NICE National Institute for Health and Care Excellence

Irritable bowel syndrome in adults

Diagnosis and management of irritable bowel syndrome in primary care

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NICE clinical guideline 61

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Contents

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Introduction

Irritable bowel syndrome (IBS) is a chronic, relapsing and often life-long disorder. It is characterised by the presence of abdominal pain or discomfort, which may be associated with defaecation and/or accompanied by a change in bowel habit. Symptoms may include disordered defaecation (constipation or diarrhoea or both) and abdominal distension, usually referred to as bloating. Symptoms sometimes overlap with other gastrointestinal disorders such as non-ulcer dyspepsia or coeliac disease. People with IBS present to primary care with a wide range of symptoms, some of which they may be reluctant to disclose without sensitive questioning.

People with IBS present with varying symptom profiles, most commonly 'diarrhoea predominant', 'constipation predominant' or alternating symptom profiles. IBS most often affects people between the ages of 20 and 30 years and is twice as common in women as in men. Prevalence in the general population is estimated to be between 10% and 20%. Recent trends indicate that there is also a significant prevalence of IBS in older people. IBS diagnosis should be a consideration when an older person presents with unexplained abdominal symptoms.

Key aspects of this guideline include establishing a diagnosis; referral into secondary care only after identification of 'red flags' (symptoms and/or features that may be caused by another condition that needs investigation); providing lifestyle advice; drug and psychological interventions; and referral and follow-up. The guideline refers to 'Referral guidelines for suspected cancer' (NICE clinical guideline 27) in relation to appropriate referral to secondary care.

The main aims of this guideline are to:

- provide positive diagnostic criteria for people presenting with symptoms suggestive of IBS
- provide guidance on clinical and cost-effective management of IBS in primary care
- determine clinical indications for referral to IBS services, taking into account cost effectiveness.

The guideline will assume that prescribers will use a drug's summary of product characteristics to inform their decisions for individual patients.

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This guideline recommends some drugs for indications for which they do not have a UK marketing authorisation at the date of publication, if there is good evidence to support that use.

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Patient-centred care

This guideline offers best practice advice on the care of adults with IBS.

Treatment and care should take into account patients' needs and preferences. People with IBS should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If patients do not have the capacity to make decisions, healthcare professionals should follow the Department of Health's advice on consent and the code of practice that accompanies the Mental Capacity Act. In Wales, healthcare professionals should follow advice on consent from the Welsh Government.

Good communication between healthcare professionals and patients is essential. It should be supported by evidence-based written information tailored to the patient's needs. Treatment and care, and the information patients are given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English.

If the patient agrees, families and carers should have the opportunity to be involved in decisions about treatment and care.

Families and carers should also be given the information and support they need.

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Key priorities for implementation

Initial assessment

- Healthcare professionals should consider assessment for IBS if the person reports having had any of the following symptoms for at least 6 months:
  - **A**bdominal pain or discomfort
  - **B**loating
  - **C**hange in bowel habit.
- All people presenting with possible IBS symptoms should be asked if they have any of the following 'red flag' indicators and should be referred to secondary care for further investigation if any are present:[1]
  - unintentional and unexplained weight loss
  - rectal bleeding
  - a family history of bowel or ovarian cancer
  - a change in bowel habit to looser and/or more frequent stools persisting for more than 6 weeks in a person aged over 60 years.
- All people presenting with possible IBS symptoms should be assessed and clinically examined for the following 'red flag' indicators and should be referred to secondary care for further investigation if any are present:[1]
  - anaemia
  - abdominal masses
  - rectal masses
  - inflammatory markers for inflammatory bowel disease.

    Measure serum CA125 in primary care in women with symptoms that suggest ovarian cancer in line with Ovarian cancer (NICE clinical guideline 122)[2].

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- A diagnosis of IBS should be considered only if the person has abdominal pain or discomfort that is either relieved by defaecation or associated with altered bowel frequency or stool form. This should be accompanied by at least two of the following four symptoms:
    - altered stool passage (straining, urgency, incomplete evacuation)
    - abdominal bloating (more common in women than men), distension, tension or hardness
    - symptoms made worse by eating
    - passage of mucus.

    Other features such as lethargy, nausea, backache and bladder symptoms are common in people with IBS, and may be used to support the diagnosis.

Diagnostic tests

- In people who meet the IBS diagnostic criteria, the following tests should be undertaken to exclude other diagnoses:
    - full blood count (FBC)
    - erythrocyte sedimentation rate (ESR) or plasma viscosity
    - c-reactive protein (CRP)
    - antibody testing for coeliac disease (endomysial antibodies [EMA] or tissue transglutaminase [TTG]).
- The following tests are not necessary to confirm diagnosis in people who meet the IBS diagnostic criteria:
    - ultrasound
    - rigid/flexible sigmoidoscopy
    - colonoscopy; barium enema
    - thyroid function test

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- faecal ova and parasite test
- faecal occult blood
- hydrogen breath test (for lactose intolerance and bacterial overgrowth).

Dietary and lifestyle advice

- People with IBS should be given information that explains the importance of self-help in effectively managing their IBS. This should include information on general lifestyle, physical activity, diet and symptom-targeted medication.
- Healthcare professionals should review the fibre intake of people with IBS, adjusting (usually reducing) it while monitoring the effect on symptoms. People with IBS should be discouraged from eating insoluble fibre (for example, bran). If an increase in dietary fibre is advised, it should be soluble fibre such as ispaghula powder or foods high in soluble fibre (for example, oats).

Pharmacological therapy

- People with IBS should be advised how to adjust their doses of laxative or antimotility agent according to the clinical response. The dose should be titrated according to stool consistency, with the aim of achieving a soft, well-formed stool (corresponding to Bristol Stool Form Scale type 4).
- Healthcare professionals should consider tricyclic antidepressants (TCAs)[3] as second-line treatment for people with IBS if laxatives, loperamide or antispasmodics have not helped. TCAs are primarily used for treatment of depression but are only recommended here for their analgesic effect. Treatment should be started at a low dose (5–10 mg equivalent of amitriptyline), which should be taken once at night and reviewed regularly. The dose may be increased, but does not usually need to exceed 30 mg.

[1] See Referral guidelines for suspected cancer, NICE clinical guideline 27, for detailed referral criteria where cancer is suspected.

[2] This recommendation was updated in September 2012 in line with more recent guidance on the recognition and management of ovarian cancer in Ovarian cancer (NICE clinical guideline 122).

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[3] At the time of publication (February 2008) TCAs did not have UK marketing authorisation for the indication described. Informed consent should be obtained and documented.

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1 Guidance

The following guidance is based on the best available evidence. The full guideline gives details of the methods and the evidence used to develop the guidance.

Diagnosis and management of irritable bowel syndrome (IBS) can be frustrating, both for people presenting with IBS symptoms and for clinicians. Both parties need to understand the limitations of current knowledge about IBS and to recognise the chronic nature of the condition.

1.1 Diagnosis of IBS

Confirming a diagnosis of IBS is a crucial part of this guideline. The primary aim should be to establish the person's symptom profile, with abdominal pain or discomfort being a key symptom. It is also necessary to establish the quantity and quality of the pain or discomfort, and to identify its site (which can be anywhere in the abdomen) and whether this varies. This distinguishes IBS from cancer-related pain, which typically has a fixed site.

When establishing bowel habit, showing people the Bristol Stool Form Scale (see appendix D of this document and appendix I of the full guideline) may help them with description, particularly when determining quality and quantity of stool. People presenting with IBS symptoms commonly report incomplete evacuation/rectal hypersensitivity, as well as urgency, which is increased in diarrhoea-predominant IBS. About 20% of people experiencing faecal incontinence disclose their incontinence only if asked. People who present with symptoms of IBS should be asked open questions to establish the presence of such symptoms (for example, 'tell me about how your symptoms affect aspects of your daily life, such as leaving the house'). Healthcare professionals should be sensitive to the cultural, ethnic and communication needs of people for whom English is not a first language or who may have cognitive and/or behavioural problems or disabilities. These factors should be taken into consideration to facilitate effective consultation.

1.1.1 Initial assessment

1.1.1.1 Healthcare professionals should consider assessment for IBS if the person reports having had any of the following symptoms for at least 6 months:

- **A**bdominal pain or discomfort

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- **B**loating
- **C**hange in bowel habit.

1.1.1.2 All people presenting with possible IBS symptoms should be asked if they have any of the following 'red flag' indicators and should be referred to secondary care for further investigation if any are present:[4]

- unintentional and unexplained weight loss
- rectal bleeding
- a family history of bowel or ovarian cancer
- a change in bowel habit to looser and/or more frequent stools persisting for more than 6 weeks in a person aged over 60 years.

1.1.1.3 All people presenting with possible IBS symptoms should be assessed and clinically examined for the following 'red flag' indicators and should be referred to secondary care for further investigation if any are present:[4]

- anaemia
- abdominal masses
- rectal masses
- inflammatory markers for inflammatory bowel disease.

  Measure serum CA125 in primary care in women with symptoms that suggest ovarian cancer in line with Ovarian cancer (NICE clinical guideline 122)[5].

1.1.1.4 A diagnosis of IBS should be considered only if the person has abdominal pain or discomfort that is either relieved by defaecation or associated with altered bowel frequency or stool form. This should be accompanied by at least two of the following four symptoms:

- altered stool passage (straining, urgency, incomplete evacuation)

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- abdominal bloating (more common in women than men), distension, tension or hardness
- symptoms made worse by eating
- passage of mucus.

Other features such as lethargy, nausea, backache and bladder symptoms are common in people with IBS, and may be used to support the diagnosis.

1.1.2 Diagnostic tests

1.1.2.1 In people who meet the IBS diagnostic criteria, the following tests should be undertaken to exclude other diagnoses:

- full blood count (FBC)
- erythrocyte sedimentation rate (ESR) or plasma viscosity
- c-reactive protein (CRP)
- antibody testing for coeliac disease (endomysial antibodies [EMA] or tissue transglutaminase [TTG]).

1.1.2.2 The following tests are not necessary to confirm diagnosis in people who meet the IBS diagnostic criteria:

- ultrasound
- rigid/flexible sigmoidoscopy
- colonoscopy; barium enema
- thyroid function test
- faecal ova and parasite test
- faecal occult blood
- hydrogen breath test (for lactose intolerance and bacterial overgrowth).

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1.2 Clinical management of IBS

1.2.1 Dietary and lifestyle advice

1.2.1.1 People with IBS should be given information that explains the importance of self-help in effectively managing their IBS. This should include information on general lifestyle, physical activity, diet and symptom-targeted medication.

1.2.1.2 Healthcare professionals should encourage people with IBS to identify and make the most of their available leisure time and to create relaxation time.

1.2.1.3 Healthcare professionals should assess the physical activity levels of people with IBS, ideally using the General Practice Physical Activity Questionnaire (GPPAQ; see appendix J of the full guideline). People with low activity levels should be given brief advice and counselling to encourage them to increase their activity levels.

1.2.1.4 Diet and nutrition should be assessed for people with IBS and the following general advice given.

- Have regular meals and take time to eat.
- Avoid missing meals or leaving long gaps between eating.
- Drink at least eight cups of fluid per day, especially water or other non-caffeinated drinks, for example herbal teas.
- Restrict tea and coffee to three cups per day.
- Reduce intake of alcohol and fizzy drinks.
- It may be helpful to limit intake of high-fibre food (such as wholemeal or high-fibre flour and breads, cereals high in bran, and whole grains such as brown rice).
- Reduce intake of 'resistant starch' (starch that resists digestion in the small intestine and reaches the colon intact), which is often found in processed or re-cooked foods.
- Limit fresh fruit to three portions per day (a portion should be approximately 80 g).

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- People with diarrhoea should avoid sorbitol, an artificial sweetener found in sugar-free sweets (including chewing gum) and drinks, and in some diabetic and slimming products.
- People with wind and bloating may find it helpful to eat oats (such as oat-based breakfast cereal or porridge) and linseeds (up to one tablespoon per day).

1.2.1.5 Healthcare professionals should review the fibre intake of people with IBS, adjusting (usually reducing) it while monitoring the effect on symptoms. People with IBS should be discouraged from eating insoluble fibre (for example, bran). If an increase in dietary fibre is advised, it should be soluble fibre such as ispaghula powder or foods high in soluble fibre (for example, oats).

1.2.1.6 People with IBS who choose to try probiotics should be advised to take the product for at least 4 weeks while monitoring the effect. Probiotics should be taken at the dose recommended by the manufacturer.

1.2.1.7 Healthcare professionals should discourage the use of aloe vera in the treatment of IBS.

1.2.1.8 If diet continues to be considered a major factor in a person's symptoms and they are following general lifestyle/dietary advice, they should be referred to a dietitian for advice and treatment, including single food avoidance and exclusion diets. Such advice should only be given by a dietitian.

1.2.2 Pharmacological therapy

Decisions about pharmacological management should be based on the nature and severity of symptoms. The recommendations made below assume that the choice of single or combination medication is determined by the predominant symptom(s).

1.2.2.1 Healthcare professionals should consider prescribing antispasmodic agents for people with IBS. These should be taken as required, alongside dietary and lifestyle advice.

1.2.2.2 Laxatives should be considered for the treatment of constipation in people with IBS, but people should be discouraged from taking lactulose.

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1.2.2.3 Loperamide should be the first choice of antimotility agent for diarrhoea in people with IBS.[6]

1.2.2.4 People with IBS should be advised how to adjust their doses of laxative or antimotility agent according to the clinical response. The dose should be titrated according to stool consistency, with the aim of achieving a soft, well-formed stool (corresponding to Bristol Stool Form Scale type 4).

1.2.2.5 Healthcare professionals should consider tricyclic antidepressants (TCAs)[7] as second-line treatment for people with IBS if laxatives, loperamide or antispasmodics have not helped. TCAs are primarily used for treatment of depression but are only recommended here for their analgesic effect. Treatment should be started at a low dose (5–10 mg equivalent of amitriptyline), which should be taken once at night and reviewed regularly. The dose may be increased, but does not usually need to exceed 30 mg.

1.2.2.6 Selective serotonin reuptake inhibitors (SSRIs) should be considered for people with IBS only if TCAs have been shown to be ineffective[8].

1.2.2.7 Healthcare professionals should take into account the possible side effects when prescribing TCAs or SSRIs. After prescribing either of these drugs for the first time at low doses for the treatment of pain or discomfort in IBS, the person should be followed up after 4 weeks and then at 6–12 monthly intervals thereafter.

1.2.3 Psychological interventions

1.2.3.1 Referral for psychological interventions (cognitive behavioural therapy [CBT], hypnotherapy and/or psychological therapy) should be considered for people with IBS who do not respond to pharmacological treatments after 12 months and who develop a continuing symptom profile (described as refractory IBS).

1.2.4 Complementary and alternative medicine (CAM)

1.2.4.1 The use of acupuncture should not be encouraged for the treatment of IBS.

1.2.4.2 The use of reflexology should not be encouraged for the treatment of IBS.

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1.2.5 Follow-up

1.2.5.1 Follow-up should be agreed between the healthcare professional and the person with IBS, based on the response of the person's symptoms to interventions. This should form part of the annual patient review. The emergence of any 'red flag' symptoms during management and follow-up should prompt further investigation and/or referral to secondary care.

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[4] See Referral guidelines for suspected cancer, NICE clinical guideline 27, for detailed referral criteria where cancer is suspected.

[5] This recommendation was updated in September 2012 in line with more recent guidance on the recognition and management of ovarian cancer in Ovarian cancer (NICE clinical guideline 122).

[6] In certain situations the daily dose of loperamide required may exceed 16 mg, which at the time of publication (February 2008) was an out of licence dose. Informed consent should be obtained and documented.

[7] At the time of publication (February 2008) TCAs did not have UK marketing authorisation for the indication described. Informed consent should be obtained and documented.

[8] At the time of publication (February 2008) SSRIs did not have UK marketing authorisation for the indication described. Informed consent should be obtained and documented.

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2 Notes on the scope of the guidance

NICE guidelines are developed in accordance with a scope that defines what the guideline will and will not cover. The scope of this guideline is available.

The guideline covers adults (18 years and older) who present to primary care with symptoms suggestive of IBS, and the care that is provided by primary healthcare professionals, indicating where secondary care referral is appropriate. It does not cover:

- people with other gastrointestinal disorders such as non-ulcer dyspepsia or coeliac disease
- children and young people under 18 years
- inflammatory bowel disease.

How this guideline was developed

NICE commissioned the National Collaborating Centre for Nursing and Supportive Care to develop this guideline. The Centre established a Guideline Development Group (see appendix A), which reviewed the evidence and developed the recommendations. An independent Guideline Review Panel oversaw the development of the guideline (see appendix B).

There is more information about how NICE clinical guidelines are developed on the NICE website. A booklet, 'How NICE clinical guidelines are developed: an overview for stakeholders, the public and the NHS' is available.

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3 Implementation

The Healthcare Commission assesses the performance of NHS organisations in meeting core and developmental standards set by the Department of Health in 'Standards for better health', issued in July 2004. Implementation of clinical guidelines forms part of the developmental standard D2. Core standard C5 says that national agreed guidance should be taken into account when NHS organisations are planning and delivering care.

NICE has developed tools to help organisations implement this guidance. These are available on our website.

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4 Research recommendations

The Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future.

4.1 Low-dose antidepressants

Are low-dose TCAs, SSRIs and serotonin and norepinephrine reuptake inhibitors (SNRIs) effective as first-line treatment for IBS, and which is the most effective and safe option?

Why this is important

Reviews have shown that TCAs and SSRIs have each been compared with placebo in the treatment of IBS, but not at low doses. In practice, TCAs are used at higher doses, and concordance with treatment is poor because of side effects. The Guideline Development Group clinicians believe that at low doses (5–10 mg equivalent of amitriptyline), TCAs could be the treatment of choice for IBS, but there is a lack of evidence to support this. A newer type of antidepressant, SNRIs, may also be useful in the treatment of IBS-associated pain. A large randomised trial is proposed, comparing an SSRI, a TCA and an SNRI with placebo. Participants should be adults with a positive diagnosis of IBS, stratified by type of IBS and randomised to treatments. The type of IBS is defined by the predominant bowel symptom: diarrhoea, constipation or alternating symptoms. The primary outcome should be global improvement in IBS symptoms. Health-related quality of life should also be measured, and adverse effects recorded. Study outcomes should be assessed 12, 26 and 52 weeks after the start of therapy.

4.2 Psychological interventions

Are the psychological interventions CBT, hypnotherapy and psychological therapy all equally effective in the management of IBS symptoms, either as first-line therapies in primary care, or in the treatment of people with IBS that is refractory to other treatments?

Why this is important

Reviews show some evidence of effect when comparing psychological interventions with a control group, with the greatest effect shown in people who have refractory IBS. Many trials are small in size. Certain psychological interventions – namely, CBT, hypnotherapy and

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psychological therapy – are thought to be useful in helping people with IBS to cope with their symptoms, but it is unclear at what stage these should be given, including whether they should be used as first-line therapies in primary care. A large randomised trial is proposed, comparing CBT, hypnotherapy and psychological therapy (in particular, psychodynamic interpersonal therapy). Participants should be adults with a positive diagnosis of IBS, and they should be stratified into those with and without refractory IBS and then randomised to treatments. The primary outcome should be global improvement in IBS symptoms. Health-related quality of life should also be measured, and adverse effects recorded. Study outcomes should be assessed 12, 26 and 52 weeks after the start of therapy.

4.3 Refractory IBS

What factors contribute to refractory IBS?

Why this is important

Most people with IBS experience symptoms that are relatively short-lived or that only trouble them on an intermittent basis. Some people, however, develop chronic and severe symptoms that are difficult to treat. There are relatively few prospective studies that have investigated this problem.

A large, prospective, population-based cohort study is proposed, which would evaluate people in the community with IBS symptoms according to measures of bowel symptomatology, physical symptom profile, psychological symptoms, childhood adversity, psychiatric history, social supports, quality of life and other relevant potential predictors. Participants would be re-evaluated 12 and 24 months later using similar measures. Baseline variables would be used to predict chronicity of symptoms, quality of life and healthcare utilisation at 12 and 24 months.

4.4 Relaxation and biofeedback

What is the effect of relaxation and biofeedback therapies on IBS symptoms and patient-related outcomes?

Why this is important

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Reviews of biofeedback and relaxation therapies suggest a positive effect on the control of IBS symptoms, but evidence is limited and not sufficient to make recommendations. Patient representation in the Guideline Development Group supports this view, from a personal and anecdotal perspective.

Recent developments in computer-aided biofeedback methods merit investigation. A large randomised trial is proposed to compare relaxation therapy, computer-aided biofeedback therapy and attention control in primary care. Participants should be adults with a positive diagnosis of IBS, and they should be stratified into those with and without refractory IBS and then randomised to treatments. The primary outcome should be global improvement in IBS symptoms. Health-related quality of life should also be measured, and adverse effects recorded. Study outcomes should be assessed 12, 26 and 52 weeks after the start of therapy. Qualitative data should be generated relating to how people with IBS perceive their condition.

4.5 Herbal medicines

Are Chinese and non-Chinese herbal medicines safe and effective as first-line therapy in the treatment of IBS, and which is the most effective and safe option?

Why this is important

Reviews of herbal medicines suggest a positive effect on the control of IBS symptoms, but evidence is limited and not sufficient to make recommendations (eight comparisons from the six trials provide heterogeneous data, which are very difficult to interpret). A large randomised placebo-controlled trial is proposed, comparing Chinese and non-Chinese herbal medicines (both single and multiple compounds) that are available in the UK as standard preparations. Participants should be adults with a positive diagnosis of IBS, and they should be stratified by type of IBS and then randomised to treatments. The primary outcome should be global improvement in IBS symptoms, with symptom scores recorded using a validated scale. Health-related quality of life should also be measured, and adverse events recorded. Study outcomes should be assessed 12, 26 and 52 weeks post-intervention.

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5 Other versions of this guideline

5.1 Full guideline

The full guideline, 'Irritable bowel syndrome in adults: diagnosis and management of irritable bowel syndrome in primary care' contains details of the methods and evidence used to develop the guideline. It is published by the National Collaborating Centre for Nursing and Supportive Care, and is available from our website.

5.2 Information for the public

NICE has produced information for the public explaining this guideline.

We encourage NHS and voluntary sector organisations to use text from this booklet information in their own information materials.

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6 Related NICE guidance

Faecal incontinence: the management of faecal incontinence in adults. NICE clinical guideline 49 (2007).

Physical activity. NICE public health intervention guidance PH002 (2006).

Referral guidelines for suspected cancer. NICE clinical guideline 27 (2005).

Depression: management of depression in primary and secondary care. NICE clinical guideline 23 (2004). [Replaced by NICE clinical guideline 90].

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7 Updating the guideline

NICE clinical guidelines are updated as needed so that recommendations take into account important new information. We check for new evidence 2 and 4 years after publication, to decide whether all or part of the guideline should be updated. If important new evidence is published at other times, we may decide to do a more rapid update of some recommendations.

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Appendix A: The Guideline Development Group

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Patient/carer representative, The Gut Trust (formerly the IBS Network)

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Dr Miranda Lomer
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Ms Marion Saunders
Patient/carer representative

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Ms Theresa Shaw (Chair)
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Appendix B: The Guideline Review Panel

The Guideline Review Panel is an independent panel that oversees the development of the guideline and takes responsibility for monitoring adherence to NICE guideline development processes. In particular, the panel ensures that stakeholder comments have been adequately considered and responded to. The panel includes members from the following perspectives: primary care, secondary care, lay, public health and industry.

Dr Robert Walker (Chair)
General Practitioner, Workington

Dr John Harley
Clinical Governance and Prescribing Lead and General Practitioner, North Tees PCT

Dr Mark Hill
Head of Medical Affairs, Novartis Pharmaceuticals UK Ltd

Mrs Ailsa Donnelly
Patient representative

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Appendix C: The algorithm

The full guideline contains a care pathway overview and algorithms.

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Appendix D: The Bristol Stool Form Scale

The full guideline contains the Bristol Stool Form Scale.

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Changes after publication

January 2012: minor maintenance

September 2012: Recommendation 1.1.1.3 in this guideline has been partially updated by recommendation 1.1.2.1 in 'Ovarian cancer' (NICE clinical guideline 122; published April 2011). The previous recommendation was:

'All people presenting with possible IBS symptoms should be assessed and clinically examined for the following 'red flag' indicators and should be referred to secondary care for further investigation if any are present:

- anaemia
- abdominal masses
- rectal masses
- inflammatory markers for inflammatory bowel disease.

  If there is significant concern that symptoms may suggest ovarian cancer, a pelvic examination should also be considered.'

The final sentence has been replaced with:

'Measure serum CA125 in primary care in women with symptoms that suggest ovarian cancer in line with 'Ovarian cancer' (NICE clinical guideline 122).'

October 2013: minor maintenance

February 2014: minor maintenance

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About this guideline

NICE clinical guidelines are recommendations about the treatment and care of people with specific diseases and conditions in the NHS in England and Wales.

The guideline was developed by the National Collaborating Centre for Nursing and Supportive Care. The Collaborating Centre worked with a group of healthcare professionals (including consultants, GPs and nurses), patients and carers, and technical staff, who reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

The methods and processes for developing NICE clinical guidelines are described in The guidelines manual.

We have produced information for the public explaining this guideline. Tools to help you put the guideline into practice and information about the evidence it is based on are also available.

Your responsibility

This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

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