

EDITORIAL

## Irritable bowel syndrome (IBS) subtypes: Nothing resembles less an IBS than another IBS

Two new members of “IBS Patient Association” met at a meeting. Feeling somewhat lost, not knowing anybody present, they introduced themselves to each other. After exchanging names, one asks the other - “What’s your problem?” The other one answers - “I got constipation that laxatives fail to relieve, and my belly, which is always bloated, sometimes hurts so much that I can’t even leave home”. Deeply surprised, the first individual inquires – “What are you doing here then?” “Why, I came to this meeting looking for some help for my irritable colon”, she answered. “Irritable colon? That’s no irritable colon. Irritable bowel syndrome is what I suffer from, and it’s diarrhea that won’t let me be; can’t stop running to the toilet, and cramps just pop up any time”. Now both looked surprised. Both thought they had come to the wrong meeting, and both were on the verge of leaving. Luckily, the Association’s secretary showed up and explained that both had IBS.

As is well known, IBS clinical manifestations are highly variable and heterogeneous, and various symptom associations may develop. This includes both patients with abdominal pain and diarrhea, and individuals who suffer from constipation, with abdominal distension or bloating also representing a common finding (1). Furthermore, patients with IBS usually report symptoms characteristic of other functional disorders, whether digestive or otherwise. Thus, about half of IBS cases have gastroesophageal reflux disease (GERD) or functional dyspepsia (2,3), and IBS is also commonly associated with fibromyalgia, chronic fatigue syndrome, interstitial cystitis, tensional headache, etc. (4,5).

Most outstanding, possibly, is the fact that this syndrome includes both patients with constipation and patients with diarrhea, or even individuals where these two symptoms alternate. This is why, according to the Rome II criteria, three IBS subtypes were described years ago: 1. With predominant constipation; 2. With predominant diarrhea; and 3. With mixed bowel pattern (6). Subtypes were established according to the following symptoms: 1. Fewer than 3 stools per week; 2. More than 3 stools per week; 3. Hard or ball-shaped feces; 4. Soft or liquid feces; 5. Straining during stool evacuation; 6. Urgency. Hence, the predominant constipation subtype is considered when 1, 3 and/or 5 and neither 2, nor 4 nor 6 are present; the predominant diarrhea subtype requires 2, 4 and/or 6 and none of 1, 3, 5; and the mixed subtype requires diarrhea/constipation changes not meeting the above two criteria. However, according to Rome III recommendations, subtypes were later defined according to stool consistency as assessed using the Bristol Stool Scale (7). Thus, when over 25% of stools correspond to type 1 or 2, the patient is deemed to suffer from IBS with constipation; when over 25% of stools are of type 6 or 7, the patient is considered to have IBS with diarrhea; when over 25% of both (1 or 2, 6 or 7) are present, IBS with mixed bowel habit is diagnosed; finally, when less than 25% of both are present, the case is said to be unspecified bowel pattern. The term “alternating” is restricted to changes along prolonged periods.

The distribution of the various IBS subtypes is approximately one third for each subtype, although this may vary according to criteria and the population assessed (8,9). In turn, while stability over time is debated for these subtypes, the key fact is that the transition from constipation to diarrhea or vice versa is uncommon, whereas both subtypes may ultimately result in or from the mixed (or alternating) type (10,11).

In the paper by Cristiane Kibune-Nagasako et al. (Campinas, São Paulo, Brazil) included in this issue of *The Spanish Journal of Gastroenterology (Revista Española de Enfermedades Digestivas)* the differences between IBS subtypes are again underscored (12). The authors conclude that IBS with mixed bowel habit (IBS-M) is characterized by both constipation and diarrhea (IBS-C and IBS-D) symptoms, which is obvious, and note that patients with this subtype suffer from higher anxiety and comorbidity levels, including GERD.

May this paper help recall IBS heterogeneity and the need to define cases according to each individual’s predominant symptoms and associated complaints. Establishing an origin or primary pathophysiological mechanism for each case is also crucial. In fact, subtypes should not be limited to IBS-C, IBS-D and IBS-M. When pain or distension/bloating predominates, IBS management differs, and the addition of subtypes such as IBS-P and IBS-B would seem logical. Similarly, IBS could be classified according to potential causes: IBS-post-infection (13), IBS-post-trauma (14), IBS-atopic (15), IBS-post-diverticulitis (16), IBS-associated with emotional factors (17), etc.

Kibune-Nagasako et al. conclude in their paper that patients with IBS-M have special characteristics to be considered regarding their management. This mark-hitting claim should be extrapolated to all IBS subtypes and to each and every patient with this syndrome. As a matter of fact, in the above-mentioned “IBS Patient Association” meeting no two cases were exactly alike.

Fermín Mearin

*Instituto de Trastornos Funcionales. Chairman, Roma IV Committee on Functional Gastrointestinal Disorders. Centro Médico Teknon. Barcelona, Spain***REFERENCES**

1. Longstreth GF, Thompson WG, Chey WD, et al. Functional bowel disorders. *Gastroenterology* 2006;130:1480-91. DOI: 10.1053/j.gastro.2005.11.061
2. Balboa A, Mearin F, Badía X, et al. Impact of upper digestive symptoms in patients with irritable bowel syndrome. *Eur J Gastroenterol* 2006;18:1271-7. DOI: 10.1097/01.meg.0000243870.41207.2f
3. Gasiorowska A, Poh CH, Fass R. Gastroesophageal reflux disease (GERD) and irritable bowel syndrome (IBS) - Is it one disease or an overlap of two disorders? *Dig Dis Sci* 2009;54:1829-34.
4. Vandvik PO, Wilhelmsen I, Ihlebaek C, et al. Comorbidity of irritable bowel syndrome in general practice: A striking feature with clinical implications. *Aliment Pharmacol Ther* 2004;20:1195-203. DOI: 10.1111/j.1365-2036.2004.02250.x
5. Whitehead WE, Palsson OS, Levy RR et al. Comorbidity in irritable bowel syndrome. *Am J Gastroenterol* 2007;102:2767-76. DOI: 10.1111/j.1572-0241.2007.01540.x
6. Thompson WG, Longstreth GF, Drossman DA, et al. Functional bowel disorders and functional abdominal pain. *Gut* 1999;45(Supl. 2):1143-7. DOI: 10.1136/gut.45.2008.ii43
7. Lewis SJ, Heaton KW. Stool form scale as a useful guide to intestinal transit time. *Scand J Gastroenterol* 1997;32:920-4. DOI: 10.3109/00365529709011203
8. Guilera M, Balboa A, Mearin F. Bowel habit subtypes and temporal patterns in irritable bowel syndrome. Systematic review. *Am J Gastroenterol Am J Gastroenterol* 2005;100:1174-84. DOI: 10.1111/j.1572-0241.2005.40674.x
9. Mearin F, Balboa A, Badía X, et al. Irritable bowel syndrome subtypes according to bowel habit: Revisiting the alternating subtype. *Eur J Gastroenterol Hepatol* 2003;15:165-72. DOI: 10.1097/00042737-200302000-00010
10. Mearin F, Lacy B. Diagnostic criteria in IBS: useful or not? *Neurogastroenterol Motil* 2012;24:791-801.
11. Drossman DA, Morris CB, Hu Y, et al. A prospective assessment of bowel habit in IBS: defining an alternator. *Gastroenterology* 2005;128:580-9. DOI: 10.1053/j.gastro.2004.12.006
12. Kibune-Nagasako C, Garcia-Montes C, Silva-Lorena SL, et al. Irritable bowel syndrome subtypes: Clinical and psychological features, body mass index and comorbidities. *Rev Esp Enferm Dig* 2016;108:59-64.
13. Thabane M, Kottachchi DT, Marshall JK. Systematic review and meta-analysis: the incidence and prognosis of post-infectious irritable bowel syndrome. *Aliment Pharmacol Ther* 2007;26:535-44. DOI: 10.1111/j.1365-2036.2007.03399.x
14. Perona M, Benasayag R, Perelló A, et al. High prevalence of functional gastrointestinal disorders in women who report domestic violence to the police. *Clin Gastroenterol Hepatol* 2005;3:436-41. DOI: 10.1016/S1542-3565(04)00776-1
15. Tobin MC, Moparty B, Farhadi A, et al. Atopic irritable bowel syndrome: a novel subgroup of irritable bowel syndrome with allergic manifestations. *Ann Allergy Asthma Immunol* 2008;100:49-53. DOI: 10.1016/S1081-1206(10)60404-8
16. Cohen E, Fuller G, Bolus R, et al. Increased risk for irritable bowel syndrome after acute diverticulitis. *Clin Gastroenterol Hepatol* 2013;11:1614-9. DOI: 10.1016/j.cgh.2013.03.007
17. Chang L. The role of stress on physiologic responses and clinical symptoms in irritable bowel syndrome. *Gastroenterology* 2011;140:761-5. DOI: 10.1053/j.gastro.2011.01.032