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 exacerbations 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