



Editorial

DOI:
[10.1111/apt.14659](https://doi.org/10.1111/apt.14659)

[Link to publication record in Manchester Research Explorer](#)

Citation for published version (APA):

Whorwell, P. J. (2018). Editorial: preventing unnecessary investigation and surgery in the irritable bowel syndrome—the critical role of the general practitioner. *Alimentary Pharmacology & Therapeutics*, 47(11), 1558-1559.
<https://doi.org/10.1111/apt.14659>

Published in:

Alimentary Pharmacology & Therapeutics

Citing this paper

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Editorial: preventing unnecessary investigation and surgery in the irritable bowel syndrome—the critical role of the general practitioner

Irritable bowel syndrome (IBS) patients attending secondary and tertiary care gastroenterology clinics not infrequently give a history of surgical interventions as well as multiple investigations which sometimes do not appear to be entirely necessary. The commonest operations are hysterectomy, cholecystectomy, appendicectomy, pelvic floor procedures and even back surgery. The outcome from these operations is not always good and on occasions patients claim that their IBS symptoms, especially abdominal pain, have been worse since the surgery. In 1986, we reported that, compared to healthy controls, IBS patients experience a range of 'non-colonic' symptoms such as gynaecological complaints, urological symptoms, nausea, fatigue and low backache.¹ We subsequently went on to investigate the prevalence of IBS in gynaecology^{2,3} and urology clinics⁴ where we found an excess of the condition with these individuals having a poor outcome compared to those with proven gynaecological or urological pathology. We have even found that IBS in elderly care clinics is seldom detected with the potential for patients to undergo excessive investigation.⁵ We have also shown that not only does the presence of these non-colonic symptoms help to substantiate the diagnosis of IBS,⁶ but also that patients sometimes report that a particular non-colonic symptom may be more intrusive than their bowel problem.⁷ This latter observation led us to speculate that if a patient in primary care had a particularly troublesome non-colonic symptom they may be referred to the "wrong" specialty, where they could undergo inappropriate investigation or even surgery. However, there is little information on the prevalence of non-colonic symptoms in primary care and it could be argued that these features may tend to be confined to secondary care patients where the IBS is more bothersome and severe.

Clevers et al,⁸ in a recent issue of *Alimentary Pharmacology and Therapeutics*, now confirm that primary care IBS patients also suffer from the non-colonic symptoms that we have previously reported as well as a range of other somatic symptoms. This finding is of profound importance as it suggests that how the general practitioner reacts to these symptoms may dictate the outcome of a patient's journey through the healthcare system. For instance, if a patient has dyspareunia which is relatively common in IBS⁹ they may be referred to a gynaecologist who then finds fibroids, who then does a hysterectomy that then exacerbates their IBS. One of the most important pathophysiological features of IBS is visceral hypersensitivity,¹⁰ which may not be confined to the gastrointestinal tract and possibly explains the tendency of IBS patients to develop post-operative pain syndromes. It may even amplify the pain of conditions such as minimal endometriosis, and explain why patients

develop persistent pain after a procedure as apparently straightforward as a laparoscopy.¹¹

What is the take home message? In a patient with a range of unexplained somatic symptoms, a simple enquiry about bowel function not only in terms of frequency but importantly also consistency, urgency or incomplete evacuation could provide a clue to the possibility of IBS—which then needs substantiating. In the absence of red flags, treating the IBS should be the initial first step in their management. This rule also applies to secondary care where perhaps an enquiry about bowel function in a patient referred with low backache may suggest a functional cause rather than their mildly arthritic spine.

ACKNOWLEDGEMENTS

Declaration of personal interests: Over the last 2 years PJW has acted as a consultant for, or received research grant support from, the following companies: Danone Research, Ironwood Pharmaceuticals and Allergan Pharma.

FUNDING INFORMATION

None.

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LINKED CONTENT

This article is linked to Clevers et al paper. To view this article visit <https://doi.org/10.1111/apt.14612>.

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DOI: 10.1111/apt.14663

Editorial: measuring hypervigilance and anxiety in oesophageal disorders

Clinical oesophageal disorders can overlap with functional syndromes, contributing to the “disconnect” between the perceived symptom burden and the actual clinical severity of oesophageal disorders such as eosinophilic oesophagitis,^{1,2} oesophageal motor disorders,³ and gastro-oesophageal reflux disease.⁴ The ability of patients to cope with their symptoms or their diagnosis also influences their symptomatic outcome. Furthermore, affective disorders contribute prominently to oesophageal presentations.⁵ These factors can lead to hypervigilance and catastrophising, which can perpetuate symptomatic presentations. If all aspects of a patient's oesophageal syndrome—including hypervigilance and anxiety—are not targeted and addressed, clinical management is unlikely to be deemed effective by the patient. Finally, there is evidence of genetic predisposition for higher anxiety scores and more profound oesophageal symptom burden, independent of oesophageal acid burden, in symptomatic individuals undergoing ambulatory reflux monitoring.⁶ However, despite the well-established significance of affective disorders, hypervigilance and catastrophising, we have not had a simple but effective clinical tool to measure or quantify hypervigilance or disease-specific anxiety in oesophageal disorders.

The report by Taft et al⁷ in a recent issue of AP&T is an important step towards the quantification of affective and emotional factors in symptomatic oesophageal presentations. The generation of the 15-item oesophageal hypervigilance and anxiety scale (EHAS) is innovative, pulling in items from four existing validated questionnaires, and adapted for oesophageal symptoms. Taft et al report that the EHAS was successfully completed by almost 1000 individuals with a wide distribution of symptomatic oesophageal disorders, with excellent internal consistency, split-half reliability, and construct validity suggesting that this tool functions well in the symptomatic oesophageal realm. The EHAS provides subscales for assessing symptom-specific

anxiety and hypervigilance, thereby enabling clinicians and researchers to quantify these elements separately from the full EHAS score.

The development of the EHAS is a crucial element in further defining perceptive populations (as distinct from “normal” perception or hyposensitivity) who report higher symptom burden and are more likely to have diagnosed affective disorders.^{6,8,9} The EHAS tool also has potential to quantify coping behaviours, which can affect management outcome. Beyond the full EHAS score, further development and validation of distinct subscales for hypervigilance, hypersensitivity, catastrophising, coping behaviours and disease-associated anxiety is critical. These subscales have the potential to define characteristics of the poor responder to therapy, and more importantly, allow targeting of management. For instance, patients with functional bowel disorders with superimposed affective disorders or somatization often do not tolerate, or do not respond well to, antidepressant therapy;¹⁰ these patients could be offered treatments specific for their identified mechanism. Future investigations must address how EHAS values should be interpreted—distributions of data from normal and abnormal patient populations are needed to further define thresholds for each subscale. The precise role of each subscale element in symptomatic patients not responding to typical therapies can be evaluated, which can lead to better understanding of symptom generation and persistence. However, it is the outcome of differential therapies targeted towards abnormal EHAS scores that will solidify the role of this tool in clinical oesophagology.

ACKNOWLEDGEMENT

Declaration of personal interests: The authors have no relevant personal or competing interests.