suggest an immune reaction going on throughout the body. Also, unintentional weight loss. So, we see weight loss commonly in our patients who have very aggressive disease because they're malabsorbing,nutrition and then part of that malabsorption, probably one of the most common and obvious things that we see, is iron deficiency, so signs of anemia specifically iron deficiency anemia that go unchecked. Likewise, there's another thing that we should discuss which is psychosocial triggers. Both IBD and irritable bowel syndrome have comorbid anxiety and depression, but we oftentimes see that IBS is typically triggered by some type of psychosocial stressor in the environment. So, looking at the history, asking the patient, you know, what makes this better? What makes it worse? Looking and doing a mental health history and seeing if there, a stressful environment or stressful factors trigger their episodes – all of these things are very key, so nocturnal awakening, constitutional alarm signs and looking at psychosocial triggers are clinical pearls, really, that can help you distinguish between IBD and IBS.

Dr. Caudle:
You know, that, that's really helpful, you know, you're, you're talking about how IBS and IBD display different symptoms, I think is, is very helpful for our viewers. But now, let's shift over to how they differ when it comes to their treatment and long-term prognosis. So, what can you tell us about that?

Dr. Nandi:
So, the treatments are very markedly different, as you may know. In inflammatory bowel disease, it's an immune reaction. It's an immune system mediated reaction where our lymphocytes, for another lecture, all the reasons for why is another lecture, but they're attacking the lining of the gut and, therefore, we resort to immunosuppressants. Now, prior to the late 90s, it was really just steroids, but now we have, biologics in small molecules that suppress just a portion of the immune system rather than the entire immune system like steroids. So, monoclonal antibodies, there are anti-TNF agents, anti-integrins such as vedolizumab, and anti-IL23 agents like ustekinumab, and in small molecules like tofacitinib exist in the IBD space, and there are multiple anti-TNFs. All of these agents suppress a portion of the immune system.

In ulcerative colitis, mild to moderate, there is a role for mesalamines. Mesalamines are not immunosuppressants, but they're almost like a topical salve, with an anti-inflammatory effect, that can be beneficial in certain types of mild to moderate ulcerative colitis. IBS is not really about traditional immune suppression. The immune system may have a role, but today's treatments in 2019 are mostly, and sadly, symptomatic meaning we use antidiarrheals we use laxatives, stool softeners, and then we can also use antispasmodics like dicyclomine. Those are all conservative measures. When those fail, depending on the type of IBS, we might use prescription strength, medications, there are several agents, for IBS diarrhea. We may use, eluxadoline for IBS-D patients. And we also may use rifaximine in our IBS-D patients. It's estimated that up to 60% of IBS-D is due to some type of dysbiosis and possibly small intestinal bacterial overgrowth. That's a controversial field but emerging and so there is a role for certain types of antibiotics like rifaximine. IBS constipation when conservative medicines fail, is usually managed with prescription strength medicines that work on chloride channels to increase water secretion into the gut and, thereby, help the patients have voluminous stool. Because of that mechanism of action, one of the common, most common side effects is actually diarrhea if you're going to have a side effect to the medicine. And then, there're a couple other treatments that I think really deserve strong attention, and that is treating the visceral hypersensitivity. And what I mean by that is I mentioned earlier that IBS patients are very sensitive to gas and distention. They've done animal models where you take a balloon and you inflate it inside the rectum of a patient with IBS and a patient without IBS, and the patient with IBS, at that balloon which is meant to

kind of stimulate stool, they will feel it feel pressure at a much lower threshold than the patient without IBS, and it's, they're triggering stress receptors in the gut and they feel uncomfortable. So, that is felt, or sensed, through neurotransmitters, and so, of course, we have neurotransmission inhibitors tricyclics, SSRIs. These can be used under physician guidance, of course to go ahead and blunt the nervous system from sensing that pressure and discomfort. Also, gut hypnotherapy. Gut hypnotherapy is done by certain types of trained psychotherapists, and in some clinical trials has up to 80% efficacy, which is better than many of our medications. And then, of course, there's diet is profoundly helpful,in IBS, and can be useful in inflammatory bowel disease, but they're used differently. In IBS we talk about FODMAPs. FODMAPs are fermentable oligosaccharide, disaccharide, monosaccharide and polyols, that's a mouthful, so we like to say FODMAPs, of course. All foods turn out to be created from different proportions of carbohydrates and our gut bacteria ferment them before you and I can even ever digest them. When they digest them, just like you and I, they release waste products of gas, that cause distention, or other products that can cause diarrhea or constipation, predominantly. Some foods are high in FODMAPs, some are low in FODMAPs. So, it turns out that if you favor foods that are lower in FODMAPs, you may lessen your abdominal bloat and distention. The folly of the diet is some patients may over-restrict or permanently restrict their triggers rather than reintroducing them, and that can lead to malnourishment and weight loss. So, one of the most important tenets of implementing a low FODMAP regimen is making sure that after you identify your triggers, you reintroduce them at lower amounts so that you have nutritional variety and have variety in your taste buds. Now, diet in IBD is a bit different. Patients, there's lots of different diets out there. Many are controversial and there's some great research ongoing right now to look at the role of Mediterranean diet and other diets, the effect on the microbiome and Crohns. But, by and far, what I can tell you is eating clean, healthy diet seems to help IBD patients feel better. Avoiding fiber during a flare seems counterintuitive, but it exacerbates symptoms because the fiber's hard to digest, so we tell patients to, when they're health and not flaring, to focus on a healthy diet that is, also includes a diet high in fiber.

Dr. Caudle:
Excellent. Well, you know, this has been so insightful, Dr. Nandi, and before we wrap up, um, I'd like to ask, um, if you have any final thoughts that you'd like to leave our audience with today.

Dr. Nandi:
I think that in 2019 we can finally say that Western society's finally becoming more comfortable talking about poop. Patients are finally talking about their bowels more than they ever have before. And I think it's really important that as clinicians we start to elicit and ask these very personal questions from our patients. So it's good that we have a lot of science, a lot of medicines, a lot of therapies, but it's really important that we elicit this and help our patients feel comfortable and talk to us about these GI symptoms, because you'd be surprised how many just don't have anybody to talk to about it out of taboo shame, or fear. And that once we do, you know, hopefully this, video can help our clinicians out there, know when to pick up on the warning signs that there might be, you know, underlying Crohns or ulcerative colitis, so they can get into the right specialist. So, I think, we have a lot more research and science to do, but I think there's hope and I'm so happy, to be here today. Thank you very much.

Dr. Caudle:
That's great, and I think one of the biggest takeaways from this discussion is the importance of differentiating inflammatory bowel disease from irritable bowel syndrome. I'd really like to thank my guest, Dr. Neil Nandi, for joining me to help us better understand that difference. Dr. Nandi, it was great having you in the program.

Dr. Nandi:
Thank you so much for having me.

Announcer:
This program was brought to you in collaboration with the Crohn's & Colitis Foundation. If you missed any part of this discussion, or to find others in this series, visit ReachMD.com/foundation, where you can be part of the knowledge.