

# PostScript

## LETTER

### Update on irritable bowel syndrome

We read with interest the recent article on the management of irritable bowel syndrome (IBS).<sup>1</sup> The authors present an overview of the epidemiology, impact, aetiology, diagnosis, and management of IBS. Although the article is informative, we believe that several topics require clarification in light of current knowledge about the pathophysiology of IBS and treatment options for IBS patients.

#### AETIOLOGY: PSYCHOLOGICAL FACTORS

The authors mention that significant psychological symptoms prevail in IBS, particularly among patients referred to gastroenterology clinics. It is true that studies have shown that 54%–94% of patients seen in tertiary referral centres meet the criteria for at least one primary psychiatric disorder.<sup>2</sup> However, only 25%–30% of patients with IBS actually seek care, and of those, fewer than 1% are referred to specialists.<sup>3,4</sup> One study estimates that, in the community setting, the percentage of IBS patients with comorbid psychiatric disturbances is approximately 18%.<sup>5</sup> Furthermore, psychiatric disorders have not been shown to be pathogenic for IBS.

#### AETIOLOGY: PHYSIOLOGICAL FACTORS

The authors acknowledge that altered somatovisceral sensitivity and gut motor dysfunction are possible pathophysiological mechanisms involved in IBS; however, they fail to discuss the role of 5-hydroxytryptamine (5-HT) and its receptors in gut motility, intestinal secretion, and visceral sensitivity.<sup>6</sup> The vast majority of 5-HT in the body (95%)

is stored in enterochromaffin cells and afferent enteric nerves of the gastrointestinal tract, where several 5-HT receptor subtypes have been identified. Substantial evidence underscores the essential role of 5-HT and its receptors, particularly the 5-HT<sub>3</sub> and 5-HT<sub>4</sub> subtypes, in the overall functioning of the gut.<sup>6</sup>

#### DIAGNOSIS

The authors state that targeted investigations are needed to exclude organic pathology when diagnosing patients with IBS. However, these tests are required *only* if “red flags” are present.<sup>7</sup> Studies have shown that additional testing does not alter the rate of IBS diagnosis.<sup>8</sup>

#### MANAGEMENT

The authors present a limited discussion on the use of 5-HT modulators in the treatment of IBS patients. Tegaserod (Zelmac/Zelnorm), which was approved by the US Food and Drug Administration in July 2002 and has also been approved in more than 65 countries worldwide, is indicated for the short term treatment of women with IBS whose primary bowel symptom is constipation. Tegaserod was one of only two IBS treatment options given a grade A recommendation—the most robust—for the treatment of women with IBS and constipation.<sup>7</sup> Both the efficacy and the safety of tegaserod have been demonstrated consistently in several large, randomised, placebo controlled clinical trials (table 1). Treatment with tegaserod 6 mg twice daily resulted in significant global relief of IBS symptoms compared with placebo.

In summary, although some patients with IBS may have comorbid psychiatric disorders, physiological factors are the primary contributors to IBS pathophysiology and symptoms. Recent evidence indicates that 5-HT and its receptors play a critical part in the pathophysiology of IBS, and the highly selective 5-HT<sub>4</sub> receptor agonist tegaserod

has proved safe and effective in relieving the multiple symptoms of IBS in women with IBS-C.

**K A Bergmann**

Dr Karen Ann Bergmann, Novartis Pharmaceuticals Corporation, One Health Plaza, Building 701, East Hanover, NJ 07981, USA; karenann.bergmann@pharma.novartis.com

#### References

- 1 Gunn MC, Cavin AA, Mansfield JC. Management of irritable bowel syndrome. *Postgrad Med J* 2003;79:154–8.
- 2 Whitehead WE, Palsson O, Jones KR. Systematic review of the comorbidity of irritable bowel syndrome with other disorders: what are the causes and implications? *Gastroenterology* 2002;122:1140–56.
- 3 Drossman DA, Whitehead WE, Camilleri M. Irritable bowel syndrome: a technical review for practice guideline development. *Gastroenterology* 1997;112:2120–37.
- 4 Drossman DA, Thompson WG. The irritable bowel syndrome: review and a graduated multicomponent treatment approach. *Ann Intern Med* 1992;116:1009–16.
- 5 Walker EA, Katon WJ, Jemelka RP, et al. Comorbidity of gastrointestinal complaints, depression, and anxiety in the Epidemiologic Catchment Area (ECA) study. *Am J Med* 1992;92:265–305.
- 6 Talley NJ. Serotonergic neuroenteric modulators. *Lancet* 2001;358:2061–8.
- 7 American College of Gastroenterology Functional Gastrointestinal Disorders Task Force. An evidence-based approach to the management of irritable bowel syndrome in North America. *Am J Gastroenterol* 2002;97(11 suppl 0):S1–S26.
- 8 Hamm LR, Sorrells SC, Harding JP, et al. Additional investigations fail to alter the diagnosis of irritable bowel syndrome in subjects fulfilling the Rome criteria. *Am J Gastroenterol* 1999;94:1279–82.

## BOOK REVIEWS

### Clinical Governance.

John Wright and Peter Hill. (Pp 219; £19.99.) Churchill Livingstone, 2003. ISBN 0-443-07126-8.

Clinical governance first arrived in the NHS in 1999, and it would be reasonable to say that initially there was some uncertainty about what it was, although general agreement that it would take some years before it was fully operational. Four years later, reflection is called for on what clinical governance has become, and what it is achieving. In publishing their overview of clinical governance, John Wright and Peter Hill have provided a helpful resource for reflection that will assist the maturation of clinical governance into the all-embracing and reliably effective quality system that health care requires.

The book is intended for medical students, junior doctors, and also senior doctors who are seeking an outline of the methods and some ideas on worthwhile activities. After a description of the principles underlying clinical governance and discussion of the core values in medicine, there are eight chapters

**Table 1** Published literature on the efficacy, safety, and tolerability of tegaserod

Tegaserod, a 5-HT <sub>4</sub> receptor partial agonist, relieves symptoms of IBS in patients with abdominal pain, bloating, and constipation	<i>Aliment Pharmacol Ther</i> 2001;15:1655–66
Safety and tolerability of tegaserod in patients with IBS and symptoms of diarrhoea	<i>Am J Gastroenterol</i> 2002;97:1176–81
Long term safety of tegaserod in patients with constipation-predominant IBS	<i>Aliment Pharmacol Ther</i> 2002;16:1701–8
A randomised, double blind, placebo controlled trial of tegaserod in female patients suffering from IBS with constipation	<i>Aliment Pharmacol Ther</i> 2002;16:1877–88
Tegaserod, a 5-hydroxytryptamine type 4 receptor partial agonist, is devoid of electrocardiographic effects	<i>Am J Gastroenterol</i> 2002;97:2321–27
An Asian-Pacific, double blind, placebo controlled, randomised study to evaluate the efficacy, safety, and tolerability of tegaserod in patients with IBS	<i>Gut</i> 2003;52:671–6

dealing with different components, including evidence based practice, lifelong learning, reducing errors, clinical guidelines, audit and changing practice, communication and complaints, outcomes and monitoring performance, team work, and working in a managed health service. Clinical governance, then, clearly covers a vast agenda.

This is not an edited, multi-author publication, and consequently the book presents a coherent picture of clinical governance, and has a consistent style. Each chapter includes several examples that both enliven the text and highlight key messages. There are also numerous figures and tables that ensure that every facet is covered somewhere, and consequently the book offers the novice comprehensive guidance in a digestible format. The book will not, nor is intended to, provide the in-depth analysis that a practitioner already familiar with, or with responsibility for leading, clinical governance would require. It is also firmly intended for doctors, and other health professionals should seek alternative publications.

The authors are to be commended for discussing core values in medicine early in the book and showing them to be the foundation for much that is involved in clinical governance. Of course, some values are open to debate, as the authors make clear in their discussion of rationing. However, although both sides of the argument should be presented, the tone sometimes became rather negative, as in the initial mention of appraisal in the first chapter that rather undermines the more detailed discussion later in the book, or in the chapter dealing with performance monitoring.

Finally, what insight does the book give into the progress of clinical governance? Much appears to have happened—structures have been set up in all NHS organisations, a wide variety of activities to improve quality and reduce error is underway, various national agencies have been created, and an image is beginning to emerge of the big idea that underpins them all. Clinical governance is both a system to improve quality and a strategy to change the way the NHS behaves towards the people who use it.

**R Baker**

University of Leicester, Department of General Practice and Primary Health Care, Leicester General Hospital, UK; rb14@le.ac.uk

### Recent Advances in Surgery.

Edited by Irving Taylor and Colin Johnson. (Pp 241; £35.) Royal Society of Medicine Press, 2003. ISBN 1-85315-551-9.

The 26th part of the Recent Advances series contains 16 chapters arranged into five sections: basic science and gastrointestinal, vascular, breast, and general surgery. Each section has a few chapters covering topical subjects. This approach works well and although the coverage is not comprehensive, the chapters provide bite sized updates that can be easily digested by a busy consultant. Keeping up to date with advancing areas in surgical specialties is relevant to all general surgeons who participate in an emergency rota and teach trainees.

The final chapter in the book contains a selection of important randomised controlled trials in surgery over the last year. Each trial is briefly described, including the main findings of the study. In addition, summary key points are listed throughout the chapter. This is a useful synopsis of randomised trials over the past 12 months, but the quality of evidence for the key bullet points is variable. Some recommendations are based on high quality meta-analyses, whereas other recommendations are based on single randomised trials that are not described in sufficient detail to reassure the reader that the methods are robust. Translating research into clinical practice requires reliable data. It would be useful if the grading of evidence could be included in these surgical trials. In general, however, the scientific standards throughout the book are good and references from high quality studies are cited to support recent advances.

The text is easy to read and well illustrated with summary tables and algorithms. There are a few typographical errors and some of the figures are poorly labelled, but overall it is excellent and clinically relevant. This book is a painless way to update your knowledge of recent advances in surgery. It is well written and suitable for a tired surgeon after a day's work.

**J M Blazeby**

Department of Surgery, Bristol Royal Infirmary, UK; j.m.blazeby@bristol.ac.uk

### Medicine & Myths.

Richard Heatley. (Pp 136; £14.99.) Published by www.medicineandmyths.com, 2003. ISBN 0-95444-2105.

Medicine is full of myths and sometimes we even recognise them as such. This book is an attempt to give us an overview of some of the myths common (mostly) in the western tradition. The text is ordered alphabetically according to "indication"—from abortion to

whooping cough. The author did well in putting a strong disclaimer at the beginning which states, "don't do this at home". Most of the "myths" relate to herbal remedies used for centuries for certain conditions. Some of the "myths" turn out to be truths—for instance, kava is a herbal anxiolytic, and this is even supported by a positive Cochrane review.

A book of this nature needs to be rated foremost on its entertainment qualities. The reader learns all sorts of interesting things. For instance, did you know that honey wine was touted as an aphrodisiac, hence the term "honeymoon"? Sadly, the reader is also often misled. Essiac, a herbal "cancer cure" has *not* been found to be "weakly effective" (p 42). The truth about Essiac is that there is not a single trial to suggest that it works.

And here is where I find this book slightly tedious. I had expected a witty and entertaining bedtime read. Instead, I found a distinctly unfunny text containing lots of misinformation and plenty of inadequately researched pseudo-knowledge. Thus I wonder who will read this text; experts will not enjoy it because it contains too many mistakes, and the lay reader might find the pseudo-scientific gloss tiresome or unnecessary. The author mentions hops, valerian, and lavender for insomnia—sadly, based on my own single case study, I recommend this book for that indication.

**E Ernst**

Department of Complementary Medicine, School of Sport and Health Sciences, University of Exeter, UK; edzard.Ernst@pms.ac.uk

## BOOKS RECEIVED

*The receipt of these books is acknowledged and this listing must be regarded as sufficient return for the courtesy of the sender. Books that appear to be of particular interest will be reviewed space permitted. The journal does not publish unsolicited reviews.*

**Probiotics for Crohn's & Colitis.** Peter Cartwright. (Pp 128; £9.99.) Prentice Publishing, 2003. ISBN 0-9544438-0-2.

**Intrapartum Care.** Thomas F Baskett and Sabaratnam Arulkumaran. (Pp 211; £22.00, £16.50 to Fellows and Members of the RCOG). Royal College of Obstetricians and Gynaecologists, September 2002, ISBN 1-900364-73-5.