Introduction
&
Aims of study:
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AIMS OF STUDY

In modern gastro-enterological practice, the
irritable bowel syndrome (IBS) is one of the most
commonly seen entity. The syndrome is hard to define
precisely but is characterised by either abdominal pain
and altered bowel habits or painless diarrhoea. Various
names like spastic colon syndrome, dyssynergia of the
colon, colonic neurosis, nervous diarrhoea, spastic
colitis, functional entero-colonopathy, membranous colitis
and mucus colitis have been used to describe this
functional disorder. Irritable bowel syndrome is now the
most widely used and is probably the most suitable term.

IBS does not separate clearly from the normal; the
individual features of the disease have been experienced
by many apparently healthy individuals at some time, but
not on a scale that give rise to the belief that an
illness has developed. Such symptoms as abdominal pain,
distension, gurgling, change in stool consistency,
straining at stool, sensation of incomplete evacuation and
even passage of mucus or rectum are familiar to many
people who count themselves normal, yet these are just the
symptoms which by their frequent occurrence in combination lead to the diagnosis of IBS.

The incidence of IBS is hard to assess. It is now apparent that those seeking medical advice, and in particular those attending hospital clinics, represent only the tip of an iceberg, and yet they are more numerous than patients with any other gastro-intestinal disorder. In developing countries, e.g. in India where gastro-intestinal infection is very common, the position is more difficult. All types of diarrhoea or abdominal discomfort may be attributed to infection, especially chronic amoebiasis, when the real problem is IBS. Equally, patients known to have IBS will periodically develop infections which must be recognised and treated. In England, the irritable bowel syndrome is twice as common in women as in men (Chaudhry & Truelove, 1962; Waller et al., 1962). But in India, Pimparker (1970) reported IBS to be three times more common in men as compared to that in women. In both sexes, it occurs principally in early adulthood and middle age, the majority of the patients developing their symptoms between the ages of 20 and 50. It is
unusual for symptoms to start after the age of 50. Two main clinical types of the irritable bowel syndrome may be distinguished:

1. **SPASTIC COLON**: Pain of colonic origin is the cardinal feature of this subgroup. The bowel action is usually disturbed but may be normal. Sometimes mucus is passed per rectum.

2. **PAINLESS DIARRHOEA**: Diarrhoea is the sole symptom of this subgroup. The motions are loose or watery but do not contain blood.

Spastic colon is much more common than painless diarrhoea. In both subgroups, the symptoms may be either intermittent or continuous.

The most common symptom is abdominal pain. It is generally continuous but sometimes may be colicky in nature. It may be dull, gnawing, sharp or crampy and may be generalised or localized to a particular abdominal segment. It may even radiate to the lower chest. In more than 50% of the patients with spastic colon, there is temporary relief of pain when defaecation occurs. This is an important point in diagnosis, because this link with defaecation should
immediately suggest that a patient's abdominal pain is likely to be of colonic origin.

Another common symptom is alteration of the normal bowel habits. In some patients, diarrhoea is a predominant symptom. The diarrhoea may either be continuous or episodic. The latter is more frequent during morning hours. Stool may be well formed and mixed with mucus. Some patients suffer from alternating constipation and diarrhoea; in them, the typical sequence is constipation with pain working up to a climax and culminating in a short bout of diarrhoea, often with temporary relief of pain; then the sequence is repeated. Some patients have entirely normal bowel habit and some are prone to constipation, which frequently coincides with a period of colonic pain.

It is possible to recognise a variety of aetiological factors in the irritable bowel syndrome. Psychological factors are of great importance and it is frequently possible to elicit by means of a careful history, the fact that the onset of the condition occurred immediately at or following a disturbing emotional event. These psychological factors may be conscious, sub-conscious
or unconscious. Such psychological factors are identified more often among the women than among the men.

An attack of dysentery, either bacillary or amoebic, is also liable to be the precipitating cause of the irritable bowel syndrome. Such patients frequently receive repeated courses of anti-dysenteric treatment from their physicians with no relief of their symptoms and a resulting feeling of despair.

Purgatives, if taken regularly for long periods, may be the cause of the irritable colon syndrome in some patients. Other patients find that specific items of diet exacerbate their symptoms.

The diagnosis of an irritable bowel syndrome depends upon both positive and negative evidence. As far as the history is concerned, there may be present one or more of the etiological factors which have been considered above. On the negative side, the history may be equally important because it may reveal that there has been no loss of weight nor other evidence which would immediately make one seek an organic explanation for the symptoms. As far as
the physical examination is concerned, the positive finding in the IBS is the discovery of a colon which is readily palpable over part or the whole of its length and is tender to fairly gentle pressure. Physical examination is also important in excluding evidence of organic disease in any system of the body.

As far as laboratory investigations are concerned, the minimum that must be done is to have the blood examined, because the haemoglobin value is normal and the E.S.R. is likewise normal in a patient with the irritable colon syndrome. In the presence of anaemia or of a raised erythrocyte sedimentation rate, an organic disease should always be suspected.

Sigmoidoscopy should always be performed in patients who suffer from colonic symptoms. Sigmoidoscopy not only permits the exclusion of the focal lesions but it also yields some positive evidence in the case of many, though not all, of the patients with the irritable bowel syndrome. The colonic mucosa is frequently flushed and secreting mucus heavily than usual. Sigmoidoscopic examination generally reveals hypaspasticity of the colon.
Barium enema again serves the double role of excluding organic disease and, sometimes, of providing positive evidence to support the diagnosis of irritable bowel syndrome. A reduced size of colonic lumen, an increased number of haustral markings and in severe cases, actual segmental spasms of the colon are strong evidence in favour of the diagnosis.

The irritable colon syndrome is of uncertain origin, but thought by many to be functional. A probable important role for psychological factors has been stressed for both spastic colon and painless diarrhoea. Alexander (1994) studied the psychological structure and life situations of patients suffering from functional disorders of gastro-intestinal tract, because of its three major functions of taking in, retaining and eliminating, was specially suitable for the expression of emotions particularly if their normal expression through the voluntary system was inhibited. According to Backus (1954), and Chaudhry and Truelove (1962), psychogenic influences have the greatest importance in the initiation of the attacks. This was further confirmed by Pimparkar (1970). Esler (1973) studied the levels of anxiety in colonic disorders. It was found that patients with IBS who had predominantly diarrhoea were significantly more anxious and more neurotic as well as significantly more
Palmer (1974) concluded that the patients who were suffering from the irritable bowel syndrome had a moderate degree of psychoneurotic disturbances in the form of both neurotic personality structure and the presence of psychoneurotic symptoms. Grossman (1978) observed that the patients with spastic colon were seemed determined to solve their problems but patients with painless diarrhoea maintained an underlying sense of personal inadequacy in dealing with problems.

Vahora (1981) reported from Bombay, that patients with irritable bowel syndrome have a more neurotic personality structure and an increased psychiatric morbidity.

In a developing country like India where altered bowel habits are generally thought to be of infective origin, the psychological and emotional factors are overlooked. While it has been seen that the patients with spastic colon are rigid obsessive and compulsive persons, and those with painless diarrhoea show more diffuse free floating or phobic anxiety.
Keeping the foregoing account in view, this study was aimed at:

1. To evaluate the organic, if any, or functional (psychological) components of the illness,

2. To determine the psychological characters of the patients, and,

3. To assess the emotional stress factors in the genesis and perpetuation of the disease.