Aetiology

- Functional bowel disorder
- Abdominal pain associated with defecation
- Young women affected 2-3x more than men

Co-existing conditions
- Non-ulcer dyspepsia
- Chronic fatigue syndrome
- Dysmenorrhoea
- Fibromyalgia
- A significant proportion of sufferers have been victims of physical or sexual abuse
Malabsorption and Coeliac Disease
Aetiology

- Abnormal host response to environmental trigger causing inflammation
- Inflammatory mediators such as TNF, IL-12 and IL-23 cause tissue damage
- Intestinal wall is infiltrated with acute and chronic inflammatory cells
Investigations

• Bloods
  • FBC – may show anaemia
  • CRP and ESR – elevated in exacerbation, due to inflammatory response
  • Albumin – may be reduced due to protein-losing enteropathy, inflammatory disease or poor nutrition

• Stool culture
  • Rule out infection

• Endoscopy with biopsy
  • Crohn’s
    • Patchy inflammation
    • Discrete, deep ulcers
    • Perianal disease (fissures, fistulas, skin tags)
    • Rectal sparing
    • Strictures are common
  • UC
    • Loss of vascular pattern
    • Granularity
    • Friability
    • Ulceration
    • Stricture formation does not happen in absence of carcinoma

• Radiology
  • Barium enema can identify strictures and narrowing – not commonly used, MRI more reliable
  • Plain XR in severe active disease can reveal dilation, oedema or perforation
Management – UC

• Treat acute attacks
  • Mesalazine – oral combined with suppositories or enemas
  • Patients who fail to respond can be given prednisolone
  • Patients who do not respond to corticosteroids can be given ciclosporin or infliximab
• IV fluids
• Prevent relapse
  • Life-long maintenance therapy
  • Oral aminosalicylates (mesalazine or balsalazide)
  • Sulfasalazine has more AEs but can be used in a pt with coexisting arthropathy
  • Thiopurines can be used in those who relapse even though on aminosalicylates
• Detect carcinoma
• Select patients for surgery
  • Colectomy in those who fail to respond to drug treatments or those who develop colonic dilatation
Management

• If asymptomatic, requires no treatment
• Constipation – high fibre diet
• Can use bulking laxatives, never use stimulant laxatives
• Antispasmodics may help
• Acute attack – 7d metronidazole w/ cephalosporin or ampicillin
• Severe cases – IV fluids, IV antibiotics, analgesia, NG suction
• Emergency surgery – severe haemorrhage or perforation
• Percutaneous drainage of acute paracolic abscesses may avoid the need for emergency surgery
• Elevtive surgery may be performed after recovery from repeated attacks of obstruction – resection of affected segment with primary anastamosis