5 *Extraintestinal Manifestations of Irritable Bowel Syndrome*

P.J. Whorwell

INTRODUCTION

The more symptoms of which a patient complains, the more suspicious a doctor becomes about the reality of that person's disease. Patients with irritable bowel syndrome (IBS) usually complain of abdominal pain, abdominal distension and an abnormal bowel habit. In addition, with increasing evidence of a more diffuse involvement of the gastrointestinal tract (Whorwell *et al.*, 1981; Kellow & Phillips, 1987), it is not surprising that patients also have other gastrointestinal symptoms depending on the localization of the abnormality. Thus, upper gastrointestinal complaints are also quite common in this disorder, leading to such diagnoses as reflux oesophagitis, non-ulcer dyspepsia and biliary dyskinesia. All this leads to a mounting list of symptoms for which extensive investigation is largely unrewarding. When the patient is then told there is nothing wrong, the patient becomes disillusioned with the doctor and the doctor starts to feel the patient is a chronic complainer. Once the doctor–patient relationship becomes compromised by this state of affairs, the patient is reluctant to admit to further symptomatology and keeps complaints to a minimum and certainly confined to the gastrointestinal system.

Some years ago we formed the clinical impression that patients with IBS were suffering from a series of non-colonic symptoms of which they were reluctant to complain. It was therefore decided to assess the more diffuse symptomatology of IBS and compare the prevalence of certain symptoms in 100 patients and 100 healthy controls (Whorwell *et al.*, 1986b). Table 5.1 lists those gastrointestinal symptoms and Table 5.2 those non-gastrointestinal symptoms which were significantly ($P < 0.001$) more common in IBS subjects. There is undoubtedly a raised incidence of psychopathology in patients with IBS (Creed & Guthrie, 1987) and it could be argued that this may account for some of these findings. For this reason patients were therefore divided into those with and without possible psychiatric disorder. There was no difference between the two groups in the prevalence of the symptoms listed in

Table 5.1. Gastrointestinal symptoms in patients with IBS ($P < 0.001$ compared with controls)

Symptom	Prevalence in IBS (%)	Prevalence in controls (%)
Nausea	29	2
Dysphagia	19	0
Early satiety	60	8
Dyspepsia	36	9
Excessive flatus	85	42

Table 5.2. Extraintestinal symptoms in patients with IBS ($P < 0.001$ compared with controls)

Symptom	Prevalence in IBS (%)	Prevalence in controls (%)
Back pain	68	28
Constant tiredness/lethargy	70	20
Bad breath/unpleasant taste in mouth	65	16
Frequent headaches	34	3
Urinary frequency	52	12
Urinary urgency	41	9
Nocturia	48	17
Incomplete emptying of bladder	50	18
Dyspareunia	41	5
Thigh pain	40	5

Table 5.2, although some psychological symptoms such as panic attacks and tremulousness were much less prominent in patients without psychiatric problems.

The presence of all these complaints in subjects with IBS, particularly those of a extraintestinal nature, raises many issues such as questions about their causation and the possibility of inappropriate investigation. Backache, thigh pain and profound lethargy are particularly difficult to account for, although they are very common. Lethargy is a frequent accompaniment of affective disorders, but in our study was no less common in subjects without any demonstrable psychopathology

UROLOGICAL ABNORMALITIES

If IBS is a more diffuse disorder of smooth muscle than previously recognized, it is possible that smooth muscle outside the gastrointestinal system may be similarly affected. In view of the frequent finding of urological symptoms in these patients, we undertook urodynamic investigation of 30 subjects with IBS, comparing the findings to those of a control group of patients attending for

Table 5.3. Urodynamic findings in patients with IBS and controls

	IBS (%)	Controls (%)	IBS with urinary symtpoms (%)
Unstable bladder	33	3	100
Steep cystometrogram	17	10	80
Stable bladder	50	87	66

urodynamic assessment (Whorwell *et al.*, 1986a). These were patients with urinary symptoms referred to a urological clinic, but in whom there was no evidence of IBS. It was considered unethical to perform urodynamic measurements in normal controls, but as the control group selected already had urinary symptoms they would, if anything, be more likely to have abnormal results and bias against a positive finding in the IBS group. Fifty percent of the patients with IBS, compared to only 13% of controls ($P = 0.006$), had some demonstrable abnormality of bladder function (Table 5.3). Detrusor instability was observed in 33% of patients, compared with 3% of controls, and a steep cystometrogram was observed in 17% of patients compared with 10% of controls. Detrusor instability is defined as the occurrence of detrusor contractions which occur during passive filling of the bladder, which the patient is unable to inhibit, and which is associated with such symptoms as frequency, nocturia and urgency. It is interesting to note that patients in our study with a tendency to a frequent bowel habit were more likely to exhibit a detrusor instability. Thus, it appears that some patients with IBS have a demonstrable disorder of bladder smooth muscle or its innervation, and it is tempting to speculate that this may be in some way associated with the pathophysiological process underlying IBS.

GYNAECOLOGICAL ABNORMALITIES

As can be seen from Table 5.2, dyspareunia is common in women with IBS and this led us to speculate that there might be an adverse effect on sexual function. Fifty females with IBS were studied and 30 patients with colonic inflammatory bowel disease; 30 patients with duodenal ulceration served as controls (Guthrie *et al.*, 1987). All subjects were interviewed by a female psychiatrist in the privacy of their own home. Eighty-three percent of IBS patients admitted to sexual dysfunction which they attributed to their gastrointestinal disorder (Table 5.4). The comparative figures for the inflammatory bowel disease and peptic ulcer patients were 30% and 16% respectively ($P < 0.001$). There was little change in the results when the data were re-analysed excluding patients with psychiatric disorder.

Table 5.4. Sexual function in women with irritable bowel syndrome IBS, inflammatory bowel disease (IBD), and duodenal ulceration (DU)

	IBS (%)	IBD (%)	DU (%)
Sexual function adversely affected by gastrointestinal disorder	83	30	16
Abdominal pain on sexual intercourse	69	7	0
Vaginal pain on sexual intercourse	17	7	12

By far the commonest complaint was the provocation, by sexual intercourse, of a pain similar to that associated with IBS and characteristically the onset of the pain was often delayed by several hours. It is not clear whether the pain arises from smooth muscle or not and if it does, whether it is gastrointestinal or genital tract in origin. However, its similarity to IBS pain suggests it may originate from the bowel. This is an aspect of IBS which would not be routinely enquired after in a gastroenterology clinic, but is probably of considerable practical importance. Such a problem could well induce marital disharmony and the stress associated with this may well lead to an exacerbation of the IBS.

The gynaecological aspects of IBS have received little attention and we have recently taken an interest in them. Preliminary data from our unit suggests that IBS in very common in patients attending gynaecological clinics, particularly in those referred for abdominal pain. In addition we have found that the outcome of a gynaecological consultation is significantly less satisfactory if symptoms suggestive of IBS are present.

The multiplicity of symptoms in IBS may lead to referral to many different specialties, depending on which predominate. Thus urologists, gynaecologists and even orthopaedic surgeons may become involved in management. A series of inappropriate investigations, occasionally leading to unnecessary surgery, may follow all to no avail. Patients are often greatly relieved to find a medical practitioner who recognizes that their seemingly unrelated symptoms can be attributed to IBS. Capacity to cope with these extraintestinal manifestations of IBS is often dramatically improved even if treatment does little to alleviate them.

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