Commentary

Defining IBS in India: A brave new world

Irritable bowel syndrome (IBS) is a condition where patients experience abdominal pain or discomfort that is thought to arise from the intestines but for which there is no detectable physical or chemical cause. The Task Force of the Indian Society of Gastroenterology (ISG) presents in this issue of the Journal a massive inquiry involving close to 3000 IBS patients and 4500 community subjects from the length and breadth of India.\(^1\) The Task Force should be commended not only for completing this mammoth task, but also for their courage in not allowing themselves to be straight-jacketed by Western-directed criteria. They have chosen instead to take the bold step to deconstruct IBS by returning the patients and their managing physicians to the center of the enquiry.

Is there justification for taking this approach? Much of what we read about IBS is based on Western profiles. This has led us to believe that IBS patients are predominantly young women presenting with pain, most commonly arising from the sigmoid colon. The Rome criteria focus on the relation to stool frequency and consistency, but ignore the relation to meals. On the other hand, in Asia it appears that men are just as likely to have IBS, patients have less painful symptoms, discomfort is more often centered in the upper abdomen, and patients are more bothered by symptoms relating to stool passage than to stool frequency and consistency.

In the ISG study, men outnumbered women among patients with a diagnosis of IBS. This mirrors early studies of IBS patients attending specialist clinics in India, which had consistently reported a 2- to 4-fold predominance of men;\(^2,3,4\) the consultation behavior of the community group, where 33% of men and 38% of women had consulted doctors, suggest that this greater male prevalence may not be merely due to more health-care seeking by men. A recent large community survey of over 2000 adults in Mumbai also recorded a higher prevalence of IBS in men (7.9%) than in women (6.9%).\(^5\) In Bangladesh, prevalence of IBS was reported at 20.6% in men and 27.7% in women, with 35% each of men and women consulting for their IBS.\(^6\) Similarly, Oriental populations in China, Hong Kong, Taiwan, Korea and Singapore reported no female predominance.\(^6\)

In Asia we have to guard against mislabeling IBS symptoms as dyspepsia as our patients appear to be more bothered by upper abdominal pain and bloating and less about their bowel disturbances. In the present study, as in earlier Indian studies, more than half the patients complained of upper abdominal pain, whereas in Western series, only about a quarter complained of pain in the upper abdomen.\(^2,3,4,7-10\) In community studies, upper abdominal pain was reported by more than half of IBS subjects in Singapore and Bangladesh, but by only one-third in the US.\(^6,10,11\)

In Singapore 77% of subjects with IBS criteria thought they had a normal bowel habit. In the ISG study, 57% had stool frequency within a Western normal range of 3 stools per week to 3 stools per day.\(^11\) In the community 99% passed stools once or more per day. It is possible that the bowel disturbances of our IBS patients may not be so marked because Asians have a relatively shorter colonic transit time (CTT). In the US, the CTT for male normal controls was a mean of 30.7 h with upper limit at 66 h.\(^12\) In studies from Mumbai and Hong Kong, the normal mean CTT for males was recorded at 15.8 h and 18 h, respectively.\(^13,14\) In Kerala the mean CTT was 24 h - 25 h for male constipated IBS patients.\(^15\) The faster CTT could explain why our patients do not appear to be so bothered by their stool frequency and consistency. In the ISG study fewer than 20% reported ribbon-like stools. In Taiwan no differences in stool frequency were found between IBS consulters and non-consulters.\(^16\) However, significantly more consulters complained of straining and incomplete evacuation.

In addition to differences in the profile of IBS in Asia, there appears to be problems of interpretation. In Beijing the prevalence of IBS was assessed to be 7.2% by the Manning criteria, and fell to 0.82% by the Rome I criteria.\(^17\) Similarly, in Hong Kong the prevalence of IBS in the female population ‘dropped’ from 21% by Manning criteria to 3.8% by Rome II criteria.\(^18\) It is possible that the time and frequency limits of the Rome criteria had been stringently applied by these Chinese investigators. In a study from Spain that had strictly adhered to the frequency requirements, 80% of subjects with Manning criteria failed to meet the Rome II criteria.\(^19\) Yet, in studies from Canada and Singapore, where a time frame of 3 months was applied across all the different criteria, the differences in prevalence were more modest.\(^11,20\)

The ISG Task Force has chosen not to apply any specific criteria and not to limit recruitment according to frequency and time criteria, and also not to insist on
the presence of abdominal pain or discomfort. Does this non-conformity with the dictates of the Rome committee weaken the study? On the contrary, I would argue that adopting an unfettered approach would serve to provide us with data that are of more enduring relevance. A recent study from Israel showed that just by changing the frequency requirement for symptoms from 25% (as dictated by Rome II) to 10% (to conform with Rome III), the prevalence of IBS in their population jumped from 2.9% to 11.4%. Concomitantly they observed a decline in the prevalence of functional constipation and functional bloating, so that in the end the combined prevalence of all functional bowel disorders (FBD) was fairly stable. This suggests that depending on how much they could remember of their discomfort in the preceding year, subjects could be shifted between IBS and one of the other FBD. To base outcomes on a questionable recall of a subjective rating of discomfort makes the Rome criteria highly unreliable.

The rest of the Asian community should draw inspiration from this bold experiment by the Indian Society of Gastroenterology. We should produce our own data, formulate our own rules and set our own guidelines. We should teach our medical students and doctors how to recognize and manage these disorders based on our own studies. We should not be afraid to challenge the current world order and, if need be, to redefine IBS.

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References


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