4. Potential approaches to IBS treatment (all subtypes)
- Dietary modifications: assess common food triggers, psyllium supplementation (soluble fibre), ensure adequate fluids
- Physical activity: 20+ minutes of exercise almost daily; aiming for 150 min/week
- Psychological treatment: patient counselling and reassurance, Cognitive Behavioural Therapy, hypnotherapy, screen and treat any underlying sleep or mood disorder where relevant
- Pharmacologic therapy: antispasmodics (hyoscine butylbromide, dicyclomine hydrochloride, pinaverium bromide), enteric coated peppermint oil

5. Specific approaches based on IBS subtypes

**IBS-D (diarrhea predominant)**
- Loperamide
- Tricyclic antidepressants
- Probiotics
- Trial low FODMAP diet
- Second line therapies: Rifamixin*, Eluxadoline*
- *See expanded details

**IBS-M/U (mixed/undefined)**
- Pay particular attention to lifestyle & dietary principles
- Tricyclic antidepressants
- Probiotics
- Trial low FODMAP diet

**IBS-C (constipation predominant)**
- Adequate fibre and water intake
- Osmotic laxatives
- Linaclotide
- SSRIs

Further testing for patients with high clinical suspicion of IBD. Do Faecal calprotectin test.

Faecal cal test > 200mcg/g

**Positive for celiac**

6. Refer for consultation and/or endoscopy

**Presumed Diagnosis of IBS**
IRRITABLE BOWEL SYNDROME (IBS) PATHWAY PRIMER

- IBS is a brain-gut disorder characterized by recurrent abdominal pain/discomfort and altered bowel habits (constipation, diarrhea, or both). It is often associated with bloating or abdominal distention. These key symptoms can vary in severity and tend to remit and recur, often affected by dietary exposures and stress.
- IBS is considered to be a manifestation of bidirectional disordered communication within the brain-gut axis that influences gastrointestinal motility, secretion, and sensation.\(^1\)
  - Contributing factors include visceral hypersensitivity, altered GI motility, post-infectious diarrhea, chronic stress, altered brain networks, and the microbiome. Alterations in the colonic immune system, neuronal activity, and gut permeability also play a role.
- It is one of the most common gastrointestinal (GI) disorders affecting approximately 10% of the general population and can have significant impact on a patient’s quality of life.\(^2,3\)
- Historically, many providers believe it is a diagnosis of exclusion, but this notion is changing and moving towards a positive, symptom-based diagnosis.
  - The current recommended diagnostic criteria for IBS are the Rome IV criteria:
    - Abdominal pain (≥1 day per week for ≥3 months) associated with two or more of the following: related to defecation, associated with a change in the frequency of stool, associated with a change in the form (appearance) of stool.
    - Typical associated lower GI symptoms include bloating and flatulence. Upper GI symptoms include nausea, burping, early satiety, and dyspepsia.
    - Relief of abdominal discomfort after a bowel movement or in association with a change in stool form or frequency is a defining feature. Bowel dysfunction includes frequent bowel movements, fecal urgency, altered stool form (hard/lumpy or loose/watery), sense of or incomplete evacuation, straining with stool passage, and passage of mucus.
    - IBS correlates with other pain syndromes, so other symptoms such as dysuria, frequent/urgent urination, widespread musculoskeletal pain, dysmenorrhea, dyspareunia, fatigue, anxiety, depression, and headaches may also be present. Pain often is variable and may be related to the subtype.\(^4\)
- IBS is subtyped according to stool consistency:
  - Constipation-predominant (IBS-C, >25% hard stools and <25% loose stools)
  - Diarrhea-predominant (IBS-D, >25% loose stools and <25% hard stools)
  - Mixed bowel habits (IBS-M, >25% loose stools and >25% hard stools)
  - Unclassified (IBS-U, <25% loose stools and <25% hard stools)
- The most common diseases mislabeled as IBS are celiac disease, Crohn's disease, and microscopic colitis. GI cancers are unlikely in patients that meet usual criteria for IBS in the absence of red flags/abnormal blood work.

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### Checklist to guide in-clinic review of your patient with IBS

<table>
<thead>
<tr>
<th>Checklist Item</th>
<th>Details</th>
</tr>
</thead>
</table>
| Recurrent abdominal pain at least one day per week (on average) in the last 3 months, with two or more of the following: | • Related to defecation (either increasing or improving pain)  
• Associated with a change in frequency of stool  
• Associated with a change in form (appearance of stool) |
| Detailed medical history and physical examination, and review of medications |                                                                                              |
| Complete baseline investigations confirming no abnormal results (CBC, ferritin, serological testing to exclude celiac disease). |                                                                                              |
| Confirm absence of alarm features (if identified recommend Specialist Consultation) |                                                                                              |
| In diarrhea predominant patients- review history of cholecystectomy and consider ordering faecal calprotectin if there is a high clinical suspicion of IBD. |                                                                                              |

### EXPANDED DETAILS

1. **Suspected IBS**
   - Are symptoms consistent with IBS? Some important questions to guide the history.
     - Do you experience pain?
     - Does the pain improve/worsen/stay the same with bowel movements?
     - When the pain is present, is it often associated with a change in stool frequency or stool form?
     - Do these symptoms represent an acute change?
   - It is vital to understand a patient’s predominant symptom (pain, constipation, or diarrhea), as this influences treatment selection.

2. **Initial workup**
   - A detailed medical history and physical examination should be performed at presentation to assess other conditions that mimic IBS. This should include a careful review of medications to identify those potentially causing GI side effects (e.g. PPI, ASA/NSAIDs, laxatives/antacids, iron/calcium/magnesium supplements, calcium channel blockers, antidepressants, opioids, diuretics, use of cannabis, and herbal products).
   - In patients with diarrhea-predominant symptoms, ask about a history of cholecystectomy and whether this coincided with onset or worsening of symptoms. Post-cholecystectomy diarrhea, due to bile acid diarrhea (BAD), can be treated with cholestyramine.
   - IBS requires few standard initial laboratory investigations. CBC and ferritin should be tested and serological testing is suggested to exclude celiac disease, but routine testing for inflammation using C-reactive protein (CRP) or food allergies is not generally recommended.
     - Anemia or other alarm features (see Section 3) increase the likelihood of organic disease. If present, the patient will require further investigation.
     - Patients often ask about **small intestinal bacterial overgrowth** (SIBO) as a cause of symptoms. Although there may be a link between SIBO and IBS, the quality of the existing evidence is low. The accuracy of the breath test for SIBO is highly variable and may be unreliable. Routine testing for SIBO is not currently recommended.1,5
       - Additional testing can be considered based on patient history. For example, order *C. difficile* or O&P if there has been recent travel and diarrhea is the main concern.

3. **Alarm features** (warranting consideration of referral for consultation/endoscopy)
   - Family history of IBD or colorectal cancer (first-degree relative)

---

• GI bleeding/anemia
• Nocturnal symptoms
• Onset after age 50
• Unintended weight loss (>5% over 6-12 months)

**Iron Primer**

Evaluation of measures of iron storage can be challenging. Gastrointestinal (occult) blood loss is a common cause of iron deficiency and should be considered as a cause when iron deficiency anemia is present.

- Two main serological tests best evaluate iron stores (ferritin, transferrin saturation) - neither of which are perfect:
  - The first step is to evaluate a serum ferritin:
    - If the serum ferritin is low, it is diagnostic of iron deficiency, with high specificity (98% specificity).
    - Ferritin is an acute phase reactant, which may be elevated in the context of acute inflammation and infection. If you suspect this to be the case, order a transferrin saturation (see below).
      - However, if the ferritin is above 100 ug/L and there is no concurrent significant chronic renal insufficiency, iron deficiency is very unlikely - even in the context of acute inflammation/infection.
  - The second step is to evaluate transferrin saturation:
    - The transferrin saturation is a calculated ratio using serum iron and total iron binding capacity. Serum iron alone does not reflect iron stores.
    - Low values (less than 10%) demonstrate low iron stores in conjunction with a ferritin <100 µg/L.
- In the absence of abnormal iron indices, anemia may be from other causes other than (occult) blood loss (e.g. bone marrow sources, menstruation).

---

4. **Potential approaches for IBS treatment (overview for all subtypes)**

Patients with IBS will benefit from a multipronged, individualized approach to treatment, including dietary modifications, psychological, and pharmacological therapies.1,6

**Dietary modifications**

All subtypes of patients with IBS are likely to benefit from dietary modifications. For some patients, a referral to a dietician will be helpful. Some key components of management include:

- **Assess common food triggers:** Follow a systematic approach to effectively guide modifications and understand the impact changes make on symptoms.
  - It may be helpful for patients to use the Food and Lifestyle Symptom Diary to understand their IBS symptoms, food triggers, and stressors. Use the diary to determine how dietary modifications, psychological, and pharmacological therapies impact their IBS symptoms.
  - Assess dietary intake compared to Canada’s Food Guide.
    - Diets high in processed foods, fatty foods, caffeine, sugar alcohols, alcohol, and insoluble fibre (e.g. wheat bran, raw vegetables, the skin of fruits, and cruciferous vegetables such as broccoli, cauliflower, brussels sprouts, and legumes) can increase IBS symptoms.
- **Psyllium supplementation (soluble fibre):** Assess intake of soluble fibre. Increased intake can help reduce IBS symptoms.
  - The recommended total fibre for adults 19-50 years old is 38 g/day for men and 25 g/day for women, and adults over 50 years old is 30 g/day for men and 21 g/day for women

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• Start with 1 tsp (3-4g)/day and increase slowly to 2.5 tsp (10g)/day. See Patient Resources section for more information on fibre supplementation.

- **Ensure adequate fluids:** 2L/day for females, 3L/day for males.

**Physical activity/exercise**

- **20+ minutes of exercise** almost daily, aiming for 150 min/week is known to be an effective strategy for stress reduction.

**Psychological treatment**

- **Patient counselling and reassurance.** A key to long-term, effective management of IBS is to provide patients reassurance after their initial IBS diagnosis and offer points of reassessment and reappraisal to establish a therapeutic relationship.
  - Reassurance regarding potential inconsistency in the pattern of symptoms in response to triggers may be necessary. Not all elimination/avoidance of food triggers consistently or predictably improves symptoms. Symptoms are often the result of multiple contributing factors and the contribution from food is complex. ("I tried cheese last week and felt just fine. Today I have terrible bloating and diarrhea!"")
- **Cognitive-behavioral therapy** and **hypnotherapy** may help with stress management and gastrointestinal symptoms.
- **Screening for and treating any underlying sleep or mood disorders** may be important.

**Pharmacological therapies**

Use of pharmaceuticals in IBS is generally reserved for those who have not adequately responded to dietary and lifestyle interventions or in those with moderate or severe symptoms that impair their quality of life. These often need to be tailored to the patient's predominant subtype presentation (e.g. pain vs. diarrhea vs. constipation).

- **Antispasmodics:** Work by relaxing smooth muscles in the gut. May be beneficial in managing or aborting acute episodes of pain; can be used as needed and patients often take reassurance in having these on-demand treatments available. Try one or two of these options (not at once).
  - **Hyoscine butylbromide (Buscopan®)** - 10mg TID-QID ($25-40/month)
  - **Dicyclomine hydrochloride (Bentylol®)** - 20mg TID-QID p.r.n. ($25-40/month)
  - **Pinaverium bromide (Dicetel®)** - 50-100mg TID p.r.n. ($50-75/month)
- **Enteric coated peppermint oil:** Has been shown to relax smooth muscles in the gastrointestinal tract. It may help reduce pain and muscle spasms.
  - **Type** - enteric coated peppermint oil capsules or IBgard®
    - Enteric-coated: about 100 mg/capsule. Max dose of 450 mg BID ($20-25/month). Take 30-60 minutes before meals.
    - IBgard®: 80 mg/capsule. Max dose is 6 capsules per day or 480 mg/day ($70-100/month). Take 2 capsules 30-90 minutes before meals.
- **Contraindications to peppermint oil** - may interact with medications. It is important to discuss use with their pharmacist, and/or healthcare team.

5. **Specific approaches based on subtypes**

Categorizing IBS by dominant subtype guides specific treatment approaches.

**IBS-D (diarrhea-predominant)**

**Faecal calprotectin**

---


Consider ordering a faecal calprotectin in IBS-D patients if there is a high clinical suspicion of IBD.

Calprotectin is a protein released into the gastrointestinal tract when it is inflamed and can be detected in the stool by laboratory assay.

Elevated levels of faecal calprotectin are found in inflammatory bowel disease (Crohn’s disease and ulcerative colitis). However, mid-range levels can also be found in several benign conditions, such as in patients on NSAIDs or PPIs or those with GI infections, celiac disease, and microscopic colitis. By contrast, in functional disorders such as IBS, faecal calprotectin levels are normal.\(^\text{10}\)

<table>
<thead>
<tr>
<th>Faecal calprotectin</th>
<th>Clinical Implication</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;100mcg/g</td>
<td>Unlikely the patient has IBD</td>
</tr>
<tr>
<td>100-200 mcg/g</td>
<td>Test again in 4-6 weeks and order a CRP test as well</td>
</tr>
<tr>
<td>&gt;200mcg/g</td>
<td>Higher risk of IBD. Refer to GI.</td>
</tr>
</tbody>
</table>

**Pharmacological therapies**

- **Loperamide (Imodium\(^\text{®}\)):** A safe \(\mu\) (mu) receptor antagonist antidiarrheal which does not affect global IBS symptoms, but may help with the frequency and consistency of BMs. Although not intended for long-term recurrent use, it is effective for shorter-term rescue therapy (e.g. for use during travel, social events). Only use in limited doses. The caution is in its tendency towards constipation, so use a low dose with a slow increase in dosage to safely avoid constipation.
  - Initial dose at 4 mg, then 2 mg post each loose BM (max 16 mg/day)

- **Tricyclic antidepressants (TCA):** TCAs have anticholinergic properties which lead to a slowing of GI transit time, thus slowing diarrhea. They can also help for chronic IBS pain.
  - Nortriptyline or amitriptyline 10-25mg qhs. Increase dose by 10-25 mg every 3-4 weeks (due to delayed onset). May require 25-50mg/day ($20-60/month); often takes 2-3 months for peak effect.

- **Probiotics:** Creating and maintaining a healthy gut microflora may help improve gut function.\(^\text{11}\) The most effective probiotic strain is unknown; patients should be encouraged to select products that are licensed by Health Canada’s Natural and Non-prescription Health Products Database. Refer to Probiotic Chart for up to

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\(^{10}\) York Teaching Hospital – NHS Foundation Trust & Yorkshire and Humber Academic Health Sciences Network (2016, July) The York Faecal Calprotection Care Pathway Information for GPs. [https://www.yorkhospitals.nhs.uk/specmsfile/?id=941](https://www.yorkhospitals.nhs.uk/specmsfile/?id=941)

date evidence. These strains have the most evidence to support benefits (a one month trial is reasonable).

Probiotics have not been conclusively shown to improve symptoms of IBS\textsuperscript{12}:

- **Bifidobacterium infantis (Align\textsuperscript{®})** - 1 capsule/day ($40/month)
- **Lactobacillus plantarum 229v (TuZen\textsuperscript{®})** - 1-2 capsules/day ($40-80/month)
- **Visbiome\textsuperscript{®}** - ½-1 sachet/day ($50-100/month)

**Low FODMAPs Diet**

- A trial of a low fermentable oligosaccharides, disaccharides, monosaccharides, polyols (FODMAP) diet is suggested, while an exclusive gluten-free diet is not. Some patients may wish to trial the elimination of a single nutrient/food (e.g. lactose, fructans, fructose, sugar alcohols) or an elimination of multiple nutrients/foods using this diet. Referral to a dietitian should be considered if this diet is planned.
  - A single nutrient/food elimination trial is the removal of a nutrient/food for 2-4 weeks. Use a symptom diary to note the impact of the dietary modification. If no improvement, the nutrient/food can be added back and a second single nutrient/food elimination trial can be tested.
  - A low-FODMAP diet trial is the removal of multiple nutrients/foods all at once for 2-6 weeks (max) until symptoms have improved. Then, a single nutrient/food is added back into the diet, using the diary to test for tolerance.

**Second Line therapies**

- Consider consulting a GI using Specialist Link, Connect MD, or e-Referral Advice Request for guidance on these treatments.
  - **Rifaximin (Zaxine\textsuperscript{®})** - A non-systemically absorbed antibiotic. The mechanisms of action have not been clearly identified, but may alter the microbiome, thus reducing gas production.
    - 550mg 3x/daily for 2 weeks (~$325). This is a safe drug, but tends to require multiple recurrent courses. There is no long-term safety or efficacy data over 3 courses.
  - **Eluxadoline (Viberzi\textsuperscript{™})** – Belongs to the class of medications called opioid receptor agonists/antagonists. Works in the bowel to regulate muscle activity and slow the rate that material passes through the digestive system, thus improving diarrhea. It can also improve the pain of IBS.
    - 100 mg po BID (should be taken with food)
    - This is a complex drug as it has several limitations to prescribing, including age (not recommended for patients over age 65 given limited evidence for safety). Contraindications include patients with significant alcohol use (more than 3 drinks per day), pancreatitis, prior cholecystectomy, and severe liver impairment.

**IBS M/U (mixed/undefined)**

- Pay particular attention to lifestyle and dietary principles. Refer to Section 4.
- Probiotics - See IBS-D treatment recommendations
- Low FODMAPs - See IBS-D treatment recommendations
- Tricyclic antidepressants - See IBS-D treatment recommendations

**IBS-C (constipation predominant)**

- Pay particular attention to lifestyle and dietary principles. Refer to Section 4.
- Adequate fibre and water are important - See Patient Resources section.
- **Osmotic Laxatives**: Non-stimulant laxatives that draw water into the colon, increase bowel movements, and allow stool to pass more easily. These help with constipation, but not necessarily with other symptoms.
  - **Polyethylene glycol (PEG 3350) (Lax-A-Day\textsuperscript{®}, RestoraLAX\textsuperscript{®}, PEGalax\textsuperscript{®}, Relaxa\textsuperscript{®})**:
    - Start with 17g dissolved in 250 mL of liquid. Titrate to effect or max 34g/day. ($25-50/month). Onset of action 48-96 hours.
    - Studies suggest this is superior to lactulose.

Milk of magnesia:
- 30-60 mL/day. Onset of action 1-6 hours

Lactulose:
- Onset of action 24-48 hours
- 15-30mL, adding 10-20g OD-TID. ($10-20/month). Onset of action 24-48 hours.
- May cause bloating, pain, or flatulence

Linaclotide (Constella®):
- A guanylate cyclase agonist which increases chloride secretion from enterocytes and increases intestinal transit, plus modulates visceral sensitivity. It has minimal systemic absorption, reducing the likelihood of drug interactions. It is indicated for both chronic constipation and IBS-C.
  - 290 mcg po daily 30 minutes before breakfast ($160/month)

SSRIs (Selective Serotonin Reuptake Inhibitors):
- Can be helpful with abdominal pain and may loosen bowel movements for patients. Use at standard dosages.

NOTE: Alternative Remedies
Given the significant impact of IBS on quality of life, many patients pursue alternative, and often complementary, therapies to treat their symptoms (e.g. acupuncture, yoga, and reflexology). Although there are no evidence-based guidelines to support these alternative therapies, it is important to keep communication open.

6. When to refer for consultation and/or endoscopy
   a. Refer if initial workup is positive for Celiac disease, there are alarm features present, or a fecal calprotectin result is >200mcg/g
   b. When else would a referral for GI consultation be advisable?
      i. In patients with diarrhea predominance who have persistent symptoms or limited benefits from treatments outlined in this pathway, a referral may be helpful to investigate for Crohn’s disease and microscopic colitis.
      ii. For patients with constipation predominance or alternating diarrhea and constipation, colonoscopy is unlikely to yield relevant findings.

In the absence of alarm features for patients under age 50, colonoscopy is unlikely to be additive for the diagnosis of IBS. Studies show that a colonoscopy does not provide reassurance to patients with IBS.

BACKGROUND

About this Pathway

- Digestive health primary care pathways were originally developed in 2015 as part of the Calgary Zone’s Specialist LINK initiative. They were co-developed by the Department of Gastroenterology and the Calgary Zone’s specialty integration group, which includes medical leadership and staff from Calgary and area Primary Care Networks, the Department of Family Medicine. and Alberta Health Services.
- The pathways were intended to provide evidence-based guidance to support primary care providers in caring for patients with common digestive health conditions within the Patient Medical Home.
- Based on the successful adoption of the primary care pathways within the Calgary Zone, and their impact on timely access to quality care, in 2017 the Digestive Health Strategic Clinical Network (DHSCN) led an initiative to validate the applicability of the pathways for Alberta and to spread availability and foster adoption of the pathways across the province.

Authors & Conflict of Interest Declaration

This pathway was reviewed and revised under the auspices of the DHSCN in 2020 by a multi-disciplinary team led by family physicians and gastroenterologists. For more information, contact the DHSCN at Digestivehealth.SCN@ahs.ca.

Pathway Review Process
Primary care pathways undergo scheduled review every three years, or earlier, if there is a clinically significant change in knowledge or practice. The next scheduled review is July 2023, however we welcome feedback at any time. Please email comments to Digestivehealth.SCN@ahs.ca.

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Disclaimer
This pathway represents evidence-based best practice, but does not override the individual responsibility of healthcare professionals to make decisions appropriate to their patients using their own clinical judgment given their patients’ specific clinical conditions, in consultation with patients/alternate decision makers. The pathway is not a substitute for clinical judgment or advice of a qualified healthcare professional. It is expected that all users will seek advice of other appropriately qualified and regulated healthcare providers with any issues transcending their specific knowledge, scope of regulated practice, or professional competence.

PROVIDER RESOURCES

Advice Options
Non-urgent advice is available to support family physicians.

- Gastroenterology advice is available across the province via Alberta Netcare eReferral Advice Request (responses are received within five calendar days). Visit www.albertanetcare.ca/documents/Getting-Started-Advice-Requests-FAQs.pdf for more information.

- Non-urgent telephone advice connects family physicians and specialists in real time via a tele-advice line. Family physicians can request non-urgent advice from a gastroenterologist:
  - In the Calgary Zone at specialistlink.ca or by calling 403-910-2551. This service is available from 8:00 a.m. to 5:00 p.m., Monday to Friday (excluding statutory holidays). Calls are returned within one hour.
  - In the Edmonton Zone by calling 1-844-633-2263 or visiting www.pcnconnectmd.com. This service is available from 9:00 a.m. to 6:00 p.m., Monday to Thursday and 9:00 a.m. to 4:00 p.m. Friday (excluding statutory holidays and Christmas break). Calls are returned within two business days.

PATIENT RESOURCES

Information

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<tr>
<th>Description</th>
<th>Website</th>
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<tr>
<td>General information on IBS (MyHealth.Alberta.ca)</td>
<td>myhealth.alberta.ca/health/pages/conditions.aspx?Hwid=hw117851</td>
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<tr>
<td>Understanding Irritable Bowel Syndrome (Canadian Digestive Health Foundation)</td>
<td>cdhf.ca/digestive-disorders/irritable-bowel-syndrome-ibs/</td>
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<tr>
<td>General information on IBS (UpToDate® – Beyond the Basics Patient information)</td>
<td><a href="http://www.uptodate.com/contents/irritable-bowel-syndrome-beyond-the-basics?source=search_result&amp;search=ibs&amp;selectedTitle=2%7E150">www.uptodate.com/contents/irritable-bowel-syndrome-beyond-the-basics?source=search_result&amp;search=ibs&amp;selectedTitle=2%7E150</a></td>
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<td>Fibre Facts</td>
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<td>Food and Lifestyle Symptom Diary</td>
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**Services available**

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<th>Website</th>
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<tbody>
<tr>
<td>Services for patients with chronic conditions</td>
<td><a href="http://www.albertahealthservices.ca/info/page13984.aspx">www.albertahealthservices.ca/info/page13984.aspx</a></td>
</tr>
<tr>
<td>Supports for working towards healthy lifestyle goals and weight management (Weight Management – AHS)</td>
<td><a href="http://www.albertahealthservices.ca/info/Page15163.aspx">www.albertahealthservices.ca/info/Page15163.aspx</a></td>
</tr>
<tr>
<td>AHS Nutrition Services (information on how to access a dietitian in your area)</td>
<td><a href="http://www.albertahealthservices.ca/info/page16475.aspx">www.albertahealthservices.ca/info/page16475.aspx</a></td>
</tr>
<tr>
<td>Inform Alberta (how to refer to a dietician in your area)</td>
<td><a href="https://informalberta.ca/public/common/index_Search.do">https://informalberta.ca/public/common/index_Search.do</a></td>
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</table>
A Patient’s Pathway for Managing Irritable Bowel Syndrome (IBS)

What is IBS?
Irritable Bowel Syndrome is a disorder that causes pain, bloating, and/or cramping. There may be constipation, diarrhea, or both.

These symptoms can vary in severity and tend to come and go, and are often related to dietary triggers and stress.

It affects approximately 10% of the general population and can have an impact on quality of life.

IBS is usually cared for by healthcare provider(s) in your family doctor’s office.

What is the IBS patient pathway?
It is a map for you and your healthcare provider(s) to follow. It makes sure the care you are receiving for IBS is safe and effective to manage your symptoms.

You and your healthcare provider(s) may modify the pathway to best suit your healthcare needs.

If symptoms cannot be managed over time, you and your healthcare provider(s) may decide a referral to a specialist would be helpful.

1. Check your symptoms
- Pain or discomfort in your stomach that is related to bowel movements and their frequency or change in form.
- Stomach pain may or may not be improved with bowel movements
- Passage of mucous, constipation, or diarrhea
- Bloating or gas

2. Make lifestyle changes to manage your symptoms (see over for details)
- Identify foods that trigger symptoms and try to avoid them
- Increase your fibre intake
- Make sure to get plenty of fluids daily
- 20+ minutes of physical activity almost daily, aiming for 150 minutes/week
- Identify stressors and find ways to manage them

3. Tests that may be done
- Blood and/or stool tests
- Test to rule out celiac disease

4. Medicine that may be tried
- Various options can be used to improve your symptoms (stomach pain, constipation, or diarrhea)
- Be sure to talk with your healthcare provider(s) about what medicines may be right for you

Be sure to tell your healthcare provider(s) if you have these symptoms:
- Family history of colon cancer
- Stool that is black in colour or has blood in it
- Symptoms that often wake you up at night
- Unintended weight loss

If your symptoms don’t improve, get worse, or keep interfering with your everyday activities, talk to your healthcare provider(s).

Once you find something that works for you, stick with it.
You may need to keep trying other options to find what works best to improve your health.
What do I need to know about my symptoms and IBS?

Working through the IBS patient pathway can take several months:

• Your healthcare provider(s) will ask you questions about your health and do a physical exam, including reviewing medicines you are taking.
• They may suggest certain tests to learn more about possible causes of your symptoms.
• They will talk with you about possible lifestyle habits that may be impacting your symptoms and how you can make changes that could help you feel better.
• You may find it helpful to record information about your symptoms and food triggers so you and your healthcare provider(s) can make a plan to manage your symptoms.
• Together, you may decided to try certain medicines to help in treating your symptoms.
• You may use medicines for a short amount of time (or possibly longer) depending on whether your symptoms improve.

To manage your symptoms try to:

• Identify foods that trigger symptoms
• Do 20+ minutes of physical activity almost daily aiming for 150 mins/week (e.g. walking, biking, gardening, stairs, favourite sports)
• Choose high fibre foods like oats, flax, chia, and barley. Slowly increase the amount of fibre you eat, targeting 25g for females and 38g for males.
• Consider the use of a psyllium fibre supplement (e.g. Metamucil)
• Drink plenty of water throughout the day, aiming for 9-12 cups
• Identify situations which cause you stress and try to manage them

Seeing a specialist may be recommended if:

• Symptoms continue or get worse after following treatment and management options in the irritable bowel syndrome pathway.
• Concerning test results or symptoms are identified by you and your healthcare provider(s).

You can find more information in the great resources:

Canadian Digestive Health Foundation
www.cdhf.ca
* search IBS

My Health Alberta
myhealth.alberta.ca
* search IBS

Nutrition Education Materials
www.albertahealthservices.ca/nutrition/Page11115.aspx
• See: Gastrointestinal → IBS
• See: Healthy Eating → Fibre Facts

Write any notes or question you may have here:

If you have any feedback about this patient pathway, contact us at Digestivehealth.SCN@ahs.ca